Focussed visits 2011-12

mentalwelfare commission for scotland

Summary of outcomes from focussed visits 2011-12

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The Mental Welfare Commission for Scotland has the duty to visit individuals with mental illness, learning disability and related conditions. This includes visiting people who are receiving care in certain types of facility (e.g. hospitals, care homes and prisons). We visit in order to:

- Allow individuals to tell us about their concerns;
- Assess whether the requirements of legislation are being met;
- Assess the facilities for individuals' care.

One way of achieving this is by what we call "focussed visits" to particular services or facilities. We undertake focussed visits for various reasons. Some facilities, e.g. secure units, are more restrictive on individuals' freedom and we visit them more often as a consequence. In other cases, we undertake focussed visits in response to concerns we have received or have expressed on previous visits. We will also visit if it has been some time since we were last in the facility. Our focus for the visits will depend on the type of facility and the concerns we have.

Between January and December 2011, we:

- Undertook 111 focussed visits. We visited individuals in various settings, including hospitals, care homes and prisons.
- Reviewed the care and treatment of 886 individuals, 652 of whom we were able to interview in person. We also interviewed 41 relatives who asked to see us during our visits.
- Made 415 recommendations for improvement following these visits. Usually, we gave services a maximum of three months to respond to our recommendations.

This is a report on the outcomes from these visits as reported to us by 31st March 2012.

In this paper, we report on the main themes and outcomes those visits. These were to individuals receiving treatment in the following types of care settings:

- Adult acute admission wards
- Care facilities for people with learning disability
- Continuing care and rehabilitation facilities
- Older people's wards in hospital

- Prison and detention centres
- Registered care homes
- Secure units
- Young people's care facilities

There were four other visits that did not fall into these categories (see below).

We have examined the main issues to emerge from these visits. We have given specific examples of improvements that services made after our visits. It was heartening to see that service managers paid great attention to our recommendations and acted on them.

Many of our recommendations addressed principles of Scottish mental health and incapacity legislation, the articles of human rights legislation and other important international conventions. We wanted to ensure that services were taking account of these when providing care and treatment. There are many examples in our reports of issues we raised. The commonest were:

- Individual recovery-based care plans. We used the principles of benefit, participation and the range of options to make recommendations. Too often, we found care plans that failed to record individual needs and interests. We wanted to see therapeutic and recreational activity designed to promote individual recovery. Range of intervention, participation, choice and provision of activity featured strongly in our recommendations.

- Poor care environments. We used the principles of benefit and minimum restriction of freedom and the right to private and family life. We made recommendations where we found environments that did not enable people enough, especially people with dementia. Poorly maintained NHS environments are unfortunately still a problem in mental health and learning disability care. They would be unacceptable if the individual was receiving care in a general hospital ward and we consider it to be unacceptable in mental health or learning disability wards. We consider this to be stigmatising toward people who use mental health or learning disability services. We have escalated concerns to senior levels within NHS Boards and will take matters to Scottish Ministers if we are not satisfied with the responses we receive.

- Compliance with treatment safeguards. During the year, we issued our report, "Not Properly Authorised". This identified that some individuals who were receiving treatment under mental health legislation were being treated without proper adherence to the safeguards in part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003. We are reporting on compliance with treatment provisions under the Adults with Incapacity (Scotland) Act 2000 this year and next year. When we visited individuals who were detained in hospital or

who lacked capacity to consent to treatment, we acted to make sure their treatment was authorised under the law and that the principles were being observed. We made recommendations to services if we found failings in their own procedures to ensure that the law was observed.

The following sections give more detail on the recommendations we made in each type of care setting. A few points to note:

- Intensive psychiatric care units (IPCUs) vary across the country. Some also act as secure units for individuals who have committed offences. We visited some IPCUs as part of our adult acute visits and some as part of visits to secure facilities.
- The four visits that did not fit into these categories provided specialist services, e.g. mother and baby services and services for people with acquired brain injury. The general points we made above are relevant for these units.

- When we use the term “individual”, we mean a person with a mental illness, learning disability or related condition.

Focussed visit summary: Visits to people in adult acute wards

Number of visits: 20

Number of recommendations: 84

Recurring themes and areas for improvement

- Therapeutic care planning including activity (31 recommendations)
- Environment including patient safety (18 recommendations)
- Communication, information and participation (17 recommendations)
- Legal compliance including consent to treatment and legal safeguards (12 recommendations)

1. Therapeutic care planning including activity (31 recommendations)

Well crafted care plans should aid recovery and reflect the principle of taking account of individual backgrounds, beliefs and abilities. We also had regard to the principles of benefit and consideration of the full range of options for care in making recommendations for improvements.

