

# *Bristol* *Mind*

First Reprint April 2004

## **USER FOCUSED STUDY OF INPATIENT SERVICES IN THREE BRISTOL HOSPITALS**

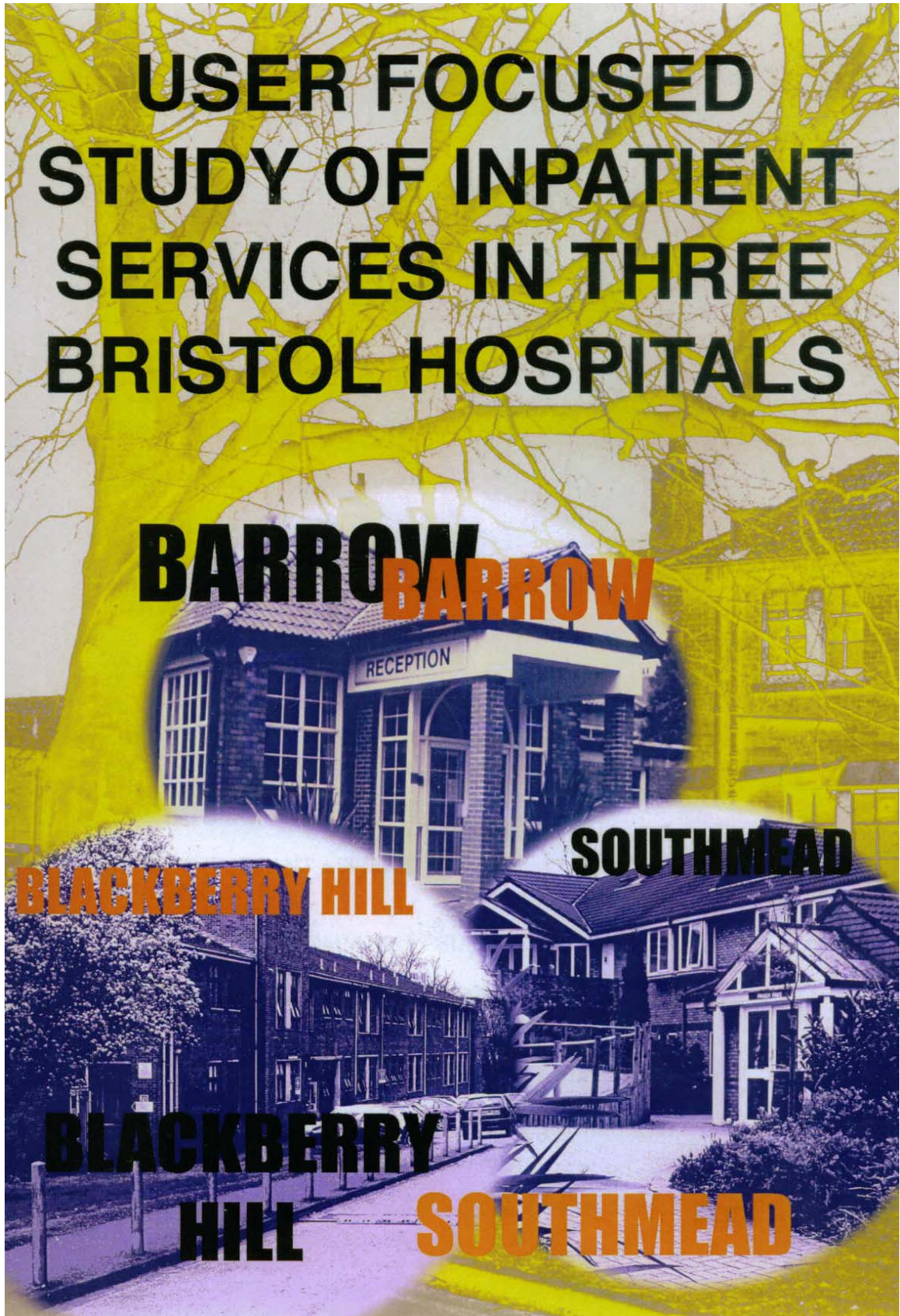
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## An Update to the Second Edition

This report - the first Bristol Mind User Focused Monitoring research project - was produced in April 2002. The motivation for service user involvement in research is a desire to improve services, so getting things to change as a result of the research was seen as very important within the UFM project.

After the report was published the UFM Action Group was set up to consider the findings of the report and see what could be done about the problems which had been identified. The report confirmed issues that service users and user groups had been campaigning on and raising for many years. The UFM Action Group was set up as a sub-group of the Bristol Clinical Governance Forum i.e. within the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). The group has had an open membership and has included service users from other user groups, UFM Service User Workers and Trust staff. The UFM Action Group provided an opportunity for health professionals and service users to work together to improve services.

The UFM Action group has tackled a number of different issues, for example, problems with provision of clean bed linen, and the lack of an allocated Key/Named nurse. Some areas that were identified as important to work on have been harder to tackle, for example, patients feeling unsafe. This is because there are no quick solutions to this issue and the action group will continue to work on this issue with others.

Of the many issues that were identified as being important, it was decided to tackle the process of admission to acute adult mental health wards, the research project found that admission was often a very difficult and stressful time, with little information being made available. The other area identified as a problem was lack of patient information about what to expect on the wards. An Admissions Sub Group was formed specifically to tackle these two areas, this was a small working group, chaired by a UFM Project Worker, which included several service users and staff.

The aim of the sub- group was to draft a Patient Information Booklet for adult mental health wards in Bristol and to develop a service user focused Admissions Checklist. As the work developed, the mental health care trust decided to develop the booklet and checklist across the whole trust area. Rosie Davis a service user linked to UFM played a lead role in developing this initiative. The Patient Information booklet is being launched across the trust area in April and May 2004, the booklet and launch being funded by the Trust.

The Patient Information Booklet will be given to all adult inpatients right across the trust area. There is also a feedback form to see whether the standards of care described in the booklet are being delivered to patients. The Group has also produced suggestions for the production of local information, that local hospital sites and wards need to provide. The Admissions Checklist has also been agreed, and will also be implemented in all wards across AWP.

The Admissions Sub Group attempted to involve as many people as possible in the process of producing this information. There were two rounds of consultation on both the Booklet and Checklist with staff and service user groups all round the area. All feedback received was discussed carefully within the group.

The hope is that the patient information booklet and checklist will lead to better patient experiences on the wards and that it will be something that patients will be able to use as a point of reference for the standard of care they are receiving and to improve standards of care. There is a sense of achievement within the UFM team and others groups that the research and the UFM Action Group has been able to do something concrete which we hope will improve people's experience of inpatient care. Of course there is still a long way to go, there are many more recommendations in this report that we hope to see addressed in the future.

Service/Survivors and staff have all strived to make this happen and have worked hard to make things better - we look forward to this work continuing.

Bristol Mind UFM Team  
April 2004

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# Mind

## Affiliated Local Association

### A USER-FOCUSSED STUDY OF THREE INPATIENT UNITS IN BRISTOL

*A PROJECT SUPPORTED AND MANAGED BY BRISTOL MIND*

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I would like also to acknowledge the work of John Marsh and Martin Sandbrook who were consultants for the Inner City Consultation project, which both myself and other project workers attended as sessional interviewers.

**Most importantly I would also like to thank all the patients who were prepared to give of their time in order to share their experiences with the research team.**





## **USER-FOCUSSED MONITORING – AN OVERVIEW**

### **Introduction**

User-focussed monitoring (UFM) is a way of conducting mental health research that attempts to place mental health service users at the heart of the process. People who have had, or are currently experiencing mental health difficulties, are supported and given training in designing questionnaires and interviewing other service users who have recently used mental health services. This way of conducting research:

- seeks to give prominence to mental health service user's views in the type of questions that are asked and information gathered
- lets interviewees know that they are being interviewed by people who have experience of using mental health services themselves
- enables mental health service users to provide information to people directly involved in providing the services they are using or have used.

The aim of UFM projects is to evaluate and make positive changes to the way mental health services are provided and run.

User-focussed monitoring was first developed by the Sainsbury Centre for Mental Health with a group of mental health service users in the London borough of Kensington, Westminster and Chelsea<sup>1</sup>. One of the lead pioneers of this type of research is Dr Diane Rose<sup>2</sup>. User-focussed monitoring claims several advantages over health professional-based ways of getting service users' views of service provision. These include:

- the establishment of a greater rapport with the interviewees, as the interviewers have been there themselves
- users are more likely to disclose what they really think about their situation to other service users, rather than to other researchers<sup>3</sup>
- it helps to bring out views which may be different from those of professionals
- service user interviewers may better understand people's difficulties in understanding technical jargon e.g. PCG, LIG, JIP etc.

There has been a long history of service users involvement in doing research and commenting on their conditions of care<sup>4</sup>; groups such as UKAN, Survivors Speak Out, the Mental Health Foundation, and Mad Pride<sup>5</sup> also help complement existing and other forms of research<sup>6</sup>.

## **History of user-led research in Bristol**

Prior to the present study there have been a number of user-led research projects in Bristol. In 1999 John Marsh and Martin Sandbrook were commissioned to facilitate a user-led research project looking at the needs of mental health service users in the inner city<sup>7</sup>. The Barrow Hospital Patients' Council carried out a small-scale evaluation study of service users' experiences of using the recently formed 'South Bristol Intensive Support Team'<sup>8</sup>. They also undertook a joint project with the Black advocacy organisation Black Orchid looking at the views of service users in medium secure accommodation as to how a new rehabilitation inpatient unit could be provided<sup>9</sup>.

In the light of the success of these and other user-led research projects in the South West, and a government-led emphasis on putting service users' experiences at the centre of the planning process (see: National Service Framework for Mental Health) the Bristol Local Implementation Group secured a budget leading to a tendering process for a local organisation to set up a pilot project looking at patients' experiences of using inpatient facilities in the Bristol area. Bristol Mind was awarded the contract.

The decision to look at inpatient facilities was the result of extensive consultation with service user groups and statutory and voluntary service providers. It was opportune as the mental health Trust has plans to extensively modernise its inpatient facilities, partly due to the fact that some of the facilities (particularly those at Barrow Hospital) are structurally badly in need of refurbishment.

The central aim of the present study is to feed back to both service providers and people responsible for commissioning services the views of patients who have recently experienced a period of time as a psychiatric inpatient at one of the three Bristol psychiatric hospitals: Barrow, Southmead and Blackberry Hill. The commissioning managers of the two new Bristol Primary Care Groups have undertaken to feed some of the findings into the service commissioning process in the interests of trying to drive up inpatient standards of care. We hope to avoid the fate of user-led studies gathering dust on shelves while nothing practical is implemented; however only time will tell.

## **HOW THE STUDY WAS CARRIED OUT**

### **Initial months**

The project budget allowed Bristol Mind to recruit a Project Development Worker who spent the first couple of months publicising the project, holding open meetings for people who wanted to work with the project and attending service user groups to talk about the project. Ethical approval from the local medical ethics committee was also obtained. The project recruited 18 service users most of whom stayed with the project throughout, despite sometimes having to take time out due to health, work or family commitments.

As well as making a small payment of £10 to people being interviewed in recognition of their time and trouble in sharing their views and experiences, everyone doing work for the project was to be paid. This involved doing some initial work with the Benefits Agency around ensuring that people who wanted to could register for therapeutic earnings; for this we developed some Benefits Agency and G.P.-friendly forms. The Sainsbury Centre for Mental Health who provided some training input and consultancy advice for the project were very helpful at this stage.

### ***Sample of interviewees***

With the help of the Avon and West Wiltshire Partnership NHS Trust (AWP), we calculated that approximately 1000 people were admitted to the three hospitals, Barrow, Southmead and Blackberry Hill within the year April 2000-April 2001. The Trust wrote randomly to 500 of these former patients enclosing an invitation to participate in the study and including information on Bristol Mind and the purpose of the study. Former patients were assured that participation was voluntary and their comments would be kept confidential, in as much as the patient wouldn't be identifiable. Of these 500 people, 109 replied saying they would be willing to participate and 20 replied saying they were not willing to take part.

All 109 respondents were offered the opportunity of an interview; of these, 76 interviews were completed. Most were face-to-face interviews with service user interviewers either at the respondent's home or at the Bristol Mind office. Two chose to be interviewed over the phone and two chose to self-complete the form and return it.

### ***Training the interviewers***

All interviewers engaged in a six half-day training programme which was partly facilitated by the Sainsbury Centre for Mental Health. Some service users found the training a little too rushed so additional days were organised at Bristol Mind to help improve people's confidence and iron out any difficulties with the questionnaire. Initially, we used a questionnaire designed by the Sainsbury Centre, but by the end of the process the original was barely recognisable and our preferred questionnaire had become a bit of a weighty but comprehensive tome.

### ***Data collection***

Our initial intention was to collect the views of about 80 patients who had been inpatients as well as the views of about 50 people who were currently inpatients. The latter stage of the project was rather unsuccessful with a very poor response rate. I suspect we were over optimistic in thinking that from a sample of 100 people who were currently inpatients we would get a return of 50 patients replying. We were only able to conduct five interviews with current inpatients. This was partly due to the fact that people are often ill when in hospital and we also found that mail sometimes goes astray in inpatient units.

Before the main interviews, we carried out two community interview pilots and two pilot interviews with inpatients. These led to only minor modifications being made to the original questionnaire.

We had planned to compare the ethnicity of our sample with that of the general ethnic makeup of the overall number of inpatients admitted to the three hospital sites in the year we were sampling. Unfortunately that information was unavailable from the AWP Trust. In our community sample we had four patients who identified as being non-white. We felt that this was probably unrepresentative of the overall inpatient population so we contacted both Dhek Bhall (Bristol's Asian women's group) and Black Orchid (Bristol's Black advocacy group) and carried out some more in-depth interviews with one service user from the former group and five from the latter group. We also interviewed one service user who had used the Rough Sleeper Initiative provided by one of the mental health supported housing associations. We do not claim to have covered all the groups necessary to ensure the study was totally representative. However we hope these interviews may have made up for some of the possible sample bias that a randomised self-complete postal interview invitation may have produced.

### ***Data analysis***

We used a mixture of five-point satisfaction scales, comment sections for qualitative information and a section at the end of the questionnaire for more open-ended questions. All the service users involved with the project were active in helping to suggest and phrase the questions in the final schedule. We used the statistical package SPSS for analysing the quantitative aspect of the study, and themed analysis for exploring the qualitative material.

At the end of the questionnaire we asked several questions as to how interviewees had found the interview. We were pleased to find that 90% of our total respondents found the interview questions clear. Despite the fact that the interviews often took a long time, just over 80% of people felt the time taken by the interview was about right. Some interviewees commented that it was the first time they had ever been asked their views regarding the services they had been receiving.

An important element of the project was Bristol Mind's ability to be able to send out information about a range of issues to people who had been interviewed. Many interviewees had little knowledge of what community support was available and the project sent out lots of information including: crisis card packs, information on advocacy services, information about patient support and self-help groups, telephone support lines and drop-ins etc.

### **Later stages**

#### ***Drawing up the recommendations***

After the initial information gathering and analysis, the team met over three whole-day sessions and used the information gained to make recommendations. This drew upon the results that had been found from the analysis and the experiences team members had often had of being inpatients themselves.

### **Notes**

<sup>1</sup> Diane Rose et al (1998) 'In our experience'. Sainsbury Centre for Mental Health: London.

<sup>2</sup> Diane Rose (1996) 'Living in the community'. Sainsbury Centre for Mental Health: London; Diane Rose (2001) 'Users' voices'. Sainsbury Centre for Mental Health: London.

<sup>3</sup> Rogers, A., Pilgrim, D. & Lacey, R. (1993) 'Experiencing psychiatry: Users' views of services'. Macmillan and MIND: London.

<sup>4</sup> In 1845, a group of ex-patients formed the *Alleged Lunatics' Friend*

*Society* in an attempt to combat the oppression of British psychiatric patients and ex-patients.

<sup>5</sup>Curtis, T., Dellar, R., Leslie, E. & Watson, B. (2000) 'Mad Pride: a celebration of a mad culture'. Spare Change Books: London.

<sup>6</sup>Faulkner, A. & Thomas, P. (2002) 'User-led research and evidence based medicine'. *British Journal of Psychiatry*, 180.

<sup>7</sup>Marsh, J. & Sandbrook, M. (1999) 'Everyone has a stake in mental health'. Unpublished but available at: [www.tqp.com](http://www.tqp.com)

<sup>8</sup>Patients' Council (1999) 'South Bristol Intensive Support Team Service User Study'. Unpublished but available from: The Patients' Council, Barrow Hospital, Barrow Guernsey, Bristol.

<sup>9</sup>Patients' Council/Black Orchid (2000) 'Low Secure Study'. Unpublished but available from: The Patients' Council, Barrow Hospital, Barrow Guernsey, Bristol.



## ABOUT THE STUDY RESPONDENTS

### Characteristics of the study respondents<sup>1</sup>

#### *Number of patients at each hospital site:*

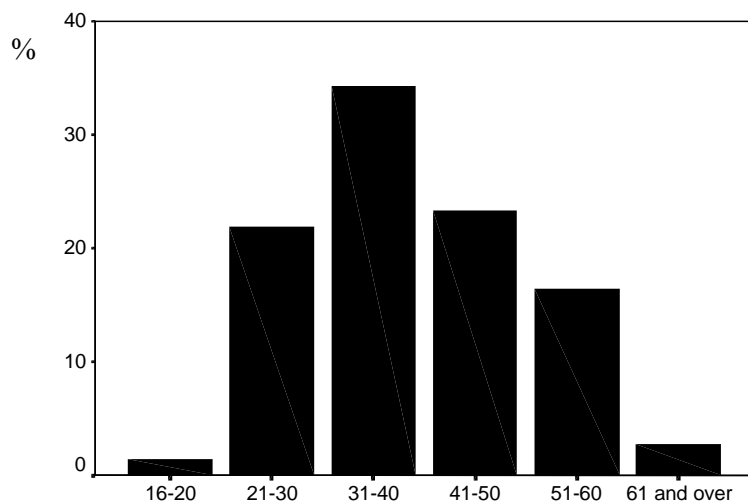
Barrow	52% (n=39)
Southmead	32% (n=24)
Blackberry Hill	16% (n=12)

#### *Gender:*

Male	43% (n=32)
Female	57% (n=42)

#### *Age range:*

n=73



Age group

#### *Sexual orientation:*

Straight	76% (n=58)
Gay/lesbian	3% (n=2)
Bisexual	5% (n=4)
Answer not given or unclear	16% (n=12)

#### *First psychiatric admission:*

No	75% (n=57)
Yes	25% (n=19)

***Type of diagnosis patient said they were given:***

<b>Type of diagnosis patients said they were given</b>	<b>Number of respondents</b>
Depression	25
Dual diagnosis	13
Bi-polar disorder	12
Schizophrenia	6
Mania	3
Eating disorder	2
Personality disorder	2
Other	8
Don't know or no diagnosis given	5

***Number of patients agreeing with diagnosis:***

Agree	50.0% (n=38)
Disagree	18.4% (n=14)
Don't know	15.8% (n=12)
No reply or Not applicable	15.8% (n=12)

**Notes**

<sup>1</sup>%=valid percentages used throughout study.



## **THE THREE HOSPITALS IN THE STUDY**

The three hospitals included in the study are all very different.

**Barrow** is an old hospital site. Many of the wards are in need of major refurbishment and have shared accommodation in dormitories. It is situated about seven miles outside Bristol near the village of Long Ashton. A hospital bus runs between the hospital and the Bristol Royal Infirmary near the city centre. Barrow is surrounded by protected woodlands and the wards are built around a horseshoe shaped driveway about a mile all round. There are no local community facilities off site, the village being about a 25-minute walk from the hospital.

**Southmead** is a newish psychiatric inpatient unit built on the site of a larger general hospital. It offers single rooms and is accessible by public transport. The site is surrounded by local authority housing stock. There are no easily accessible off site shops or community facilities.

**Blackberry Hill** has one acute psychiatric inpatient ward and is based on a site that acts as a teaching campus for Health and Social Care students, including nurses. The site used to be called 'Glenside' and was an old Victorian asylum which was wound down and closed in the 1990s. The site also has a forensic medium secure unit called 'Fromeside' and a recently opened 'Low secure –rehabilitation unit'. There are extensive plans to expand forensic services on this site in the near future. The site also has several outpatient facilities specialising in substance misuse and a more general psychiatric outpatient facility. The nearest shops are about a 15-minute walk and the site is surrounded by new build housing developments. It is serviced by local public transport.

## **SECTION 1: ADMISSIONS**

**This first section deals with patients' admission to hospital and includes such things as: how they reached hospital, patients' awareness of their legal rights, and information about the hospital facilities and routines as well as patients' impressions of the hospital site. It also includes their knowledge and awareness of their Named or Key Nurse who may play a vital role in how their care is coordinated while they are in hospital.**

## ADMISSION TO HOSPITAL

Three-quarters (75%, n=57) of the people in the study had had a previous admission to a psychiatric hospital; two-thirds (65%, n=49) had already been admitted to the hospital in question, and over half 52% (n=39) had had a previous admission to the particular ward. The majority of patients for whom this was their first admission to a psychiatric hospital were under the age of 40.

At the time of admission, 83% (n=63) of the patients were not offered any alternative to a hospital admission. Over a half (54%, n=40) of the patients said that they were satisfied with the way they were admitted, but almost a quarter (23%, n=17) were very dissatisfied. Reasons given for such dissatisfaction were:

- Having to wait and hang around a long time prior to admission i.e. in A&E.
- Feeling that it would have been better to be cared for at home.
- Dissatisfaction with having to share with a stranger.
- ‘Shocked at the state of the wards.’
- A lack of information about suitable personal articles allowed on the ward.
- Not being allowed to take herbal sleeping tablets.
- Staff not making time to welcome the patient to the ward or explain the hospital routines.

Almost two-thirds (63%, n=22) of the women interviewed, and over a third (37%, n=13) of the men felt that the way they were admitted to the hospital could be improved.

The things that most people wanted to be improved were:

- The way in which patients were welcomed to the ward.
- The provision of information about the hospital or ward on admission.

One patient commented:

*“When I arrived they just told me where the room was...didn’t say there were any rules...just finding out as I went along... I had to try to remember from ten years ago.”*

### **Contact with the police prior to admission**

Almost a quarter of the patients interviewed had had some contact with the police prior to admission (including all four service users from minority ethnic groups). Of these 16 patients, half felt as though they had been treated with dignity and respect throughout their contact with the police, and half did not. Some patients praised the sensitivity of the police in not arresting them if they were causing difficulties in a public place, and in the supportiveness of certain officers:

*“One officer was brilliant when I’ve needed help regarding problems...he looked in on my family and is going to support us in relation to an automobile accident.”*

However some comments give rise to concern:

*“Police asked if anyone available to look after children, but didn’t follow up.”*

*“Backdoor framework kicked off - house wasn’t locked up - it was reported the next day to the council, but not repaired. This is why everything was taken.”*

*“Would have helped if they had talked more before knocking down the door. Door was broken down on top of me.”*

(Comment by female patient who was also unhappy about being physically removed from the house by two male officers)

*“The police acted like I was the law breaker and therefore I was treated like a criminal, and my concerns voiced over me going to hospital were insignificant to the police.”*

(Comment by Black female patient)

Worryingly, one service user commented that during a domestic dispute her partner had alerted the police to her mental health history. This had resulted in her being detained. Whilst detained, the patient’s partner had stolen her possessions.

### **Admission under the Mental Health Act**

Approximately a quarter (n=18) of patients had been admitted under a section of the Mental Health Act, including three of the four service users from ethnic minority groups. Ten of those detained reported receiving no information of their rights under the Mental Health Act. Of the eight



detained patients who did receive information about their rights, only four found the information helpful.

Eleven of the 18 detained patients appealed against their section, most patients (seven of the 11) appealing to a Mental Health Act tribunal. Of the 11 patients who had appealed, seven had made use of an advocate and five said that they had found advocacy helpful.

When asked whether they thought that they had had a fair hearing, six patients felt that they had, four thought not and one did not know.

Some patients seemed to be prepared to accept a hearing's findings as fair even when they did not agree with it, as long as it was explained:

*“Fine, but didn't get the result I wanted. A manager explained the result.”*

Some, however, were less happy with both the hearing and the sectioning process:

*“They [a trainee social worker] said I would abscond and cited the example of when I was last in hospital. I was a voluntary patient then!”*

*“Husband got me sectioned, given a scrappy piece of paper.”*

*“If I had not appealed I would not have been discharged.”*

*“Doctors abused their authority, people judging.”*

It seems that the admission process for many of the service users was a unsatisfactory experience. Few were offered any alternative to admission, and most said that there was little time spent in welcoming them to the ward and providing them with sufficient information. Of the patients compulsorily detained, over half were of the opinion that they had not been fully informed about their rights, and of those had had appealed against their section, half thought that they had not received a fair hearing.

### **Location of the hospital**

Almost all of the patients in the study (96%, n=71) said that they felt the hospital to be in a pleasant location.

When asked about the accessibility of the hospital, however, there were differences between the hospitals. Patients rated Southmead as the most accessible hospital; 79% (n=19) of service users rated it as accessible, followed by Barrow (58%, n=22) and Blackberry Hill (50%, n=6). Service users' comments indicated that accessibility was a complex mix, comprising the availability of public or hospital-run bus services, the frequency of these services and the distance from the local communities within the catchment area.

In terms of accessibility to community resources i.e. off-site shops and cafes, most service users found Southmead to be the most accessible hospital (71%, n=17), followed by Blackberry Hill (67%, n=8) and Barrow (30%, n=11). The hospital's rural location and the nearest shop being a 50-minute round walk away explain the figure for Barrow. Five people mentioned that while community resources were potentially available, they were either not allowed off the ward or were only allowed off the ward with staff supervision - and that there were frequently not enough staff to allow this to happen.

At the time of the study there was a consultation exercise over the closure of the current Barrow hospital site. Patients seemed to feel passionately both in favour, and against the closure plans. Barrow is in a relatively isolated rural setting, which some patients valued but others felt was too remote and isolating. Pithily summing up both the positive and negative aspects of the Barrow site, one service user commented:

*"Lovely location, facilities crap, good bus service."*

and another:

*"Far out for people without a car, buses bad at weekends...good for sanctuary."*

### **A Named or Key Nurse**

Over a half of all the patients in the study (57%, n=42) said that it was made clear to them which nurse had overall responsibility for their care while in hospital. However, for at least one patient, the fact that they knew their Key Nurse was due to their own initiative:

*"Found out by reading the staff board."*

There were marked differences in the proportions of patients who said that they knew who their Key Nurse was by hospital. Two thirds (67%,

n=16) of patients at Southmead, 53% (n=20) at Barrow and 50% (n=6) at Blackberry Hill hospital knew who their Key Nurse was.

Given that the 'Named' or Key Nurse's responsibility is to oversee the person's stay while in hospital, including co-ordinating drawing up their care plan, the relatively high percentage of patients who did not know who their Key Nurse was, is of concern.

The importance to some patients of having a Key Nurse was evident from some of the comments:

*"No named nurse... difficult to open up to lots of different people."*

Of the patients who knew who their Key Nurse was, most (88%, n=37) were offered no choice. This was an issue for service users who preferred to have a nurse of a specific gender:

*"Insisted on female key nurse, often I'd been put with a man."*

In the event of a patient wishing to change their key nurse, over a third (37%, n=15) thought they could not and 17% (n=7) were unsure.

Of those who knew who their Key Nurse was, half (50%, n=21) were happy with the amount of time they spent with them:

*"Named nurse was very good, treated me well."*

Just under a half (40%, n=17), however, were not so happy:

*"I was told the name, but never saw the nurse - they just left me to lay in bed, apart from medication."*

*"Told name of nurse, but she spent more time in the staff room rather than the ward."*

The lack of knowledge many patients had of their key worker, and in some cases the relatively little interaction between key worker and patient may explain why service users often felt that their mental health needs were not properly assessed in hospital, why they were not very often involved in care planning, and why a lot of service users felt there was an absence of individual talking therapies. We shall return to this theme later.

## SUMMARY AND RECOMMENDATIONS

One theme to emerge was that patients had to wait a long time prior to admission, particularly in A&E.

- **Perhaps hospitals could simplify the procedures in A&E for people with a prior mental health support needs so admission could be speeded up. It may be that the solution is a better community based assessment or a dedicated walk-in centre specialising in mental health.**

Another was the lack of support and information provided at admission.

- **At admission, staff should use a checklist to confirm whether patients have immediate requirements like toiletries, nightwear etc, and be able to supply any missing items.**
- **Basic information about the ward, including where things are, what happens when etc should be given on admission, provided the patient is well enough to take this information in. If not, this should be done as soon as is appropriate. This information should be provided both verbally and in writing.**
- **If a patient has been sectioned they should also be given both written and verbal information about their section and their rights. This information should be in an accessible form and available in different languages.**
- **Hospitals should have quick access to interpreters to help people who do not speak English.**
- **At admission, patients should be shown around the ward so they know where things are, and introduced to staff and patients. They should meet their key worker as soon as possible after admission.**
- **There should be checklists on file to confirm that these things have been done and by whom. It should be the Key Nurse's responsibility to ensure that all such procedures are followed. Patients should also be given copies of the checklists so they are aware of what information they should have received.**

Eighty-three percent of our respondents were not offered any alternative to hospital and we are currently aware that there are not many options.

- **A wider range of care, including crisis care in the community and crisis houses would be beneficial.**

Eleven out of 18 people appealed against being held under a section of the Mental Health Act, which indicates high levels of dissatisfaction with the process and/or a lack of understanding of the need for such action.

- **While many people may be very distressed and angry about being sectioned when they are very ill, it may be possible for this process to become more understandable and less of a cause of dissatisfaction if staff were to spend more time explaining the process and the reasons for actions taken. This may need to be done several times, as a person may not be well enough to take everything in on arrival.**

Almost all of the patients in the study thought the hospital was in a pleasant location, but fewer thought that the hospital was accessible.

- **Those involved in the provision of mental health services should maintain a commitment to providing hospital care in pleasant locations, with good access by public transport and in reach of community resources.**

Quite a high percentage (41%) of patients were not clear whether they had a Key Nurse. Of those who had a Key Nurse, only half were happy with the amount of time the nurse spent with them.

- **All patients should be informed about their Key Nurse on admission, and initial information about the ward should make it clear what can be expected from them. In our view the Key Nurse should be the prime contact for the patient in hospital, and the person who provides continuity and develops the strongest relationship with them. Patients commented that it was difficult to open up to a lot of different people. Given that our study had identified a lack of communication between patients and staff, Key Nurse time would be one obvious way to address this problem.**

- **A Key Nurse should:**
  - **make themselves known to patients as soon as possible after admission**
  - **see patients regularly - at least twice a week for a minimum of half an hour**
  - **be present at ward rounds**
  - **discuss the care plan with the patient**
  - **discuss the patient's needs**

- **make sure that other appropriate information, support and activity is being provided; this could be done through the use of checklists**
- **ensure that relevant information about the patient is communicated to other ward staff and in the ward round**
- **check that the patient understands the information and assessment they are being given, and respond appropriately if they are not.**





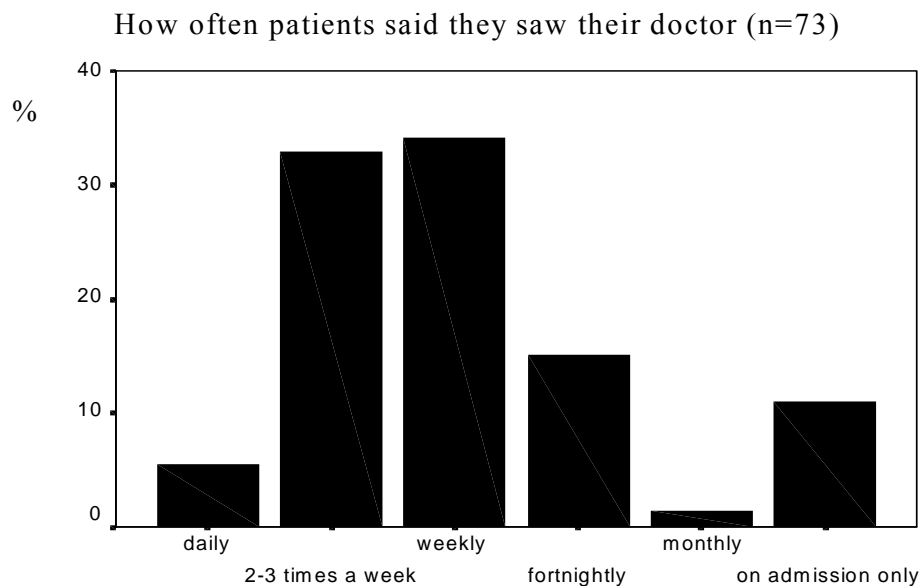
## **SECTION 2: HEALTH CARE PROFESSIONALS**

**This section looks at some of the key professionals involved in someone's care while an inpatient including consultant psychiatrists and junior doctors, nursing staff and care assistants, and other key professionals.**

## HEALTH CARE PROFESSIONALS

### **Relationship with consultant/junior doctor**

Initially, the study had sought to distinguish between consultants and junior doctors, but many patients were unsure of the exact rank of the doctor they saw. A more composite picture was therefore obtained, suggesting that most patients saw a doctor at least once a week. The graph below shows the frequency with which the patients in the study said that they saw a doctor.



Patients were asked to evaluate their relationship with their consultant, if they knew who this was. Of the 71 patients who thought they knew who their consultant was, 61% were happy with their relationship with him/her.

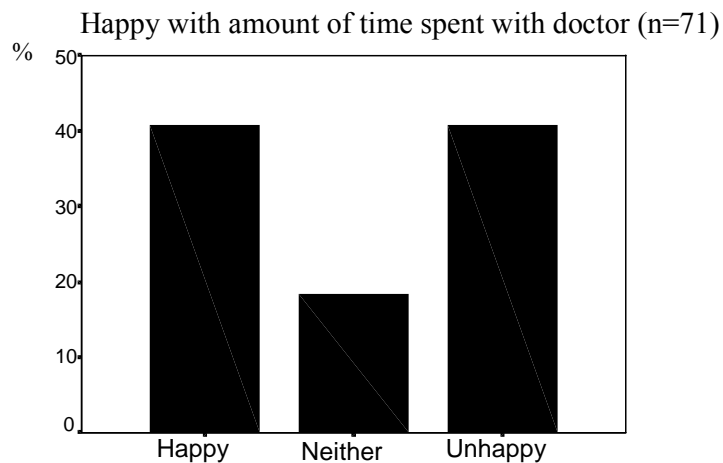
More generally, when asked about the helpfulness of their doctors, three quarters of the patients in the study (76%, n=56) said their doctor spoke to them in a way they could clearly understand, 57% (n=42) felt their doctor negotiated medication levels with them when appropriate, and 49% (n=35) felt their doctor helped them with any medication difficulties they might be experiencing. Some patients spoke highly of their doctors:

*“Doctor good at negotiating medication levels... very patient.”*

while for others, the picture was more mixed!

*“...good relationship with first consultant... second one a wanker.”*

Patients were rather less happy with the amount of time that they spent with their doctor, as the graph below shows.



Several patients mentioned experiencing frustration at not knowing when they would get to see their doctor:

*“Patients told they would see doctor but given no appointment times - had to hang around waiting.”*

Other patients would have liked to see their doctor more promptly:

*“Only saw one in two weeks... was not happy.”*

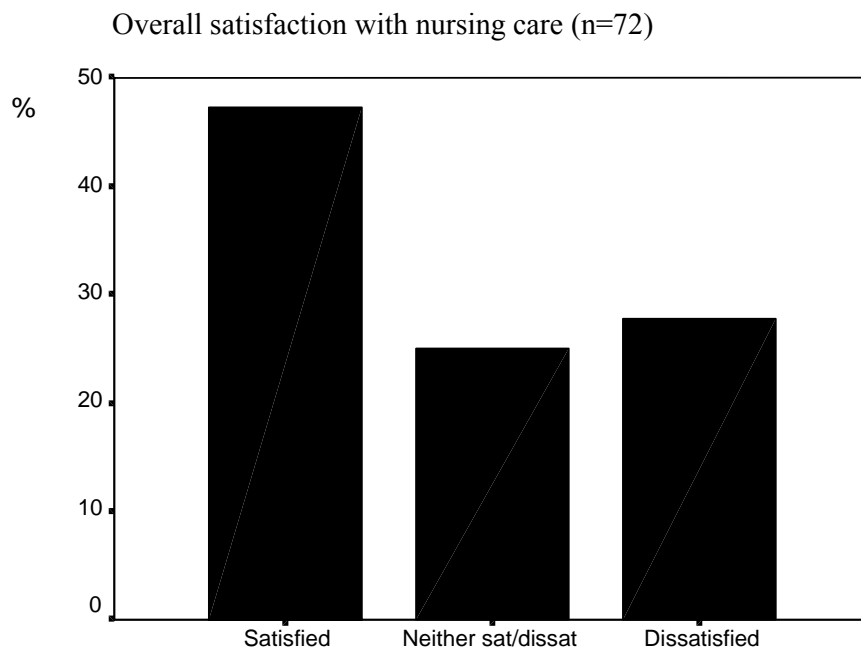
*“Wanted to go on home leave - but couldn't as consultant not around.”*

### Care staff and the quality of care provided by them

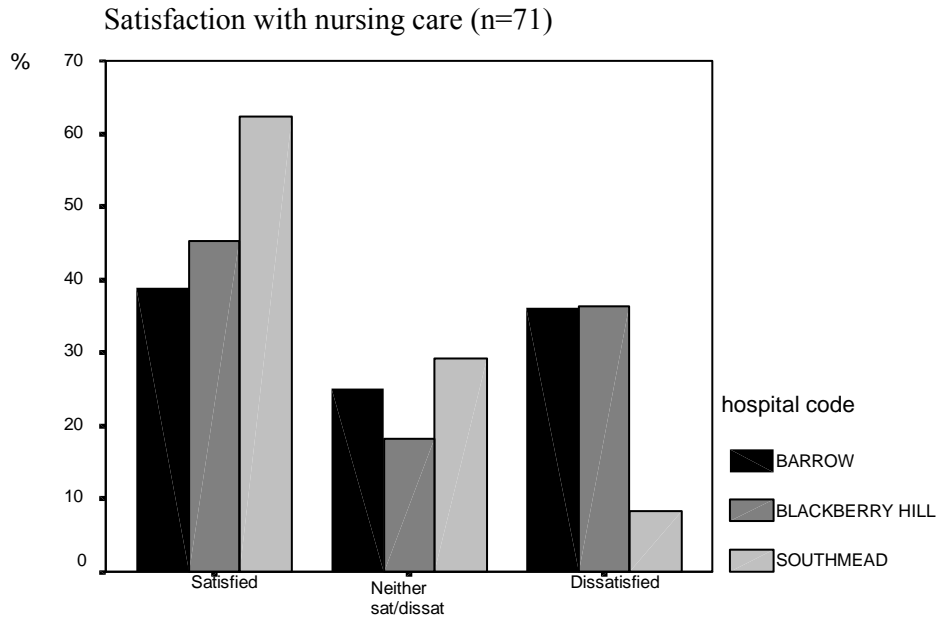
Patients may have contact with a number of different care staff during their stay in hospital. Respondents were therefore asked about their satisfaction with the care provided by each of the different groups of workers.

#### *Nursing staff*

Almost a half of all respondents were satisfied with the nursing care that they received from professional, trained nursing staff, as the graph below illustrates.



There were, however, notable differences in the proportion of satisfied patients according to hospital, as the graph below shows.



Obviously care needs to be taken in interpreting these results as nursing care is dependant on staffing levels as well as individual and ward practice, but patients in this study tended to rate nursing care higher in Southmead than in Barrow or Blackberry Hill.

Ten patients chose to comment positively on the nursing care they had received:

*“The nurses are nice - they can’t do enough for you, they were fantastic.”*

*“Worked as a team, explained what was going on.”*

However, 25 patients were concerned about the lack of time and interaction they had had from nursing staff:

*“Often not available. Always in staff room.”*

*“Staff don’t interact with patients enough, not available, them and us atmosphere ...staff chatting with feet up.”*

*“Seen as an alcoholic...wasn't approached much, not much time made for me by staff.”*

Two patients expressed particular dissatisfaction with the use of bank staff, whom they said seemed to have little investment in the care of the patients.

### ***Social workers***

Twenty-six patients had had contact with a social worker whilst an inpatient: just over half of these (n=14) expressed satisfaction with the care provided by them. There was no consistent theme as to which aspects of the social work role that patients felt was useful. However, one positive comment included:

*“Spent a good couple of hours with me and contacted my parents.”*

Nine patients expressed dissatisfaction with the care that they had received from their social worker, with one patient saying:

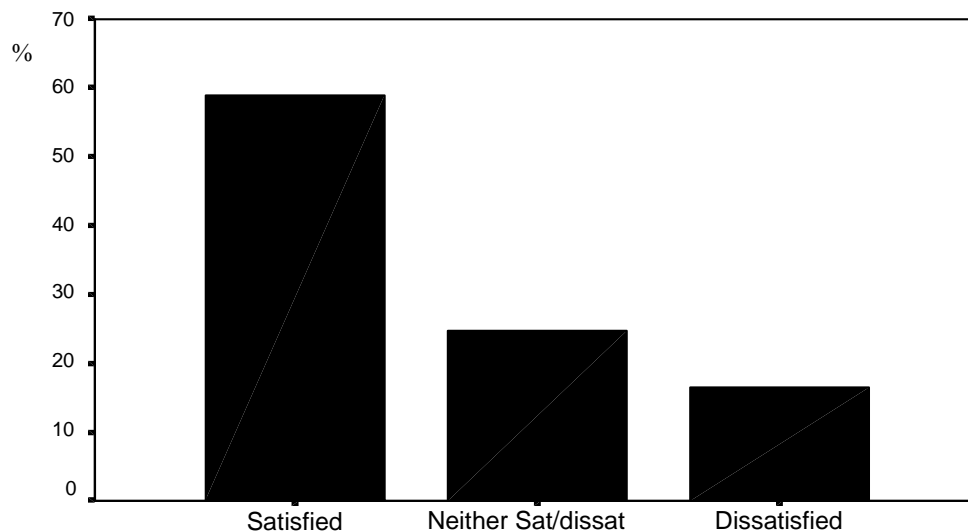
*“Just did what my husband wanted him to do.”*

A further five patients said that they would have liked a social worker but thought that there was a long waiting list.

### ***Care assistants***

Of the patients who chose to comment on their satisfaction with the care provided by care assistants, over half were satisfied, as the graph below illustrates.

Satisfaction with care assistants (n=61)



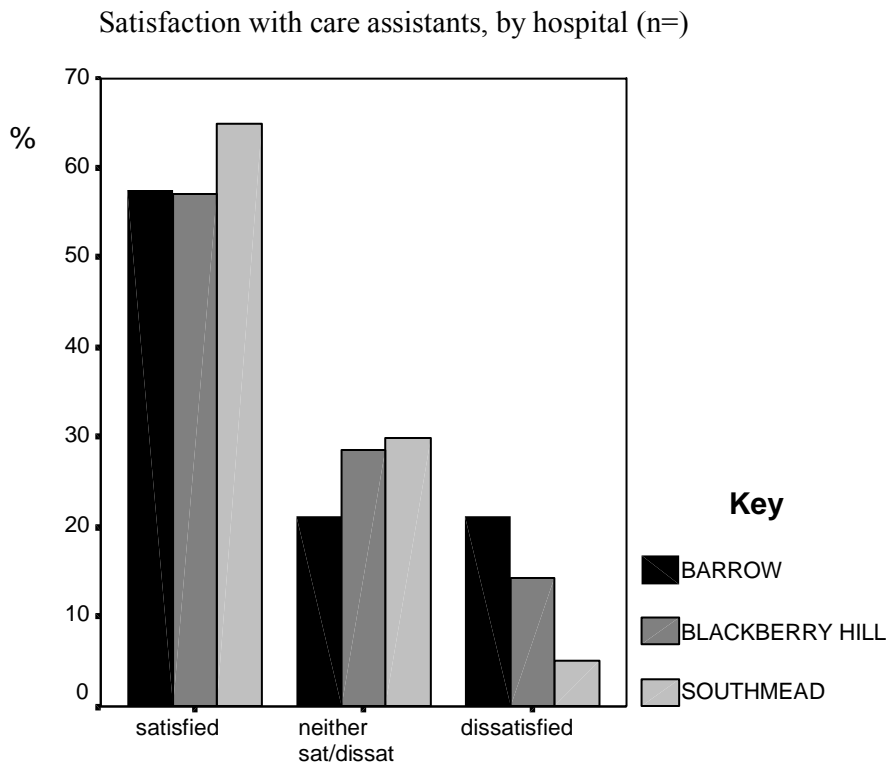
A common reason for satisfaction seemed to be that care assistants seemed to be prepared to make more time to interact with patients:

*“More accessible than trained staff, there to learn, more interested.”*

*“Friendly, chatty informal, great to have around.”*

*“Seemed to have more time, approached me.”*

There were, however, some differences in the satisfaction of the care provided by health care assistants, according to the hospitals in which they worked, as the graph below shows. Patients from Southmead seemed to be rather more satisfied with the care they received from care workers than patients from Blackberry Hill or Barrow hospitals.



### ***Physiotherapists***

Twenty-one patients said they had access to a physiotherapist while in hospital, and most of these (n=17) expressed satisfaction with the care they received. Patients valued physiotherapy as a recreational outlet:

*“At the gym - an escape from the world.”*

and as an important therapeutic intervention when a person had a physical difficulty:

*“Had arm injury, felt they were very helpful.”*

However, given the importance of physical exercise in maintaining good mental health, it is concerning that so few of the patients in the study had had access to this service.

### ***Dietician***

Eleven patients said they had contact with a dietician, and half of them (n=6) expressed satisfaction with the care that they had received. Four patients said they would have liked to see a dietician but were not offered the opportunity. Worryingly, one service user with a medical condition requiring special dietary care was not given a referral. One patient used the opportunity of talking about their satisfaction with the services of a dietician to comment on the state of the hospital catering:

*“Crap food, what's the point of a dietician!?”*

### ***Pharmacist***

Nineteen patients had made contact with the hospital pharmacist and all but one of these were satisfied with the service they received. Several patients commented that some pharmacists ran groups for patients where issues such as types of medication and possible side effects were discussed. Patients commented positively that this was a helpful and innovative example of good practice :

*“Excellent pharmacist ran a group and talks.”*

For some patients, however, their only contact with the pharmacist was on discharge when they got medication to take with them.

### ***Psychologist***

Fifteen patients reported seeing a psychologist, of whom 10 expressed satisfaction with their care:

*“Knows what I want to talk about.”*



Four patients were dissatisfied with the care they received, including one who said:

*“The psychologist was a dictator for the psychiatrist and my relative.”*

Five patients commented that they would have liked to have seen a psychologist but they had not been able to. Given the high number of patients who reported valuing ‘talking therapies’ psychologists seemed to be a valued but scarce resource.

## SUMMARY AND RECOMMENDATIONS

Almost two-thirds of the patients in the study were happy with their relationship with their doctor, but many were unsure of the rank of the doctor that they saw. Patients were frustrated by the short amount of time that they spent with a doctor.

- **It should be made clear to patients the status of the doctor they are seeing and what each doctor can and cannot decide.**
- **We recommend that doctors spend more time with patients. All consultants should see their patients at least once a week. This should be a standard of care and subject to audit.**
- **There should be a clear and known procedure for patients to make leave arrangements whether or not their own consultant is available.**
- **Appointments to meet with doctors should be arranged regularly and in advance, so that patients can prepare appropriately and be available. This should also apply to ward rounds so that patients have the opportunity to arrange appropriate support if they wish.**

The study found fewer than half of the patients in the study were satisfied with the nursing care they received. Of 35 comments made, 25 expressed concern about the lack of time nurses spent with patients and the quality of those interactions.

- **All patients should have access to high quality nursing care. Nursing staff should be more available to interact with patients and offer them quality contact time.**

A third of patients expressed dissatisfaction with the quality of care from social workers.

- **All patients should be taken through a checklist of needs on admission (or as soon as the patient is stable enough to respond effectively). This checklist should enable identification of need for referral to social workers; need for liaison with housing providers so people are not discharged without somewhere to live; need for information and support in relation to benefits claims; and need for liaison in relation to home care. It must be clear who holds responsibility for this process and they should also be responsible for prompt referral to other agencies. Before**

**discharge there should be a review of this process with the patient to make sure the necessary actions have been taken.**

Over half of the patients in the study were satisfied with the care they received from care assistants. The study shows how much patients value interest, friendliness, approachability and informality in interactions with care assistants. Other staff should be trained to demonstrate more of these qualities.

Half of the patients who had seen a dietician were satisfied with the care they received, but some patients were not offered the opportunity to see one.

- **Where patients have eating disorders or have physical illnesses with special dietary requirements they should see a dietician as a matter of urgency.**
- **Staff should enquire on admission about food allergies or other special dietary needs, and these needs should be actioned promptly. Choice of diet should reflect both cultural needs and/or personal preferences.**

The study indicates that contact with a pharmacist offers very helpful information and advice on medication and side effects. The groups run by some hospital pharmacists were mentioned positively by several patients and provide a useful way of better informing patients about medication issues.

- **All patients should be offered access to a pharmacist either on an individual basis or in a group.**

Our study shows that patients value ‘talking therapies’.

- **Access to for instance psychologists or staff with counselling skills should be increased.**

Patients generally valued their access to physiotherapy. However, only 21 people were offered this opportunity.

- **Given the benefits of exercise to mental health patients, access to physiotherapy should be increased. Doing exercise in hospital could also support patients to develop a healthier life style and decrease the boredom of a long stay in hospital.**



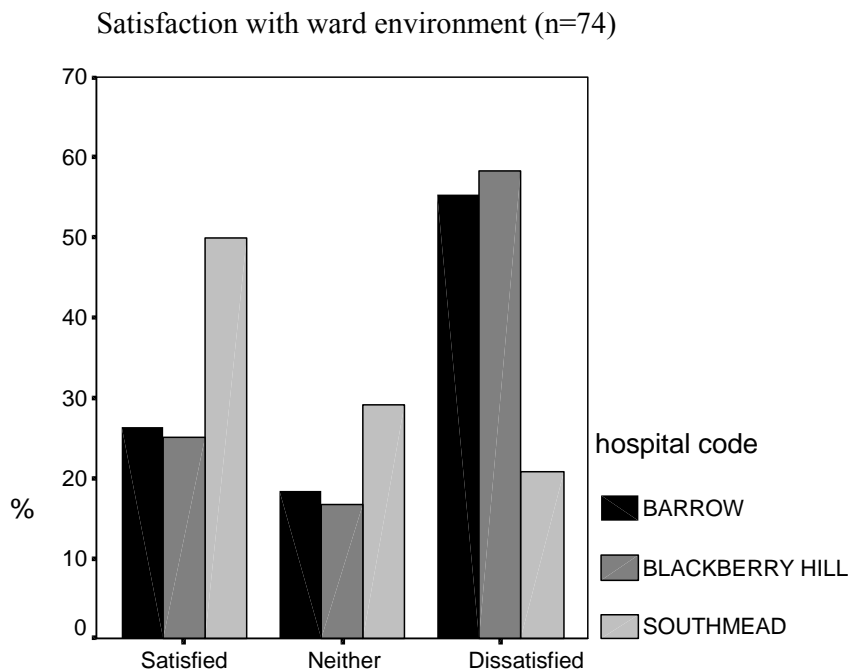
**SECTION 3: WARD ENVIRONMENT, DAILY**  
**ROUTINES AND ACTIVITIES**

**This section deals with the general condition of the wards, what facilities were available to patients, what type of therapeutic and/or recreational activity was available, and what the quality of food and catering facilities at the hospital were like.**

## WARD ENVIRONMENT, DAILY ROUTINES AND ACTIVITIES

### **The ward environment**

The overall level of satisfaction with the ward environment varied according to hospital, as the graph below shows. Half of the patients at Southmead were satisfied with the ward environment, compared with approximately a quarter of the patients at Barrow or Blackberry Hill hospitals.



The reasons for dissatisfaction with aspects of the ward environment are shown in the Table below.

<b>Reason for dissatisfaction</b>	<b>% of patients dissatisfied</b>
Privacy for making phone calls	67
State of furnishings and decorations.	53
Privacy in bedroom	41
Wards comfort and welcome	40
Overall privacy	38

Most of the comments from patients focussed on the lack of privacy, and the general ‘tattiness’ of wards. Some patients recommended re-painting some of the wards and replacing broken or damaged furniture.

Other suggestions to improve the ward environment included:

- More access to games and/or organised activities.
- Greater ventilation for smoking areas, and a request that smoke didn’t affect non-smoking areas.
- Single rooms.
- Access to music in people’s bedroom.
- Appropriate siting of phones to ensure private phone calls were possible.
- Wards to be regularly kept clean especially toilet areas.
- Some control of the temperature of patients’ rooms. This was cited as a problem in both Barrow and Southmead.
- Access to decent books.
- Some plants.
- Some patient involvement when refurbishment is undertaken.
- Women only areas.

### **Single sex ward?**

With the exception of the Mother and Baby Unit almost all the patients in the study were on mixed wards. When asked if they would prefer to be on a single sex ward, almost a third of the female patients (31%) but only a handful of male patients said ‘yes’, as the Table below shows.

	Whether patients would prefer to be on a single sex ward		
	Yes	No	Don't know
Males	6% (n=2)	84% (n=27)	9% (n=3)
Females	31% (n=13)	50% (n=21)	14% (n=6)

It seems, therefore, that there ought to be an element of choice available to patients, in particular women, as to whether they are in a mixed or single sex ward.

### **General atmosphere and freedom on the ward**

Inevitably, every ward will have particular routines to ensure its smooth running. Such rules and regulations may need to be enforced more stringently than others, but with most there ought to be a degree of flexibility to meet the needs of the patients. The graph below shows the respondents' degree of satisfaction with the daily routines on the ward, by hospital. It shows that patients at Southmead were more satisfied with their daily routines than those at Blackberry Hill or Barrow. The routines included such things as flexibility in getting up and going to bed, the choice and range of activities etc. Comments included:

*“Television cables were taken away, kitchen was locked, fire drills in middle of night, music room locked.”*

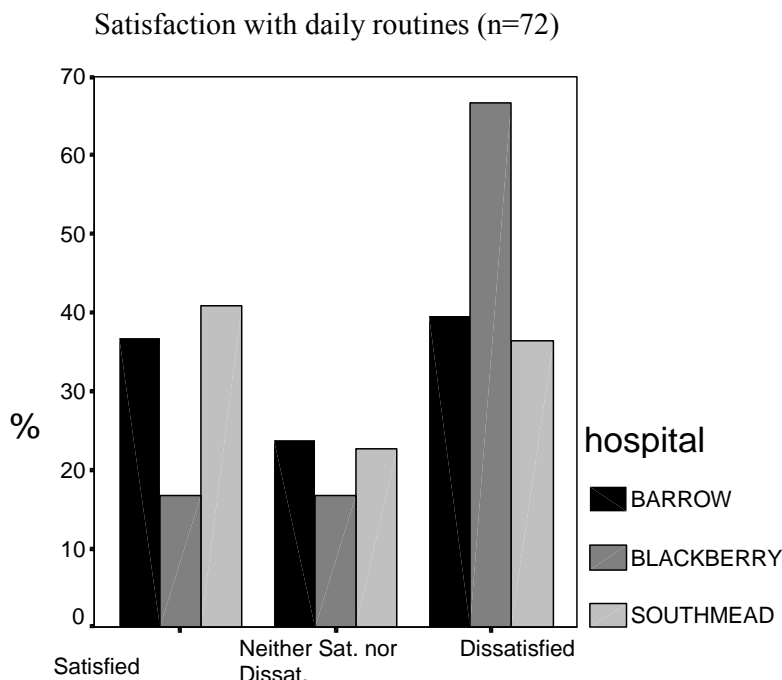
*“Strict about times visitors turned up.”*

*“Did not consider what sort of night you'd had - treated like a case not a human being.”*

*“Didn't get up till 5 o'clock, not encouraged to do anything myself.”*

*“Able to go to gym or art/cookery when wanted to, or go to other wards. Some time when nothing left to do. Shop shut too early.”*





### Restrictions put on leaving the ward

Slightly worryingly, of the 52 patients who were admitted voluntarily, 40% (n=21) claimed there were restrictions placed on their leaving the ward and a further 21% (n=11) said that there were sometimes restrictions placed on their leaving the ward. More work would need to be done to find out whether this was a result of staff seeking a patient's voluntary agreement not to leave the ward due to concerns about their mental health or, as one patient claimed, a policy of threatening to section voluntary patients if they decided to leave.

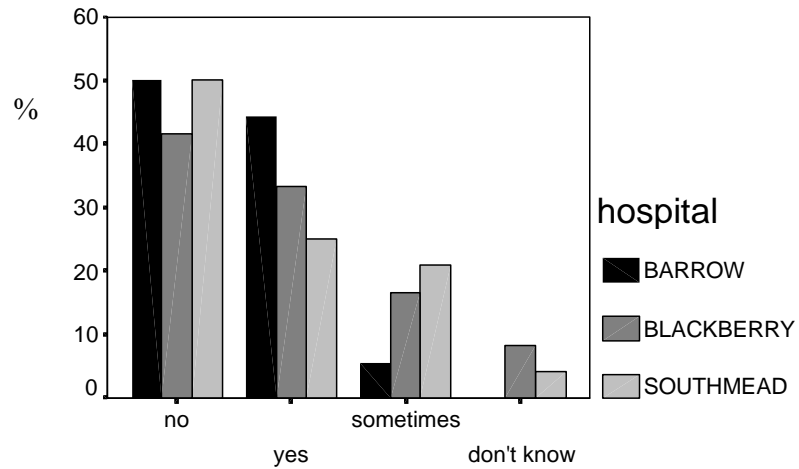
### Patients' ability to freely express their emotions

The ability, and acceptability of patients to freely express how they are feeling to staff is often regarded as important for two reasons: firstly, for some people it can act as an aid to recovery, and secondly it can help assess a patient's emotions. Obviously how able a patient is to express their feelings will be dependant on staff availability. Yet patients also commented that they were reluctant to let staff know how they were feeling, fearing the risk of a prolonged inpatient stay or increased medication:

*“Crying is seen as a sign of illness leading to a longer stay in hospital and more medication.”*

The graph below shows whether patients at each of the hospitals felt that they could freely express their emotions. Fewer than half of the patients in any hospital said that they could. Indeed, half of those in Barrow and Southmead said that they could not.

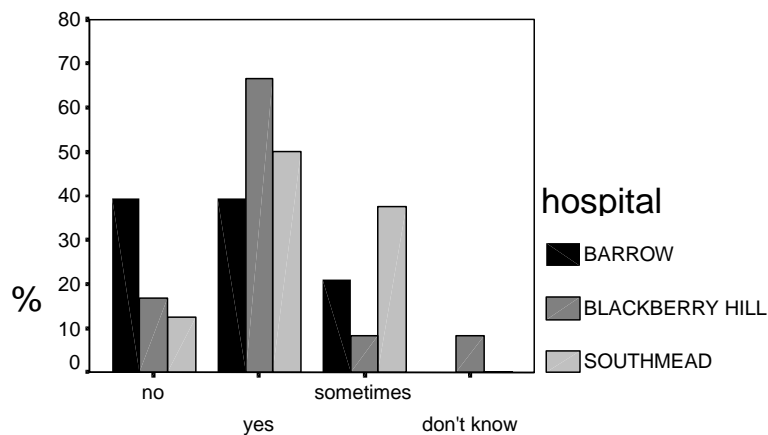
Able to express emotions freely (n=72)



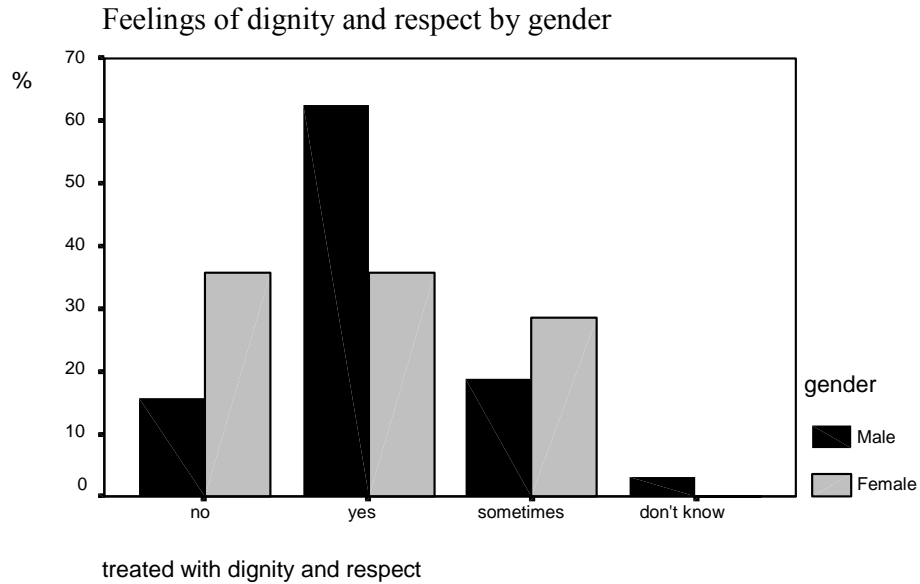
### Dignity and respect

There was considerable variation between hospitals as to whether patients felt they had been treated with dignity and respect, as the graph below shows.

Patient felt treated with dignity and respect (n=74)

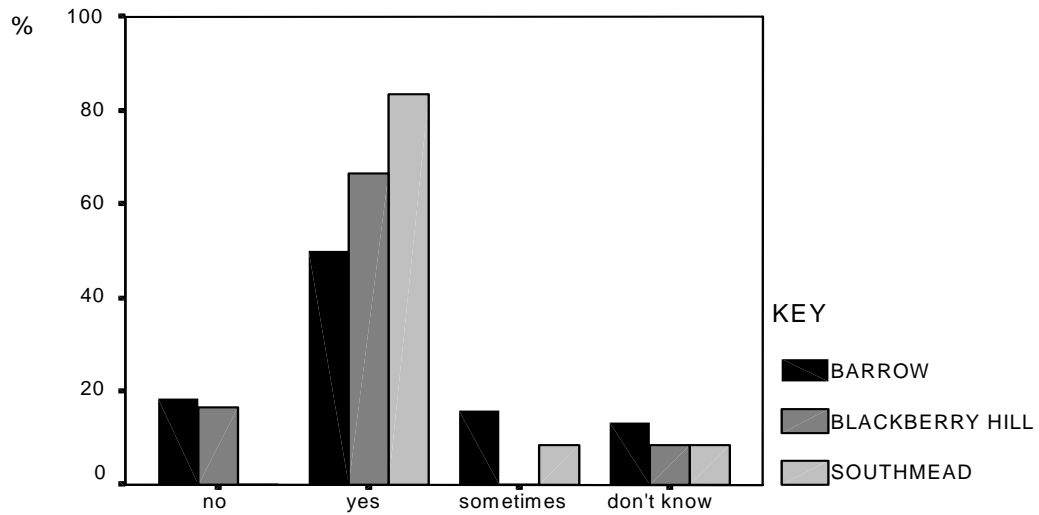


Additionally, there was a notable difference between male and female patients. Female patients were much less likely to feel they had been treated with respect and dignity than male patients, as the graph below shows.



Often the ability to know when visitors have called, and to spend time with them if possible, is important for a patient's ability to keep in touch with the world outside the hospital. Generally, most patients thought that the ward staff treated their friends and visitors courteously, as the graph below shows. Nevertheless, some patients commented that the ward seldom had anyone at the reception desk, due to poor staffing levels or hand-over meetings of the staff. Obviously this has implications for the safety of patients on the ward, and the staff's ability to know which patients are on the ward at any one time.

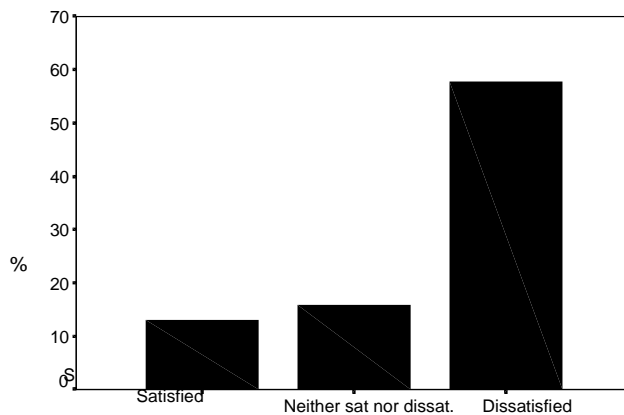
Staff courteous to friends and visitors (n=73)



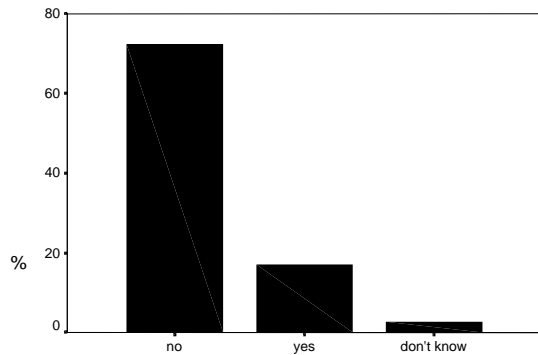
**Activities on the ward**

The lack of sufficient activities for patients, in the daytime as well as during the evenings or weekends, was evident from the responses given by patients, as the graphs below show. Two thirds of the patients said that they did not have enough to do to occupy their time, and over three-quarters mentioned a lack of activities at weekends. Overall, three-quarters were dissatisfied with the activities available for them to do on the ward.

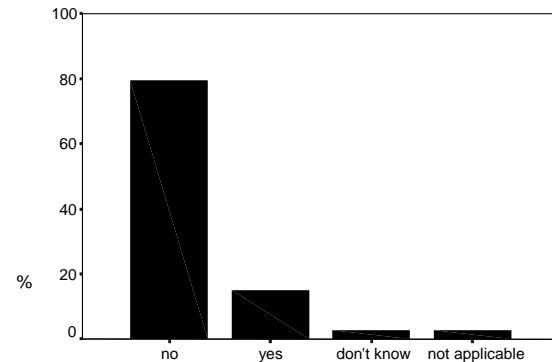
Satisfaction with things to do on ward (n=66)



Enough to do to occupy your time? (n=70)



Any arrangements for activities at weekends? (n=73)



Together, this suggests that boredom was likely to be a major problem for many patients. Although several patients mentioned that they had access to a gym, they felt the hours that it could be used were very restrictive. In addition, although occupational therapy support was available during 'working' weekday hours, it was often not available at weekends.

Patients made many positive suggestions as to how to improve the range and availability of activities. These included:

- Access to a study area with computer and internet access.
- More tactile therapy including head massage and yoga.
- Gym to be open all day.
- Keep fit, table tennis and Tai Chi.
- Decent supply of up-to-date books (not Oxfam rejects).
- Evening shop.
- Access to a vending machine for snacks.
- More educational and social activities.
- Better supply of games/puzzles on wards.

Given the large number of patients reporting dissatisfaction with the range and availability of activities, the Trust might give consideration to the employment an Activities Co-ordinator. The opportunity to engage in some form of structured activity and avoid what might be described as 'mental bedsores' is often cited as important in recovering from mental health difficulties<sup>1</sup>.

## **Other facilities for patients in hospital**

### ***Access to clean sheets, towels and night wear***

Three-quarters (77%, n=56) of patients said they had access to sufficient clean sheets, towels and nightwear while in hospital. Nevertheless, 22% (n=16) said they did not. The provision of clean sheets, towels and nightwear is an important aspect of care for all patients, but especially so if the patient is admitted as an emergency. It is an aspect that needs to be addressed as part of someone's admission to the ward.

### ***Sufficient telephones in working order***

Fewer than a half (45%, n=33) of the patients said there were enough phones in working order that they could access. In distant rural locations, the telephone is often the only opportunity to keep in contact with friends or family. It also provides an important outlet for patients to request advocacy and support in confidence. The necessity for access to phones, coupled with their location to ensure confidentiality, should be addressed as a priority.

### ***Hospital shop***

Almost all patients (94%, n=66) said there was a shop on site, although four said that they either did not have access to a shop, or didn't know if they had access. Half (51%, n=31) said the shop was open at times they wanted, and almost three-quarters (71%, n=46) said the shop sold items they needed or wanted to buy.

Some of the items patients felt were most useful for the shop to sell were: cigarettes, chocolate, drinks, toiletries, papers, fruit and condoms.

Suggestions as to what other items the hospital shops could sell were:

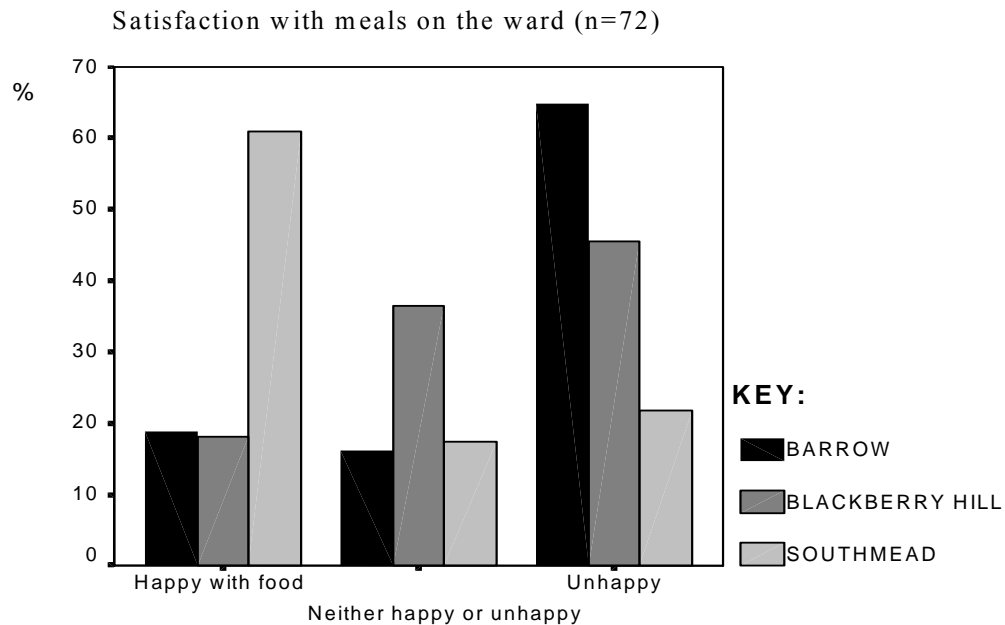
- Tobacco
- Magazines and newspapers
- Better range of toiletries
- Suntan lotion
- Microwaveable food
- Mineral water
- Fresh fruit
- Sanitary towels
- Batteries
- Top up cards for mobile phones
- Pencil sharpeners
- Better range of food and snacks

- Alcohol
- Slippers
- Ice cream

### Meals and drinks

A third (33%, n=24) of patients said they were happy with the meals on the ward, but almost a half (46%,n=34) were dissatisfied. Of all of the patients in the study, a half (46%, n=34) were unhappy with the choices available, and a quarter (27%, n=20) were unhappy with the quantity of food available.

Overall satisfaction with the meals on the wards varied by hospital, as the graph below shows. In general, patients at Southmead were three times more likely to be satisfied than patients at Barrow or Blackberry Hill, which may, in part at least, be due to the different catering arrangements at Southmead.



Of the four patients from ethnic minorities, three were unhappy with the food. In a follow up interview, one service user who had recently been discharged from Barrow said:

*“I like rice and peas but not every day for three months!”*

Some patients mentioned that getting vegetarian or vegan food was sometimes difficult. One of the difficulties seemed to be that if a menu card system was not in place and patients queued for food, the vegetarian food ran out before everyone had been served. A number of patients also mentioned that they would like more fresh fruit:

*“Very little fresh fruit - when I asked nurses were helpful.”*

***Facilities and opportunities to make snacks and drinks***

Half (53%, n=39) of patients said there were facilities to make a light snack on the ward if they wanted to. Some patients suggested that access to a microwave might also facilitate patients making snacks outside of meal times.

Most of the patients in the study (84%, n=61) said they had access to facilities to make a drink, but only two-thirds (66%, n=47) said they could make a drink when they wanted to. Reasons why some patients said that it was difficult to make a drink when they liked included:

*“Kitchen locked at night.”*

*“Often ran out of tea and coffee.”*

*“Access at night staff’s discretion.”*

*“Not able to make drinks at night.”*

Given that for some patients living in a strange place, coupled with the effects of some mental health difficulties, makes sleeping difficult, thought needs to be given to allowing patients to make drinks as they need them.



## SUMMARY AND RECOMMENDATIONS

Fewer than half of the patients were satisfied with the ward environment.

- **All patients should have single rooms.**
- **Telephone booths must be available so patients can make private telephone calls.**
- **Patients should be able to get change for telephones from the ward staff.**
- **Where patients are admitted in crisis they should be allowed to make phone calls to friends and relatives.**
- **A small crisis loan should be available to patients who are admitted without cash.**
- **The ward needs to be a comfortable, well decorated, welcoming and well maintained environment.**
- **Damaged or broken furniture should be replaced immediately. This should be facilitated by each ward having a small maintenance budget.**
- **Other suggestions to improve the ward environment are: more access to games and/or organised activities; greater ventilation for smoking areas and a request that smoke did not affect non-smoking areas; access to music in bedrooms; some individual control of temperature in bedrooms; access to a better selection of books; plants; a women only area.**

A third of females in the study said that they would prefer to be in a single sex ward.

- **Hospitals need to offer single sex accommodation.**
- **As a minimum facility there should be a women-only area within each ward.**

Most patients were dissatisfied with the daily routines on the ward.

- **Daily routines on hospital wards should be patient-centred with some flexibility for individual needs.**

- **Ward routines need to include TV, video and drinks available at night, and flexibility over visiting hours.**
- **Hospitals should modify ward routines so that levels of patient satisfaction are increased.**

Two-fifths of the patients admitted voluntarily said that there were restrictions placed on their leaving the ward. A further fifth said that restrictions were sometimes put in place.

- **Voluntary patients who are unwell need to be discouraged from leaving the ward. However, this should be done with more sensitivity to avoid patients feeling they are being threatened with the possibility of being sectioned.**
- **There should be further investigation of restrictions of movement both from patients and staff viewpoints.**

Fewer than half of the patients said that they could express their emotions freely on the ward.

- **There is a need to have the expression of emotion accepted as important.**
- **Wards need to ensure that they are places where emotions can be freely and safely expressed.**
- **Both key and shift nurses need to identify a daily slot with patients they are responsible for to provide a regular opportunity for patients to explore and express their feelings.**
- **Nurses may need further training to consolidate existing skills in this area, for example by providing counselling training.**
- **Wards should have spaces where patients can safely let off steam with a punch bag, and where they can relax, listen to music and take time out, away from staff.**

Female patients were less likely to feel that they had been treated with dignity and respect than male patients.

- **Dignity and respect are crucial to the provision of good person-centred inpatient care. These qualities of care are complex and difficult to define and quantify.**

- **Feeling treated with dignity and respect may be a function of other aspects of care, for example, patients having an input into care plans, being listened to, having a single room and privacy.**
- **Being treated with dignity and respect is dependent on being treated as a person not someone with a label.**
- **The noticeable gender difference in perception of being treated with dignity and respect needs further investigation and action.**
- **To avoid institutional perceptions of patients as diagnoses and labels it is important to see people as having lives beyond their mental distress. There need to be ways of ensuring that staff have wide perceptions of patients.**
- **It is important to remember that visitors and phone calls are vital connections for patients to the community. It is therefore important to have visitors treated courteously and phone calls and messages passed on to patients.**
- **The admissions checklist needs to include clarification of who the patient does and does not want to keep in touch with while in hospital.**

The study highlights boredom as a serious source of dissatisfaction in hospital. Two-thirds of the patients said that they did not have enough to do to occupy their time, and over three-quarters mentioned a lack of activities at weekends.

- **There needs to be a range of activities that provide physical, mental and therapeutic benefits. Wards should also provide ways of passing the time actively.**
- **Facilities should be continually upgraded.**
- **Each ward should have an individual budget which should be spent in consultation with patients.**
- **All patients need to be given information about, and much quicker access to, whatever occupational therapy and other activities are available. The information should be clearly publicised on ward notice boards etc.**

- **The Key Nurse should discuss how each patient is spending their time on the ward and encourage participation in activities as appropriate.**
- **It may be helpful to employ an Activities Co-ordinator; this has been a successful innovation in other hospitals.**
- **There should be an audit into the correlation between boredom and activity levels of patients with levels of medication. Thirty-nine percent of patients in our study felt over-medicated, and this may interfere with their ability to engage in meaningful activity.**
- **Other suggestions for activities are: access to a study area with computer and internet access; more tactile therapy including head massage and yoga; gym to be open all day; keep fit; table tennis; Tai Chi; good supply of up-to-date books; evening shop; access to a vending machine for snacks; more educational and social activities; better supply of games and puzzles on wards.**

The provision of other facilities for patients was variable.

- **When patients are admitted in an emergency the ward should provide items for personal hygiene and nightwear.**
- **There is a serious need to ensure that telephones are in working order and are situated so conversations are private.**
- **Wards could provide vending machines for sanitary towels, toiletries, snacks, and food that can be heated in a microwave oven. The ward should have a microwave oven for heating food.**

Almost a half of the patients were dissatisfied with the food provided in hospital. Some patients said that it was difficult getting suitable special diets. Although most of the patients in the study said they had access to facilities to make a drink, only two-thirds said they could make a drink when they wanted to.

- **Wards need to provide menu cards.**
- **Wards need to provide more fresh food, for example fruit, and not cook chill food.**
- **There should be adequate catering for those from different cultural groups as well as for vegans and vegetarians.**

- **Hospitals should consider the possibility of an open canteen/voucher system for patients, allowing people to eat when they want.**
- **Wards need to provide working fridges.**
- **Wards need to provide access to a kitchen on a 24-hour basis. (This should already be happening and has been promised by hospital management for some time. Only recently a notice was seen in a Barrow ward saying the kitchen was to be locked after midnight. Hospital managers need to be aware whether staff are following their directives).**
- **Wards need to make sufficient provision for snacks.**
- **Wards need to provide 24-hour access to vending machines.**
- **Wards need to provide water dispenser and coolers. These are already in place in Barrow for Woodside management.**

**Notes:**

<sup>1</sup> The Mental Health Foundation (2000) 'Strategies for living: a report of user-led research into people's strategies for living with mental distress.' The Mental Health Foundation: London.



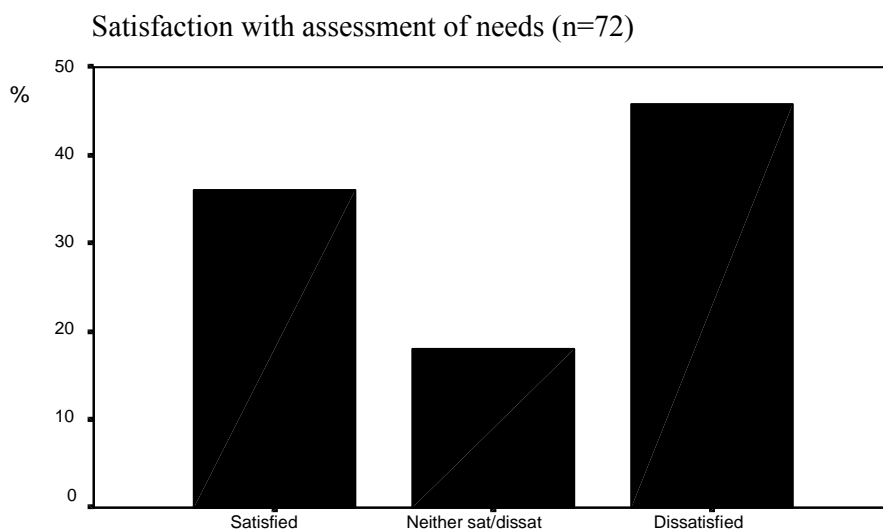
## **SECTION 4: ASSESSMENT**

**The fourth section looks at how patients' needs were assessed while in hospital, how well did they felt their needs were understood by staff and what input they had in terms of being allowed to describe and comment on how their difficulties appeared from their own perspective.**

## ASSESSMENT OF NEED

### **General needs**

Although a third of patients were satisfied with the way their needs in hospital were assessed, almost half (44%) were not, as the graph below illustrates.



Twice the proportion of female patients expressed dissatisfaction (58%) as did male patients (29%). A number of reasons were given for the patients' dissatisfaction:

- Almost two-thirds (64%) of patients said that they did not feel the staff helped them identify any personal strengths, which might have helped them cope with their mental health difficulty.
- Nearly a half (44%) felt unhappy about how staff paid attention to what they said.
- Some were dissatisfied with the labels attached to them:

*“Given a lot of labels, diagnoses which I didn’t think applied”.*

### **Cultural needs**

A quarter (n=11) of the 43 patients who felt they had cultural needs were unhappy with how the hospital attempted to meet these needs. Of the four patients from ethnic minorities, two were satisfied and two were not.



Seventeen respondents felt that there were other patients on the ward who needed an interpreter, but had no one to help them communicate:

*“It was a problem for a Somalian girl - her English was poor, she just walked round and round. I felt sorry for her.”*

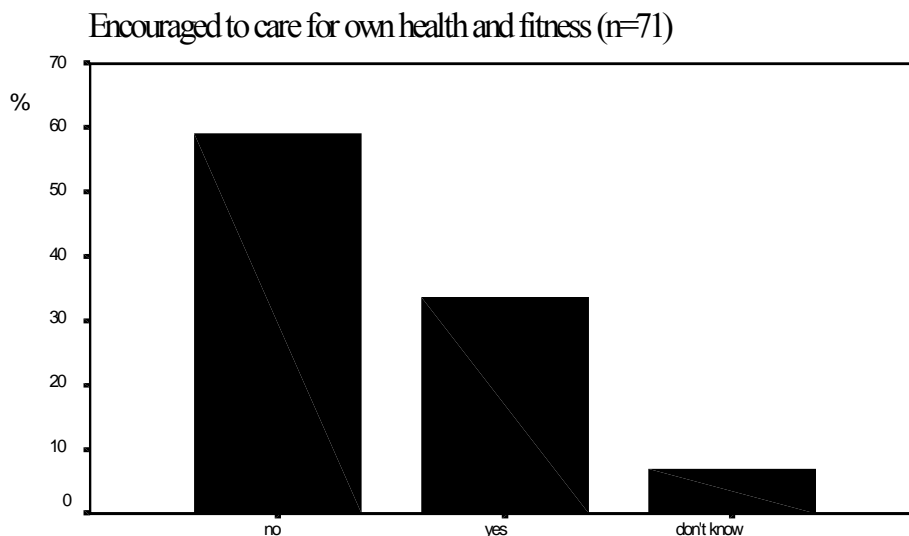
*“There was an Indian woman not able to communicate but in great distress... was medicated to quieten her.”*

Given that language difficulties can cause problems when assessing the needs of patients, this raises issues of staff training and awareness in cultural issues, communication skills, awareness of interpreting and translating services and how to access them, as well of the recruitment of staff from diverse backgrounds.

### **Physical health needs**

Twenty patients reported dissatisfaction with how their physical health needs were assessed and met. These included one patient with a painful intestinal disorder who did not think that they had their dietary needs properly assessed and met; another reported that some painful pre-admission burns were not properly attended to.

While a significant minority of patients reported dissatisfaction with how their physical health needs were assessed, most respondents said that they were also not encouraged to care for their own health and fitness needs, as the graph below shows.



### **Care/Treatment plan**

Approximately a half (47%) of all patients reported being aware of having a treatment plan, but there were significant differences here by hospital: 53% of the patients in Barrow and 52% of those in Southmead were aware of having a care plan, compared with 33% of those in Blackberry Hill hospital.

Of all the patients (n=36) who were aware of having a treatment plan, a quarter (n=12) said that they had been given a written copy of it and a half (n=18) said they had been involved in drawing it up:

*“No written copy of care plan...came into meeting and care plan already done.”*

Patients were twice as likely to be satisfied with their care plan if they had been involved in drawing it up, than if they had not been involved:

*“If I had had my own copy I would have felt more involved.”*

Involvement in ward rounds was a further source of dissatisfaction for many patients in respect to getting their needs assessed. Just over a half (55%, n=40) said they were involved in ward rounds, and of these a half (n=22) said they were satisfied that they were allowed an opportunity to have a say and a half (n=20) felt that they were listened to. Nevertheless, just under a half of patients were not involved in ward rounds where their needs were discussed, and even when patients were involved, a third said that they often did not know who was present because there were no introductions:

*“Lots of strangers, only one person I knew - the psychiatrist.”*

Several patients commented that going into a room full of strangers was intimidating, especially when one was unwell. One patient made the suggestion:

*“Structure is intimidating... might be better if patient was in the room first.”*

## **SUMMARY AND RECOMMENDATIONS**

The study shows that 44% of patients were dissatisfied with the way their needs in hospital were assessed. Within this figure there is a gender imbalance, 58% of women were dissatisfied as opposed to 29% of men.

A similar proportion of patients also felt unhappy about how staff paid attention to what they said. Forty-three percent of patients were not aware of having a care plan, and fewer than a half of patients were involved in ward rounds where their needs were discussed,

- **All patients should have a written copy of their care/treatment plan and have been actively involved in drawing it up.**
- **The assessment process should be more open, enabling discussion during which patient perceptions should not be dismissed. Patients should have opportunities to follow up on discussions and seek clarification.**
- **Nursing staff, especially key workers, should help patients to identify personal strengths that might help them with their mental health problems, and staff should have appropriate training to be able to facilitate this process effectively.**
- **On admission, or as soon as patients are stable enough to respond effectively, they should be asked about their cultural needs. Identified needs should be shared with all staff as soon as possible. Patients should not be prejudged to have any particular cultural needs.**
- **Given the difficulties that language problems can cause for accurate diagnosis and treatment it is vital that hospitals should have quick access to interpreters. Information should also be provided in different languages, particularly on admission procedures, rights under the Mental Health Act, mental health diagnoses, and medication and their possible side effects.**
- **Physical needs should be checked on admission, or as soon as the patient is stable enough to respond effectively. Hospitals should have fast access to patients' general medical notes and hospitals need to ensure good communication about these issues between staff.**



**SECTION 5: TREATMENT, MEDICATION,**  
**TALKING THERAPIES AND INFORMATION ABOUT**  
**MENTAL HEALTH ISSUES**

**The next section looks at the different types of treatment a patient may encounter in hospital including the prescribing of drugs and counselling. It also looks at the information a patient may be given or want to be given concerning their mental health condition.**

## **TREATMENT, MEDICATION, TALKING THERAPIES AND INFORMATION ABOUT MENTAL HEALTH ISSUES**

### **Medication and side effects**

Almost all of the patients in the study (97%, n=73) said they were on some form of medication when in hospital and two-thirds (68%, n=50) found their medication helpful. Most of those taking medication (68%, n=50) had been told what it was for, but almost a quarter (23%, n=17) said that they had not:

*“I didn’t know what I was taking, it was frightening it should have been explained.”*

*“The only information I had was what was written on the box.”*

There were, however, some examples of good practice:

*“Very happy with the nurses, everything was explained.”*

Just over half of the patients in the study (55%, n=40) felt their medication was reviewed frequently enough, and a similar proportion (57%, n=41) felt able to discuss their medication with staff. Nevertheless, this leaves a substantial minority of patients wanting their medication to be reviewed more frequently (41%, n=30) or unable to discuss their medication with staff (40%, n=30).

### ***Side effects of medication***

Almost three-quarters of patients (70%, n=51) reported experiencing side effects from their medication. Of these patients, most (82%, n=42) rated the side effects as being ‘quite’ to ‘very’ distressing. Two-thirds (63%, n=32) said they were not given enough information about the side effects of their medication and how to deal with them, and over a third (39%, n=27) felt they were over-medicated:

*“Felt medication made me ‘trip’.”*

*“Blurry eyes, shaking and diarrhoea.”*

### ***Refusal to take medication***

Most patients (70%, n=49) had not refused to take their medication, although 14 people commented that they felt under pressure to take it:

*“Threatened with injection.”*

*“Put under pressure by staff to take medication. One nurse put it [a tablet] up to my lips to take.”*

While some patients in the study did report examples of good practice regarding the provision of information about medication, there were many patients who felt they needed:

- more information and explanations about their medication
- information about possible side effects
- the opportunity to be involved in decisions about the medication it was suggested they should take.

### **Talking therapies**

In the study, talking therapies were defined as:

*‘Structured sessions arranged in advance, either on an individual or group basis, where you are encouraged to talk about your mental health difficulties and explore solutions or different ways of thinking about any difficulties. They may be led by a nurse, psychologist or psychiatrist’.*

The reason for using this definition was the criteria that the sessions were scheduled in advance, allowing the patient some time to think about the issues they wanted to raise. Some patients, however, used this question to comment on other types of therapy that they either had, or would have liked to have had, such as relaxation, acupuncture and/or stress management. Hence the respondents may have had a broader interpretation of talking therapies than the one initially intended by the questionnaire.

Nevertheless, of those replying to this question, over three-quarters (79%, n=59) said that they had no access to talking therapies, including all four of the patients from ethnic minority groups.

Of the patients who did not have access to any form of talking therapies, a half (54%) wished they had some. Patients mentioned a number of types of therapies that they wanted, as are detailed in the Table below.

<b>Type of therapy wanted</b>	<b>Number of patients</b>
Counselling (type unspecified)	10
Group therapy	7
Key nurse/keyworker time	4
Psychologist	4
Psychotherapy	4
Stress reduction	2
Anxiety management	2
Art therapy	2
Relaxation	2
Psychiatrist contact	2
'Help with inpatient issues'	1
Cognitive therapy	1

While the Table shows a mixed list of requests, what is clear is that of those patients who commented, a large number requested some meaningful individual therapy sessions with a trained professional - a request that was, in the main, not being responded to.

One patient commented:

*“During my stay in hospital I had a lack of alternative ‘mental’ [as opposed to drug] therapies and therefore this brought out feelings that I was put in hospital as it was a punishment, like a prison.”*

### **Occupational therapy (OT)**

Just over a half of the patients in the study (57%, n=41) said they had had access to occupational therapy. Eighteen of these patients said they were happy with the service they received; 10 patients said they were unhappy.

Some of the factors contributing to satisfaction with the service were that it helped occupy people’s time, and provided a social activity where it was possible to meet other service users. Three patients commented that the staff were friendly and three patients said that there was a good



choice of activities. In general, of the patients who used the service, most found it helpful.

However 14 patients commented that either OT was not available, staff had not told them about it, or the referral process took too long. Possibly this relates to it not being made clear to patients on admission what services the hospital offered, and/or patients not having enough access to their Key Nurse in order for them to make a referral.

Two patients mentioned that activities were often cancelled due to staff shortages, and two people commented that they felt too 'drugged up' to participate with OT.

### **Other treatments or interventions**

#### ***Observation***

Most patients (63%, n=47) did not find levels of nurse observation while in hospital intrusive. However, almost a quarter (23%, n=17) said that they did. Obviously where there are issues connected with suicidal intention or self-harm, a degree of vigilant observation may be appropriate. However, several patients commented that they found the practice of staff shining torches in their face at night distressing and, in some cases, made getting a good nights rest extremely difficult.

#### ***Seclusion***

In the study we defined seclusion as:

*'The supervised confinement of a patient alone in a room which may be locked for the protection of others from significant harm.'*

At the time the study took place none of the hospitals had an official seclusion policy as defined under the Mental Health Act. Nevertheless, 38 patients said that they were not satisfied with seclusion arrangements, which may indicate that although not officially placed in seclusion as defined by the Act, patients may have felt as though they were in seclusion:

*"Was in a locked ward."*

*"Locked in a room and watched non stop for three days."*

#### ***Electroconvulsive therapy (ECT)***

Only four patients in the study said they had received ECT during their last admission to hospital. Another two patients said they had specifically

requested the treatment, but had their request refused. Of the four patients who had received ECT, three were female and one male; three were aged between 51 and 60 and one was aged between 41-50.

Comments from those who had received ECT included:

*“Poor concentration and memory loss... I think I consented.”*

*“Didn’t feel it was a problem... consent asked for.”*

Another patient who had refused to have ECT said:

*“Would have run a mile from ECT.”*

The numbers in our study are far too small to draw any firm conclusions about the helpfulness of ECT or the satisfaction by patients as to the way in which it was administered. Carrying out a user-focussed study on the process and effectiveness of ECT might be worth investigating in more depth in the future.

### **The provision of information**

*“No one explained why I was in hospital.”*

Two-thirds (65%, n=49) of the patients in the study said that they had been given no information that might have helped them with their mental health difficulty. Of the 19 patients for whom this had been their first admission, 12 said that they did not receive any information.

Thirty-six patients in all had been given some information. Of these, a half (n=17) said that they were satisfied with the information given to them, nine were neither satisfied nor dissatisfied, six were dissatisfied and two did not know or could not remember how helpful the information had been.

Of the patients commenting about who had given them the most useful information, half (n=9) mentioned the nurses, and half (n=8) their consultant or junior doctor.

When patients were asked what information might have been helpful, they gave a number of responses, as the Table below shows:

<b>Number of responses</b>	<b>Type of information</b>
10	Drugs and medication and their side effects
6	Practical support eg for relatives, with benefits, with employment or housing issues
7	Emotional issues
3	Length of stay/likely discharge date
3	Availability of support groups
2	More information on diagnosis

These responses tend to suggest that more work needs to be done disseminating useful and accessible information to patients.

## SUMMARY AND RECOMMENDATIONS

Almost two thirds of patients said they were not given enough information about side effects; 41% felt medication could have been reviewed more frequently; 39% felt over medicated; 23% did not know what their medication was for and 22% found medication unhelpful.

- **All patients should know what medication they are on and what it is for.**
- **All patients should be told what the potential side effects of their medication are.**
- **All patients should be given both verbal and written information about their drugs and the possible side effects and an opportunity to digest and discuss this information.**
- **Staff should ask patients whether they are experiencing any side effects from medication and take action where necessary.**
- **Within the context of their particular situation, patients should have the opportunity to consider the balance of the advantages of taking a drug against its possible side effects.**
- **Patients should be informed if there might be other drug options that might have a better side effect profile.**
- **Patients should have access to a pharmacist to discuss issues around drugs and side effects.**
- **Patients should have regular reviews of their drug regime.**
- **Staff need to be more aware of patients' views about medication, and to be more responsive to problems patients identify.**
- **If drugs are administered forcibly this should be discussed with the patient afterwards. Wherever possible, this necessity should be circumvented by discussions with patients when they are well.**
- **Staff should encourage patients to make Advanced Agreements, where the steps to be taken if someone gets unwell can be thought through and agreed between the patient, health professionals, and others as appropriate. Staff could also look at the use of crisis**

**cards and other crisis management options. Advanced Agreements should be built into the process of creating a care plan.**

The themes of needing more time with health professionals, to receive information, to digest it and to talk through the implications of a mental health admission, have emerged strongly in our study. The responses to this question show a large demand for meaningful individual and group talking therapy sessions. An important aspect of this kind of therapy is that it creates a relationship with a particular health professional (or group) within which patients can develop some trust and so explore difficult issues. This kind of therapy also relies on regular, pre-arranged sessions held in private.

- **Patients should be offered more access to talking therapies, for example, a minimum of one hour per patient per week of individual therapy, two hours a week being desirable.**

In the study a number of patients commented on being ‘too drugged’ to be able to participate in many activities and felt they were being sedated inappropriately.

- **There should be frequent reviewing of medication levels and a preparedness to listen to patients’ accounts of the various side effects from some types of medication.**

It is clearly difficult for patients to occupy their time while they are in hospital: engaging in activities is important in this context. Engaging in social activities may also be a means of building up someone’s confidence, making friends and overcoming any social difficulties occasioned by a prolonged period of illness.

- **Patients should be made aware of all activities available on the ward, including occupational therapy. They should be given this information both verbally and in writing.**
- **Patients should have quick access to occupational therapy, which should be properly resourced and staffed. The Key Nurse, or some other staff member, should discuss with each patient how they are spending their time on the ward and help them to engage in appropriate activities.**
- **It would be helpful to have flexible access to occupational therapy, as well as provision of set sessions.**

Being observed can be both intrusive and frustrating for patients, even when it is necessary.

- **The need for observation should be explained to patients so that they know what to expect.**
- **Observation at night should be as discrete as possible within safety limits' so sleep is disturbed as little as possible.**

Thirty-eight patients felt dissatisfied by what they experienced as seclusion, even though none of the hospitals have an official seclusion policy.

- **Hospitals should look at alternatives to 'seclusion'. One possibility may be to provide space in the ward away from noise. Another alternative would be to look at how the environment of the ward affects people, and how it could be used to create a soothing or calming space.**

Four patients in our study had received ECT during their last admission.

- **The circumstances under which ECT is given in Bristol need to be clarified.**

The study has found that the majority of patients left hospital without being given relevant information about their mental health difficulty. Just under half the patients who were given information were satisfied with it.

- **Everyone should leave hospital with relevant information about their mental health difficulty. Patients should have sufficient time in hospital with health professionals to receive and discuss information (including written information) about the following areas:**
  - **Their diagnosis, medication and treatment and the possible side effects of these.**
  - **Their problems and emotional issues.**
  - **Support for relatives, benefits, support available from social workers, jobs and homes.**
  - **Length of stay and discharge dates.**
  - **Support groups and other sources of support once discharged.**
- **All patients should also have the option to have information discussed and shared with a nominated person if they wish.**

- **Staff should follow up on all patients before discharge to check whether information has been taken in and understood.**





## **SECTION 6: FEELING SAFE**

**This section deals with safety on the ward, patients' experiences of being subject to or witnessing restraint, patients' access to their medical records, knowledge and access to the Complaints Procedure, advocacy and issues surrounding confidentiality.**

## FEELING SAFE

### Safety on the ward

Safety is often a complex interaction of staffing levels and vigilance, building design, and a culture of care where disputes and conflicts are picked up and diffused. All patients have a right to their own personal safety and not to have to experience, or fear, bullying, intimidation or harassment whilst an inpatient.

Nevertheless, some of the patients in the study clearly felt unsafe on the ward, as the Table below shows.

Perpetrator	Type of bullying, intimidation or harassment (experienced or feared)			
	Sexual	Verbal	Physical	Racial
Staff	3 (3B)	8 (6B, 1S, 1 BH)	4 (3B, 1S)	1 (1B)
Other patient(s)	6 (4B, 2S)	33 (18B, 5BH, 10S)	13 (7B, 2BH, 4S)	3 (2B, 1BH)
Visitors to the ward	0	5 (4B, 1S)	3 (2B, 1S)	1 (1B)

**Code:** (Barrow (B), Southmead (S), Blackberry Hill (BH))

**Number of patients:** B = 39; S = 24; BH = 12.

Some of the comments made by patients are as follows:

*“Felt physically at risk from some male patients.”*

*“Felt uneasy about volatile unsupervised patients.”*

*“Was told to ‘shut up because I’m in charge...I don’t give a shit about you’.”* [Patient said that this was said to them by a member of staff].

*“Attacked by patient who was discharged after attack.”*

In addition to concerns about their own personal safety, almost a half of the patients in the study (46%) said they felt their possessions were not safe on the ward:

*“Lots of stealing, nothing done about it... lost CDs, crystals...”*

*“Could put stuff in locker, but no lock on it.”*

Of the 32 patients who felt their possessions were not safe, 20 were at Barrow. This is not surprising given that the majority of provision at Barrow involves patients sharing dormitories. Obviously more thought needs to be given to having a safe place where patients can safeguard personal possessions and toiletries. An atmosphere where possessions get stolen often breeds conflict and suspicion between patients and leaves staff open to accusations. On some wards the Trust has notices saying that it is not liable for the loss of any personal possessions. This is only fair if adequate provision has been made to help patients safeguard possessions in the first place.

Although half of the patients in the study felt their personal possessions to be unsafe, half thought that they were safe enough, and there were examples of good practice:

*“Possessions safe in office safe and had key to my own room.”*  
(Southmead patient)

### **Restraint**

Of the 76 patients in the study, 17 (22%) reported that staff had restrained them. Twelve of these patients were female, and five male. Seven reported being restrained in a way they felt was unsafe - and six of these seven patients were women.

All patients reporting having been restrained were either in Barrow (n=9) or Southmead (n=8); of those who felt they had been unsafely restrained three were in Barrow and four in Southmead.

Of the patients who had been restrained and chose to make a comment, seven referred to excessive or violent treatment:

*“Was not allowed to visit my partner on another ward. Male member of staff refused to keep their distance when I asked him to. I got upset and angry, eight staff were involved I had my head pushed down.”*  
(Female patient)

Three patients commented that while they felt they had been restrained for their own safety, the situation might have been better handled:

*“They did hurt me but it was necessary. On the other hand it would have been better if they could have just stood in front of the door.”*

*“It was to stop me hitting another patient. I had warned them of a conflict arising but they didn’t do anything about it. It wasn’t resolved and I hit out.”*

Over half of the patients in the study (55%, n=42) reported witnessing someone else being restrained; of these, 29 thought the restraint had been carried out safely. The remainder did not know (n=5) or thought that the patient had not been safely restrained (n=8). Six patients commented positively on the way they thought nursing staff had handled the incident:

*“The nurses were brilliant, they calmed him down and carted him off.”*

*“Restraint done safely, staff in a difficult position.”*

However some patients were rather more critical:

*“A man was restrained so harshly that he sprained his ankle and no one looked into this!”*

Nine patients commented that after witnessing a violent incident there was no debriefing for patients from staff:

*“...upsetting for other patients, no explanation given.”*

From the findings of this study, it seems that a small scale, in-depth study looking at staff and patient perceptions of unsafe or violent incidents, and appropriate training and support needs, might be appropriate.

### **Confidentiality**

A fifth of the respondents (20%, n=15) mentioned concerns about confidentiality. While examples of good practice were commented upon:

*“On both wards staff took me to a separate room to talk.”*

some concerns were:

*“I heard them talk about other patients in front of me - probably talked about me...”*

*“Talked in public situation where it wasn’t possible to open up fully about personal issue.”*

*“People could see my name through glass office window.”*  
(This patient was concerned that his name could be looked up in a phone book after his discharge)

*“Files went missing, patient left in room [staff office] alone.”*

Two patients expressed concerns that their situation had been discussed with their family without their permission; one patient mentioned that staff discussions about patients were clearly audible through the office window, which had been left open on a summer day. Obviously, as well as issues surrounding good working practices, the above suggest that the design and location of staff working space can contribute or detract from how well patient confidentiality is maintained.

### **Health records**

Over half (57%, n=41) of the patients in the study said that they wanted to see their health records. However, only eight had actually seen them.

A number of themes arose from the comments made by patients about having access to their health records. In general, patients did not know they could have access to them, they were ambivalent about seeing them or being able to change anything in them, and they felt that there was hesitancy in allowing patients access to their records. The Table below summarises the themes identified.

Number of patients	Comments about health records
8	Didn't know they could see them. (Two patients felt that if they had asked they would have been seen as 'trouble makers'.)
7	Felt that seeing records might be upsetting/and had some ambivalence about whether it would help or not: <i>"Wouldn't have liked what I read...info you can't do anything about."</i>
5	Felt there were delaying tactics and/or unreasonable restrictions placed on viewing notes: <i>"Told it would take a long time to arrange." "Only allowed an hour to read records in the presence of psychiatrist."</i>
5	Wanted to see them but hadn't.
4	Not interested in seeing notes.
2	Didn't feel their notes were accurate: <i>"Given diagnosis of personality disorder without being told...,wrong diagnosis."</i>
2	Suspicious that not all notes had been made available or that records had been removed: <i>"The previous notes had problems with accuracy and these have since been 'lost'."</i>

There are clearly difficulties that prevent hospital patients having access to their notes. Yet hospital records can play an important role in determining how a patient is cared for while in hospital, and it is a legal right that patients, in most instances, can have access to those notes. More thought needs to be given as to whether patients should be offered the opportunity to read their notes, rather than them having to request access themselves. Further, they should also be offered the opportunity to add a section of their own comments, should they feel the notes to be prejudicial or inaccurate. Having a more open access policy to records may also encourage the good practice of notes being written in a valuing way.

### **Complaints Procedure**

#### ***Knowledge of the complaints procedure***

Just over half (58%, n=43) of the people in the study said they knew how to complain about something when they were in hospital. There was a

slight difference according to hospital here: 50% of patients at Barrow knew how to complain, compared with 65% at Southmead and 67% at Blackberry Hill hospital. In terms of gender, 69% (n=22) of men compared with 51% (n=21) of women said they knew how to make a complaint.

### ***People wanting to complain***

Over half (56%, n=40) of the people in the study wanted to make a complaint. Again, there was a slight difference according to hospital here, with 67% (n=8) of patients at Blackberry Hill wanting to make a complaint, 56% (n=20) of those at Barrow and 50% (n=11) of patients at Southmead. In terms of gender, 69% (n=22) of women wanted to complain compared with 51% (n=21) of men. Of all of those patients who wanted to complain (n=40), just over a half (58%, n=22) went on to register their complaint.

### ***The handling of complaints***

Of all the patients (n=22) who made comments about how their complaint was dealt with, only two said that they were reasonably happy with the handling of their complaint. Twenty patients were less than happy:

*“Received a letter, patient wrong - staff right was all it said.”*

*“Complained about medication on the first day, was ignored - nothing was ever done.”*

*“Ward staff ignored the complaint [about a lack of coffee for all patients]...was seen as a troublemaker.”*

This patient also complained about other issues, including the closure of the women’s washing area. She said that it was only when the hospital manager got involved that action was taken.

### ***Reasons why people did not complain***

As was mentioned above, of all of those patients who wanted to complain, a large minority (42%) did not. Some of the comments given as to why patients did not complain were:

*“Didn’t want to rock the boat.”*

*“Fear of being rejected or not taken seriously.”*

*“Didn’t want to be thought a nuisance.”*

It appears from the study participants, therefore, that almost a half were unaware of the complaints procedure, but that more than a half of the respondents had wanted to complain at some time about something to do with their admission or care. The reason why this did not always happen included a lack of information, worries about the consequences of complaining, and a lack of faith in the complaints procedure.

### **Advocacy**

Fewer than half the patients interviewed (46%, n=35) understood the role of an advocate in a mental health setting. Only eight patients had made use of an advocacy service: six of these had been satisfied with the service they received, one had been dissatisfied and one declined to answer.

For patients who were unaware of what advocacy is, the following definition was given:

*‘An Advocate is someone who helps a service user present their wishes to mental health staff and may speak on their behalf at mental health hearings. Advocacy groups in Bristol include Bristol Mind, Black Orchid and Partners Advocacy’.*

Of the patients who were unaware of the possible role of an advocate in mental health settings (52%, n=38), 20 commented that it might, or would have, been useful in getting better care or in ‘being heard’:

*“Nurses would have taken notice if I had one.”*

*“Would have helped me get my point across.”*

*“Would have been helpful negotiating what I was allowed to do.”*

Of the 17 patients admitted under a section of the Mental Health Act, approximately half (n=9) had heard of an advocacy service, and seven had made use of one. However, out of the 10 detained patients who had not made use of an advocacy service, eight would have wished to do so.

The relatively high percentage of patients who had not heard of advocacy until interviewers mentioned it, coupled with the number of patients who felt that it might have been of use, raises important issues as to how widely advocacy projects publicise their work and what resources are devoted to such projects.



## **SUMMARY AND RECOMMENDATIONS**

Some of the patients in the study clearly felt unsafe on the ward. In addition to concerns about their personal safety, almost a half of the patients said they felt their possessions were not safe. All hospital wards must be safe for patients.

- **Any threatening and abusive behaviour needs to be challenged and dealt with promptly by staff.**
- **There should be space on the ward for patients to let off steam and have time out.**
- **Staff must be trained in equal opportunities awareness and how to deal with abusive behaviour, with some of the training given by people who have been abused and/or threatened.**
- **Hospitals must take seriously the level of perceived staff abuse found in the report and take appropriate action, for example, by providing greater supervision of staff.**

Almost a quarter of the patients said that staff had restrained them. Six of the seven patients who said they had been restrained in a way that had felt unsafe were women. Over half of the patients in the study said that they had witnessed someone else being restrained. Several patients commented that after witnessing a violent incident there was no debriefing for patients from staff.

- **Ward managers should ensure that staff have enough contact with patients to pick up early on where there are tensions that require intervention. This can often reduce the need to restrain patients.**
- **Training in restraint should always be embedded in a wider repertoire of techniques that enable staff to safely defuse tension without physical intervention.**
- **There should be ‘reassuring’ debriefings after incidents of restraint in the ward, both for the person involved and for witnesses. Staff should also be offered support to debrief from their line manager. It is recognised that violent incidents are difficult for all concerned.**

- **Further work needs to be done to examine why, at present, women feel the way they are restrained is unsafe. Debriefing sessions with patients may give some insight into this.**

Fifteen patients had concerns about confidentiality.

- **Good practice requires privacy for discussions with or about patients.**
- **There needs to be sensitivity and discretion about where and how staff talk about patients. Some attention needs to be given to where offices are situated and whether confidential information can be overheard.**

Over half the patients in the study wanted to see their health records, but few had done so. Patients did not know that they could have access to them, they thought that they would not be able to change anything in them, and they felt that there was some hesitancy in allowing patients access to their records.

- **It should be made clear to patients - both verbally and in writing on admission - that they have the right to see their records.**
- **Some thought needs to be given to whether patients are offered the opportunity to read their notes rather than having to request access formally, and are also offered the opportunity to add their own comments if they feel the notes are prejudicial or inaccurate.**
- **Having a more open access policy to records may also encourage the good practice of notes being written in a valuing way.**

Just over half of the patients in the study knew how to complain, but there was a gender imbalance with more men knowing how to complain than women. Over half (56%) of all patients had wanted to make a complaint but only half of these went on to register their complaint. The reasons why people did not complain included: a lack of information, worries about the consequences and a lack of faith in the complaints procedure. Of the 26 patients who did make a complaint, only two said they were reasonably happy with the handling of their complaint.

- **All patients should be informed about complaints procedures, both formal and informal, as part of the routine ward induction process. Information should be given both verbally and in writing, and it should be clear who the first point of contact is on the ward, e.g. the ward manager.**

- **All complaints should be recorded and monitored, including the action taken and the resolution. The complainant should be consulted about their satisfaction with the resolution.**
- **Complaints about abusive behaviour from staff should always be followed up by independent staff e.g. the complaints officer.**
- **Service users should be involved in the resolution of formal complaints and should be involved in training for staff.**
- **Patients should be empowered to complain in order to improve services, not discouraged. This also recognises that staff need the opportunity to develop practice, which is not always blame-orientated.**

Fewer than half of the patients interviewed understood the role of an advocate in a mental health setting. Of these, over a half thought that the use of an advocacy service might have been useful to them.

- **All patients should be informed about and have access to a quality Advocacy Service within a week of making a request.**
- **Information about advocacy should be part of routine information given both verbally and in writing on admission.**
- **All patients who are sectioned must have knowledge about and access to an advocate within 24 hours. Sectioning curtails liberty and freedom and as such has very serious implications. When someone is arrested they are entitled to legal representation before they are interviewed – we think mental health patients (who have generally committed no crime) deserve at least as much protection.**
- **The Key Nurse should discuss access to advocacy with the patient on admission and arrange it where desired.**
- **Patients should have access to an advocate for any meeting seeking to convert a Section 2 to a Section 3.**
- **If a patient is to be compulsorily treated they should have knowledge about, and access to, an advocate.**



## **SECTION 7: OTHER IMPORTANT ASPECTS OF**

### **GOOD INPATIENT CARE**

**In this section we look at how staff addressed the wider context of people's care including: how people's needs about benefits, social care arrangements, housing and religious and spiritual beliefs as well as access to and knowledge of service user support groups were dealt with.**

## **OTHER IMPORTANT ASPECTS OF GOOD INPATIENT CARE**

### **Benefits**

There are many issues surrounding people's benefit situation while in hospital, and the need for informed advice and help with filling in forms is essential if a hospital stay is not to lead to unnecessary financial difficulties. Even so, almost two-thirds (61%, n=45) of patients in the study were not asked about their benefit situation while in hospital; 40% said they needed help with this. Of the 25 patients who said they needed help with benefits, 16 said they did not get enough information and 18 did not have anyone to help them. Several commented that they had lost money because of this:

*“Lost money - should have claimed Incapacity while in hospital.”*

It therefore seems that thought needs to be given to the employment of a specialist independent advice worker or an outside agency to provide accessible benefits surgeries for inpatients.

### **Housing**

Almost a quarter (22%, n=16) of patients said they needed help with housing issues while in hospital. Of those that needed help, half (n=8) felt they were given enough information and support, and these patients were distributed evenly between Barrow and Southmead.

However, half of the patients needing housing help and support did not get any, and of these eight patients, seven were in Barrow and one in Southmead.

A small number of patients felt they needed help with other housing related issues, such as home help, cleaners, meals on wheels etc. Seven of these nine patients felt they had been given adequate information.

The comments from some patients clearly show that for some people housing issues were important:

*“If had more info would have not gone back to husband.”*

*“Only help from consultant, house was broken into, had to be emergency housed.”*

*“Staff helped with keeping my flat.”*

*“No support paying bills, no awareness - therefore afraid of services being cut off - stressed...had all to do when discharged.”*

*“House left open by police, vandalised, everything stolen. Children left uncared for for three days. One of children hid in cupboard when people came in. Kids ended up in foster care.”*

*“They just kicked me out I had to go to the Hub myself.”*

For a number of patients, a pro-active approach to sorting out housing needs is an essential aspect of their discharge plan and an important component of their recovery.

### **Religious or spiritual beliefs**

Almost two-thirds (62%, n=46) of patients had some form of spiritual or religious belief. Of these 46 patients, 20 had access to a spiritual or religious advisor, 21 did not and five did not know. Twenty-four patients said they had adequate facilities to worship, and 22 said they had adequate opportunities to worship i.e. the hospital routines were flexible enough to allow worship to take place. Examples of good practice included staff arranging for the person's needs to worship to be met on the ward, and Quakers visiting for a Sunday meeting.

Nevertheless, it seems that for approximately half of the patients with some form of spiritual or religious belief, there was little support for following their beliefs whilst in hospital.

Nine patients commented that they were not given any information concerning the hospital chapel or opportunities to worship:

*“Nowhere for singing, didn't tell me where the chapel was.”*

At other times staffing difficulties prevented patients attending services:

*“Unable to go to services as no staff available to supervise. Also unable to attend family remembrance service, I was very upset.”*

Three patients mentioned that as they were not Christians there was little alternative opportunity to worship.

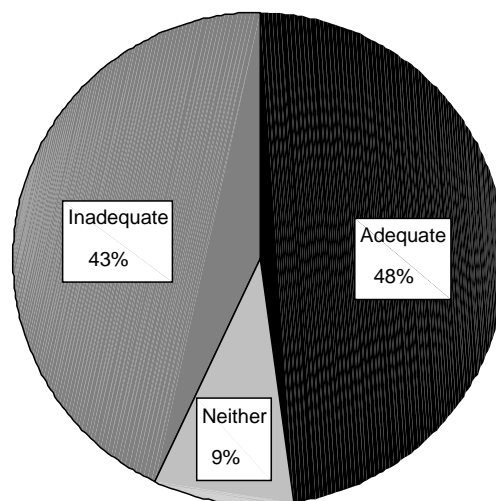
As part of a patient's induction to the ward, they need to be aware of what opportunities to worship exist within the hospital. Further, staff need to

help facilitate a person's religious needs if necessary, such as by helping the patient invite religious advisors into the hospital.

### **Social care arrangements**

Many patients admitted to hospital need help with arrangements whilst they are away from home. Such social care arrangements include things like childcare, the care of pets and/or the security of their housing. The figure below highlights how patients (n=44) rated the adequacy of social care arrangements social care arrangements.

Social care arrangements (n=44)



As the figure shows, a slightly greater proportion of patients found the arrangements to be adequate (48%) than inadequate (43%). While it may not always be the ward staff's responsibility to provide such support, they do play a crucial role in liaising with social workers and community support staff to ensure that adequate arrangements are made. It is an issue that needs to be raised at a patient's induction to a ward.

Comments made by patients about social care arrangements included:

*"They didn't ask if I needed any help, but when I moaned they said turn to your family."*

*"Needed help and felt quite embarrassed at having to talk about it at the reception desk, without any privacy."*



### **Service user groups**

The majority of patients (71%, n=54) had not been given any information about service user groups during their stay on the ward. Some of those that had been given such information said they had seen posters on the ward walls, rather than been actively given a leaflet or contact details:

*“Wasn’t told about groups, accidentally found the Patients’ Council...received information from other patient.”*

*“Not told anything... would have been interested about meetings.”*

*“Patients’ Council came round.”*

*“Lots of leaflets around if you wanted to know more.”*

Of the three hospitals covered by the study, only one has a properly funded Service User group: the Patients Council at Barrow Hospital. However there are a number of service users groups in the community, which cover the whole or part of the city, such as Bristol Survivors or the South Bristol Mental Health Forum.

A number of the patients in the study (18%, n=13) had attempted to make contact with a Service User group whilst in hospital. Of these 13 people, ten mentioned the Patients Council. Other groups mentioned included: Bristol Survivors, South Bristol Mental Health Forum, and various self-help groups including Narcotics Anonymous and the Robert Smith Unit User Group.

Five patients who had used a service user group to help them with a mental health issue had found the group helpful:

*“Helped when my stuff was stolen.”*

although two patients had felt disillusioned:

*“Hasn’t got enough power to do anything.”*

## SUMMARY AND RECOMMENDATIONS

The study shows that 61% of people were not asked about their benefit situation while in hospital. Of the 25 people who needed help with benefit arrangements, most felt they did not get enough information or help. Several patients lost money as a result.

- **The need for informed advice and help with filling in forms is essential if a hospital stay is not to lead to unnecessary poverty. As part of the admissions process staff should check on patient's financial position and benefits information should be given and explained. This should include establishing whether patients have existing support arrangements with a Community Psychiatric nurse (CPN) or social worker who could help with these issues.**
- **If patients are not able to respond effectively to questions about their financial position within seven days social services should be called in.**
- **All patients should get individual help and advice on their eligibility for benefits and with making applications.**
- **Thought needs to be given to the employment of a specialist independent advice worker or encouragement given to helping an outside agency provide accessible benefits surgeries for patients.**

Good housing is an important element in maintaining and recovering mental well being. Almost a quarter of the patients in the study said they needed help with housing issues whilst in hospital, but half of these did not get any help.

- **Housing needs should be assessed as part of the admissions process and, where necessary, referral made to a housing worker as soon as possible**
- **Patients' needs should be followed up before discharge to ensure that they have secure and suitable accommodation to go to.**
- **There should be at least two full-time, dedicated, independent, specialist housing workers, split between North and South Bristol.**
- **The housing workers should provide information, advice and assistance to solve patients' housing problems.**

- **There should be written information available on all wards on housing issues.**
- **There needs to be a wide range of housing options available to suit individual's needs.**

Only half of those with religious or spiritual beliefs said they had access to a religious or spiritual advisor, and approximately half thought they had adequate facilities and opportunities to worship.

- **Where patients have religious/spiritual beliefs they should be respected.**
- **On admission patients should be given information on what facilities are available in the hospital.**
- **Where a patient has spiritual or religious beliefs and wants to see an advisor this should be facilitated by staff. The admission process should enquire about these needs.**
- **There should be the provision of a non-sectarian place to worship and reflect, for example as at the Oncology Unit on St Michael's Hill.**

Fewer than half of all patients thought the arrangements for their social care needs were adequate.

- **All patients should have social care arrangements checked by staff as soon as possible after admission. If needs are identified there should be effective liaison with services, friends or family so that these needs are addressed.**

The majority of patients had not been given any information about service user groups during their stay on the ward.

- **All patients must be given information about service user groups both on admission and discharge. This information should include groups that are accessible within the hospital and groups in the community.**
- **Where service user groups are on site they should be clearly signposted.**
- **It is important that there should be an on-site service-user drop-in service, like the Patients' Council at Barrow, at all hospitals.**

**These need to be appropriately supported and funded. Southmead and Blackberry Hill hospitals do not have such groups at present.**

- **There should be a permanent notice board for service user groups on each ward, which must be regularly updated.**

## **SECTION 8: DISCHARGE AND COMMUNITY**

### **SUPPORT**

**This section looks at patients' experiences of discharge and how well they felt prepared for returning to the community. It also examines what support patients felt able to access in the community.**

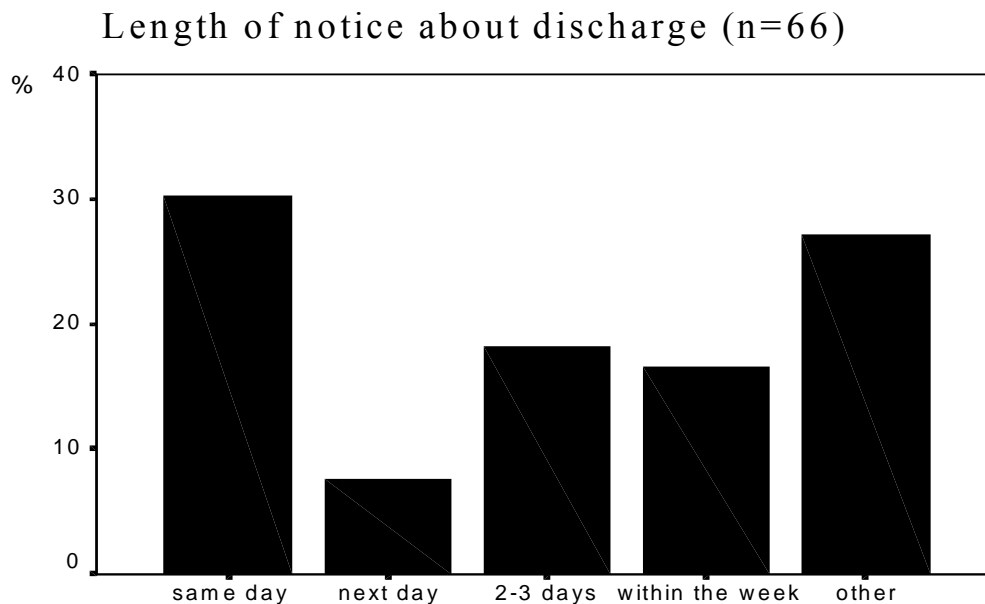
## DISCHARGE AND COMMUNITY SUPPORT

### **Discharge from hospital**

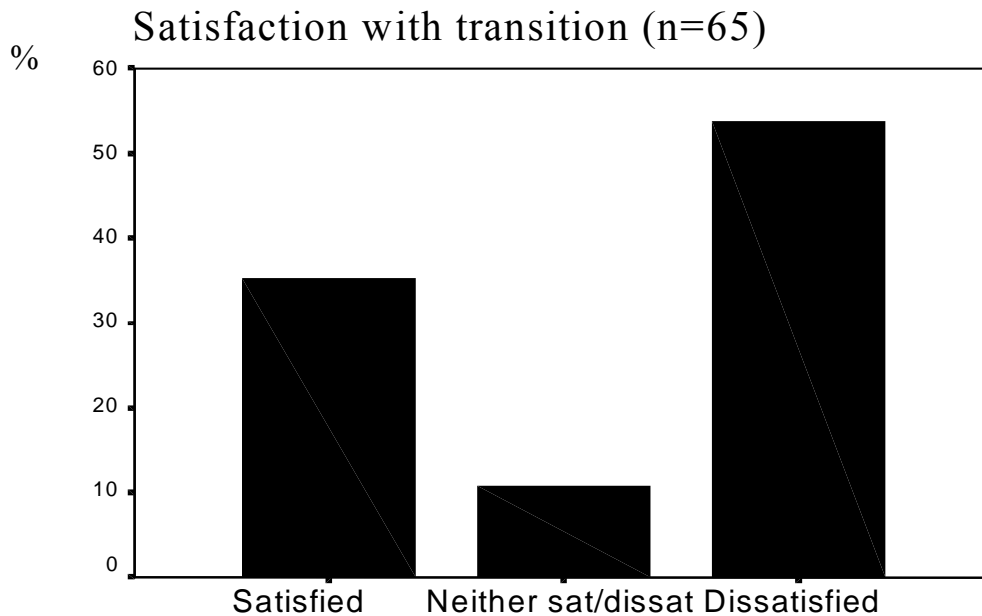
Of the patients responding to questions about discharge, half of the patients from Barrow (50%, n=16) and Blackberry Hill (50%, n=5), and just under a half of those from Southmead (43%, n=9), expressed dissatisfaction with their discharge from hospital.

In part, the dissatisfaction was about the timing of their discharge. Over a third (35%, n=25) of patients said that they did not feel ready to be discharged when they were; just over a half (55%, n=39) said they felt ready for discharge.

It is of concern that, as the graph below illustrates, a relatively high proportion of patients in the study reported having very little notice of their discharge, including almost a third who were told that they were to be discharged that same day.



Once discharged, over half of the patients in the study were not satisfied with their transition from hospital to community care, as the graph below illustrates.



The major reasons for dissatisfaction with the transition from hospital to home was largely due to having expectations of community support that never materialised:

*“Promised support but nothing given.”*

*“Felt left in the lurch.”*

*“Didn’t have support, long wait to get some.”*

*“None [support] until crisis team was called, was trying to jump off balcony.”*

Three patients did comment positively on the support they had received:

*“Seen immediately on discharge.”*

*“Very good G.P.”*

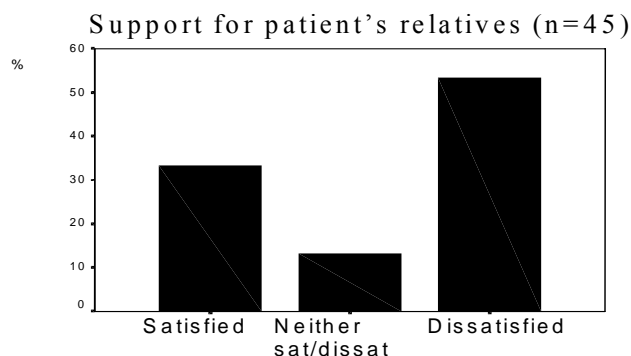
The Table below lists the type of community support that might have been available to patients on leaving hospital, and the numbers of patients who received this support.

TYPE OF SUPPORT RECEIVED	NUMBER OF RESPONDENTS
Community psychiatric Nurse	10
Community intensive support team	8
Consultant psychiatrist	6
Social worker	5
Statutory day care	5
Support worker e.g. community care worker	4
G.P.	4
Voluntary sector e.g. A.C.A.D.	3
Robert Smith Unit (Bristol specialist day service)	2
Rehabilitation services	1
Housing association	1
Family	1
Person did not mention any support or mentioned having no support	32

### Support for relatives in helping the patient return home

*“It was hard because this was the first time Mum knew.”*  
[about patient’s mental health difficulties].

With the advent of the National Service Framework (NSF) Standard 6 ‘Caring about carers’ there is a recognised need to provide appropriate support to relatives and/or carers. This is something that did not seem to have happened for the patients in the study, over half of whom were dissatisfied with the way that support was provided for their relatives or carers when they left hospital. The graph below illustrates these findings.





There appears to be evidence that their discharge from hospital is, for many of our respondents, a rather ad hoc affair. Many were unaware of their discharge plans even a few days in advance, and over half were dissatisfied with their transition from hospital to community services. Of concern too, is the high level of dissatisfaction with the support given to the relatives of respondents.

### **Information on Discharge**

It seems that comprehensive information for patients on their discharge from hospital was lacking for many of the patients in the study. Indeed, the Table below suggests that for most patients, the information given to them on discharge was either non-existent or minimal. Given that for many patients discharge is a period of high risk, this is of concern.

<b>Type of information provided on discharge</b>	<b>% of patients receiving information</b>	<b>Number of patients receiving information</b>
Arrangements for care after discharge from hospital	48%	33
The person to co-ordinate care after discharge (a 'key worker')	39%	26
The 'care programme' approach	33%	24
Support and help available in the community	21%	14
About your mental health difficulty to give to friends, relatives or carers if you wanted to.	18%	13

When asked what information they would have liked to have been given, patients gave a number of responses. These are summarised into the following categories:

- A person or point of contact if they became ill again:

*“A discharge package would have been nice!”*

- Job or career advice (some patients had been made unemployed due to illness):

*“Help with employment... I lost my license to drive buses - my key worker told me to get down the job centre.”*

- Prompt follow up appointment and/or a community worker:

*“They only contacted me three months later. I felt like a statistic.”*

- Information about support groups
- Information about the mental health condition they were being treated for.

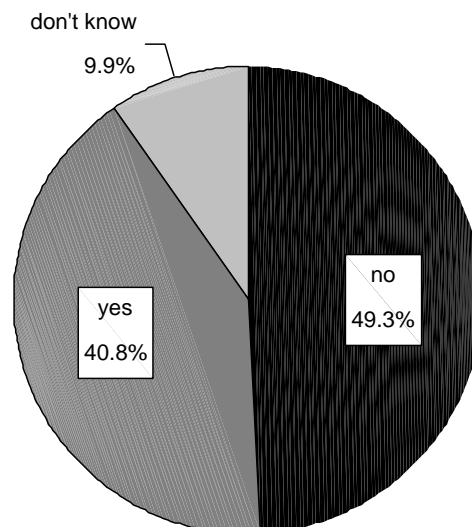
### **Support ‘after hours’ or in a crisis**

The National Service Framework (NSF) Standard 3 states that:

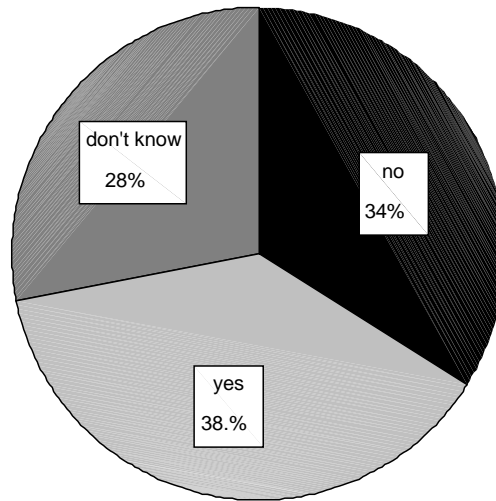
*‘Any individual with a common mental health problem should be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care.’*

A half (49%) of the patients in the study, however, did not feel they could get help quickly in the event of a mental health crisis, and a further 10% did not know. Indeed, patients often felt that there was no crisis support available, as the graphs below illustrate.

**Able to get help quickly in crisis (n=71)**



Local crisis service available? (n=71)



When asked what sort of crisis services they would like to see available, patients mentioned the following (see Table).

Type of support wanted	Number of people mentioning
Helpline or telephone support e.g. Saneline, Mindline, women's crisis line or just somebody to talk to who is understanding	19
Crisis team support i.e. Intensive support team, CIN team, PACT or out of hours day services	9
Crisis houses	5
G.P. support available on a more flexible basis	5
Hospital admission	3
Someone available to make a home visit	3
Self help groups	1
Some form of easily accessible counselling	1

### **Crisis cards**

Crisis cards may contain the name of somebody whom the holder trusts to ensure that their needs are met in case of a 'mental health emergency'. They may also contain information so that others will be able to see at a glance what actions the patient would like to be taken should they be unable to communicate directly.

Over three-quarters of the patients in the study (86%) had not heard about crisis cards. Of the 10 patients who had heard of the crisis card scheme, only two people said they had obtained one. The one patient who had actually used it commented:

*“Kept me out of hospital, people helped and are more careful about what they do.”*

Many crisis card packs were sent to patients in the study after the interview. If the scheme is to be better known and available to patients, it also needs to be more widely publicised on the wards.

## **SUMMARY AND RECOMMENDATIONS**

The transition from hospital to home can be very traumatic and is often handled badly – almost 50% of patients in the study expressed dissatisfaction with their discharge.

- **A patient's discharge should be an integral part of the Care Planning Process and the patient should be actively involved in this planning.**
- **The patient should be aware of what community support is to be made available to them and when.**
- **Patients need adequate notice of discharge. Discharge should be negotiated and agreed between patient and staff.**
- **Community staff should be involved in discharge planning to ensure a smooth and supported transition.**
- **The discharge plan should be acted on and commitments kept.**
- **There needs to be a wider range of discharge options away from home, for example, facilities available with some nursing or care support, foster beds, convalescence, or discharge houses.**
- **Hospitals need to provide appropriate support for relatives and carers.**

Comprehensive information at discharge was lacking for many of the patients in the study.

- **On discharge people should be given a discharge pack including information on:**
  - **The Care Programme Approach**
  - **Their care co-ordinator (after discharge)**
  - **Their care arrangements**
  - **An explanation of their diagnosis and mental health condition (for others)**
  - **Support and help available in the community (e.g. support groups, day centres, courses etc.)**
  - **Evaluation form for their stay in hospital**
  - **Useful leaflets with contact numbers**
  - **Information about complaints and feedback procedures**
  - **A crisis card and information about advocacy services.**

- **Every patient should have a written copy of their care plan on discharge, including contact phone numbers.**

A half of the patients in the study did not think that they could get help quickly in the event of a mental health crisis.

- **Access to crisis services must be increased in line with NSF Standard 3 to a 24-hour service, seven days a week, locally.**
- **The care plan must include a crisis plan for each patient, drawn up by the patient (with support) before discharge. This plan could take the form of an Advanced Agreement, or include the use of a crisis card.**

**SECTION 9: GENERAL COMMENTS ABOUT**  
**PEOPLE'S INPATIENT STAY**

**In this section we look at how patients' summed up their stay in hospital and what the most helpful or unhelpful aspects of their stay were.**

## GENERAL COMMENTS ABOUT PEOPLE'S INPATIENT STAY

### **Patients' general comments about being in hospital**

Respondents in the study were asked, on reflection, what the most helpful and/or unhelpful aspects of being in hospital were. Several themes emerged, and are summarised in the tables below.

<b>Most helpful thing about being in hospital</b>	<b>Number of patients commenting</b>
Ability to rest or take time out: <i>"Taken away from stressful environment, Barrow's peace, time to think."</i>	24
Safety: <i>"Kept me alive."</i>	17
Staff: <i>"The keyworker there anytime I needed."</i>	6
Treatment: <i>"My treatment for anaemia."</i>	4
Company: <i>"Being around other mums... not so isolated."</i> (Patient from Mother and Baby Unit.)	4
Other: <i>"Made divorce possible."</i>	3

<b>Most unhelpful thing about being in hospital</b>	<b>Number of patients commenting</b>
Staffing issues: <i>"No staff around when you need them."</i>	24
Boredom: <i>"Being ignored by staff and having nothing to do."</i>	5
Environment: <i>"No one believed me about the fleas."</i>	4
Stigma: <i>"Friends wouldn't visit because of stigma."</i>	2



Patients were asked to mention up to two things that could improve hospital services. Many recommendations were closely associated with the helpful or unhelpful aspects of being in hospital, as shown in the Tables above.

Twenty patients mentioned staffing issues, and the quotation below was typical:

*“Have staff listen to patients and spend more time with people.”*

Eleven patients mentioned improving activities on the wards, and better access to occupational therapy.

Six patients mentioned improving the environment of the wards.

Three patients suggested improving the catering arrangements.

Other suggestions included:

- Private telephone booth
- Better aftercare
- Access to drinking water
- More bed spaces to cut down waiting list
- Other therapies rather than drugs
- Single rooms
- Better bus system to hospital
- Better continuity of consultant care
- Hospital shop open later
- Provision of non-smoking television room
- People who are recovering from addiction problems and are mostly through their detox programme not having to mix with patients who are still withdrawing from drugs or alcohol.

### **Overall rating of hospital stay**

Patients were asked to rate, overall, what they thought of their inpatient stay. The rating scale ranged from 0 (terrible) to 10 (excellent) and was analysed as follows:

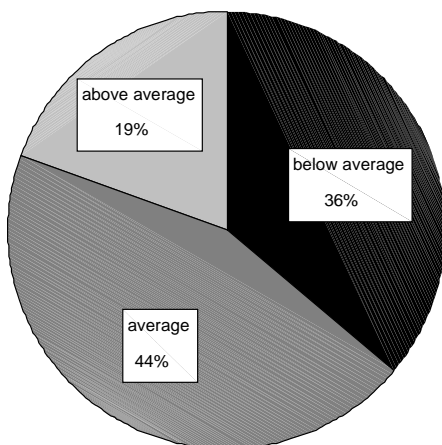
0 – 3	below average
4 – 7	average
8 – 10	above average

Of the 73 patients in the study who responded to this question, 31.5% rated their stay as above average, 39% said it was average and 31.5% thought that it was below average.

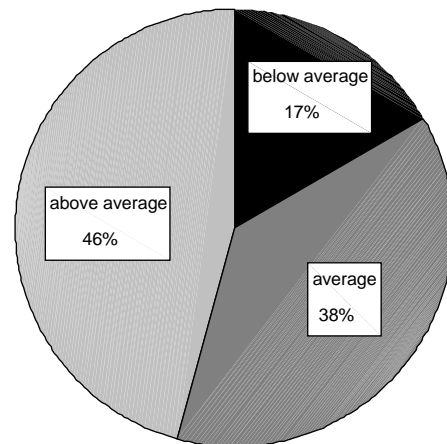
There was some difference between hospitals here, with more patients who had been admitted to Southmead (83%) rating their stay as average or above, compared with the proportion admitted to Barrow (64%) or Blackberry Hill (50%). The graphs below highlight the differences between the hospitals.

### Satisfaction ratings by hospitals

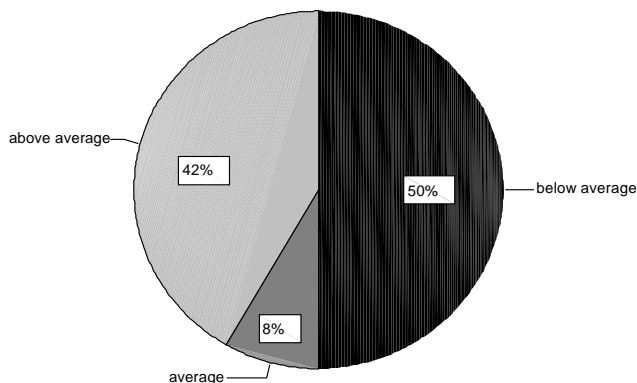
BARROW (n=36)



SOUTHMEAD (n=24)



BLACKBERRY HILL (n=12)



## **SUMMARY**

The aspect of being in hospital that patients most valued were the opportunity to take a break from the stresses of life and home in a safe environment.

The aspects of being in hospital that patients most criticised were poor patient/staff interaction and the boredom and lack of constructive activity.

Few commented specifically about the treatment provided for their mental health conditions as being important while in hospital.



## **SECTION 10: SUMMARY OF THE OTHER PATIENT**

### **INTERVIEWS**

As well as the 76 patients we interviewed in the community, we also interviewed:

- **five service users linked with Black Orchid which is a Bristol-based Black mental health advocacy service**
- **one service user linked with Dhek Bhal, a support organisation for Asian women; this is not a mental health specific organisation, but some of the people who attended the organisation had used Bristol mental health inpatient facilities.**
- **one service user who had used inpatient facilities and also had experience of ‘rough sleeping’ and had accessed one of the specialist supported housing schemes**
- **five service users who were currently inpatients at the time of the interview.**

**Four of the six service users from Black Orchid and Dhek Bhal had used inpatient facilities within the last two years.**

**While in no way do we claim that this is a representative sample, these additional interviews helped to give an insight into experiences of a group of people who may have had a distinct perspective either due to their ethnicity or experiences.**

### **Interviews at Black Orchid and Dhek Bhall**

Given that not all the service users at these two organisations had used inpatient services recently, we dispensed with the use of a structured questionnaire and instead focussed on a more wide-ranging discussion of their inpatient experiences. Some of these interviewees gave their consent to tape the interviews, which were then analysed by a member of the team not directly involved in the interview.

Unsurprisingly, many of these service users had concerns that were similar to those given in the larger part of the study population e.g. lack of involvement in care planning, lack of information, feeling not listened to by staff, not knowing how to complain and lack of information regarding claiming benefits. Four of the five service users from Black Orchid mentioned that the police had been involved in their admission to hospital. All the service users felt that having support from Black Orchid had made a positive difference to how they were treated:

*“Staff didn’t tell me about Black Orchid...once I got advocacy I got oral medication” [as opposed to an injection].*

*“Appealed [against section] several times and when I got help from Black Orchid it was lifted.”*

Being subjected to racist taunts while an inpatient was mentioned by a couple of people interviewed. One service user mentioned feeling cut off from the Black community while a patient at Barrow and another mentioned the inadequate attempts at catering for a Caribbean diet in the inpatient unit. This was a theme repeated by another Black service user in the larger part of the study.

A clear recommendation from these interviews would be appropriate funding to allow Black organisations to have a higher profile with Black service users on inpatient units. This is particularly important when it is known that Black service users tend to be over represented in certain mental health services, particularly more coercive and restrictive inpatient environments, and have difficulty accessing appropriate day services and counselling services<sup>1</sup>.

### **Service user who had experience of rough sleeping**

This service user had experienced a period of homelessness and rough sleeping as well as associated difficulties surrounding drug addiction. Two interesting themes emerged from his interview. Firstly, it is important to offer help at different times over an extended period to

someone with a substance misuse problem. He said he had been offered help at different periods of his life and it was only a few years ago that he felt his motivation was right to make a serious effort to stay clean. The AWP Trust is presently carrying out a research project looking at the role of motivational interviewing in helping people with dual diagnosis. Secondly, this interviewee had been helped by careful care planning i.e. there had been a planned path from inpatient unit to rehabilitation residential support unit to supported housing. It was because of this seamless support that he had not been forced to experience another period of homelessness, instability and vulnerability to returning to drug misuse. Some of the patients we interviewed who had attended drug rehabilitation programmes at Blackberry Hill hospital also emphasised the need for planned continuing support in helping with drug and alcohol problems.

### **Interviews with service users who were currently inpatients at the time of interviewing**

Three inpatients from Barrow and two from Southmead were interviewed. One of the Southmead patients was a Black service user, and one patient said they had had ECT. The five interviews consistently confirmed many of the key themes brought up in the main part of the study e.g. concerning trained nurses, information and consent:

*“In a rush all the time so couldn’t help....I got blamed for messing up everything.”*

*“Consent was asked and given but didn’t really want to have it [ECT]...did not feel the treatment was helpful....not enough information.”*

The two Southmead interviews provided some perspectives on Southmead worth noting. Both mentioned that they found the site somewhat claustrophobic due to its small size and the fact that one ward was on top of another. Also they commented that the rooms were on the small side.

### **Notes**

<sup>1</sup> Fernando, S. (ed.) (1995) ‘Mental health in a multi-ethnic society’. Routledge: London.





## **SECTION 11: MAIN RECOMMENDATIONS AND CONCLUDING COMMENTS**

**In this section we draw together some of the main recommendations of the study as well as the hopes and fears of those involved in the work as to how best to move forward in an effort to improve services.**

## COMMENT AND KEY RECOMMENDATIONS

### **Comment**

The completion of this report is only the first stage in the long process of trying to improve, change and build on good practice within the Bristol area. Historically mental health services in Bristol have suffered marginalisation and lack of investment. This is all too obvious when viewing some of the older facilities at hospitals like Barrow that have in some cases been closed due to health and safety concerns. The health authority is heavily overspent on health services within in the region and this raises the difficult challenge of improving services while trying to cut a budget overspend. There is a danger that mental health services are further marginalised in attempt to cut costs.

Good quality care involves staff as well as patients being empowered and supported in working together to improve services. One of the main objectives of both project team workers and those being interviewed was that their views and suggestions for improvement lead to significant change.

### **Key recommendations**

There are many recommendations made which we would want to be implemented and most are not new. Many service user groups within the Bristol area have been raising similar issues for many years. All the recommendations are important.

However, there are a number of key themes that we feel have come out of the report:

- **Firstly, service users have a key role in commenting on the services they receive, which includes studies such as the present one. There is a need to listen to service users' views on a collective and individual basis.**
- **Patients need information given in an accessible form on a far wider range of issues than they have access to at present – such as about hospital facilities and routines, their rights under the Mental Health Act, the types of community support available and information on advocacy groups, to name but a few areas.**
- **To ensure that Patients receive essential elements of good care i.e. admission information, involvement and a copy of their care plan, benefits advice etc, a checklist sheet should be on the front of each**

**patient's file with a copy given to the patient. As each element is completed a staff member should sign the relevant section on the sheet. It should be the person's Key/Named nurse's responsibility to co-ordinate this process. (Our study suggests that some patients missed out on these basics of good care.)**

- Patients need to be more actively involved in planning for their own care.**
- Staff need to be supported in spending quality time with patients both on a formal sessional and informal basis.**
- Staff need to be assisted to see patients as transcending their illness and as having strengths and capabilities which help them survive.**
- Hospital ward environments should maximise patients' privacy and dignity by providing good quality furnishings and access to choice and quality with respect to food.**
- Community services need to plan jointly with inpatient services to ensure patients are not left vulnerable after discharge.**
- Complaints and concerns raised by patients need to be listened to and addressed. Service users should be actively involved with assisting in the complaints procedure.**
- The lack of meaningful activities, both therapeutic and recreational, needs to be addressed across the inpatient units.**

We and the patients who were interviewed, would hope that real change occurs and that at a future date a similar study is undertaken showing that good progress has been made towards achieving many of the recommendations listed above.