Example of improvements following our visit

We visited an acute admission ward and found that, although staff demonstrated a commitment to person centred practice, the concept of recovery was not embedded in the written care plans

In the report back to service managers following our visit we recommended that the ethos of a recovery based approach should be reflected in care planning.

The hospital responded positively by explaining the action they had taken and further action they intended to take as a result of our visit:

- *Three staff from the acute wards attended the Scottish Recovery Indicator 2 (SRI2) training. They are currently in the process of completing the SRI2 and once this is done an action plan will be formed and implemented. There are discussions on developing a care plan workshop to refresh and guide thinking on individual care planning*.

On our next visit to this area we will look at the impact of this action and will expect to see an improvement in the quality of care planning.

2. Environment including patient safety (18 recommendations)

We make recommendations about care environments whenever we believe that an environmental factor is impacting adversely on individuals' rights to privacy and dignity. In this context many of our recommendations are related to the EHCR article 8 and the principles of benefit and least restriction of freedom. We expect to find ward environments that are clean, safe, pleasant and conducive to recovery.

Example of improvements following our visit

On one visit to an acute ward with an adjoining intensive psychiatric care unit (IPCU) we were concentred to find that entrances to both were difficult to identify and once located, were stark and uninviting. We thought this could be anxiety provoking for patients and visitors. We recommended that new signage should be provided and consideration given to improving the entrance to make it less intimidating.

The hospital has taken a practical and creative approach to addressing our recommendation:

- *The patients utilised this opportunity as an art project. The nursing and OT staff discussed the issue with patients and bought blank canvasses. The patients' art work has now been placed on the wall within the corridor with the aim of making the area less stark and intimidating.*

- *Signage is now in place from the main corridor and at the main doorway*.

3. Communication, information and participation (17 recommendations)

When visiting adult acute wards we want to find out whether people are getting the information and support they need to take part in decisions about their care. We look for evidence that individuals are actively participating as far as possible in their own care and treatment. We also want to ensure that even when people are acutely unwell their past and present wishes are taken into account.

Examples of improvements following our visit

a) We visited an NHS adult acute ward which was subject to proposed closure. We found that poor communication about the proposal was impacting adversely on patient well-being. We were struck by the anxiety this was provoking in patients and staff. We recommended that managers provide as much clarity as possible about the situation as a matter of urgency.

In response to our recommendation the hospital took the following action to improve their communication:

- *Service manager for the area meets with the senior clinical nurses at a minimum of 3 weekly*

- *Scheduled site walk arounds and face to face discussions with site staff and service users on a quarterly basis*

- *Regular updates to key stakeholder groups including the Acute in-patient forum and service improvement board which has both staff and service user involvement*

b) On another visit to an admission ward we met with a service user whose first language was not English. We were concerned that he may not have been provided with information in a way he could understand to allow him to participate fully in his care. We recommended that interpreters are used on the ward wherever possible in addition to the use of the translation line service. We also recommended that information on legislation and patients' rights be provided in the person's own language and that in all cases patients are helped to understand this information.

As a result of our recommendation improvements included:

- *Face to face and translation services are available to in-patients*
- *Physical presence of an interpreter is available at times when important information is being gathered or exchanged, with continued use of telephone translation to maintain dialogue with patients outwith these times.*
- *Examining the provision of patient information particularly relating to detention and other proceedings under the Act in the patient's own language.*

4. Legal compliance including consent to treatment and legal safeguards (12 recommendations)

Example of improvements following our visit

In the course of a visit to an acute ward and IPCU facility we were concerned to find a 'blanket policy' on the drug and alcohol testing of detained patients. Staff appeared not to understand the requirements of the Mental Health Act in relation to 'specified persons'.

Using the principles of least restriction, of making sure that a person who is detained is not treated less favourably than other patients and to ensure compliance with the legal safeguards in the MHA we made a recommendation that such testing must be authorised under the relevant specified person section of the MHA (S286) and that staff training should address this content. We have previously published guidance on this: http://www.mwcscot.org.uk/media/51854/Specified%20Persons.pdf

The hospital accepted our advice and made the following improvements to their practice:

- *Since the visit, further training for senior and junior medical staff has taken place re specified persons. Until the visit staff had been unaware of the re-*

quirement to make patients specified persons to obtain specimens even when they consented to do so. The trainer has been asked to incorporate emphasis on this in his sessions. The mental health act administrator will now be informed when there is discussion around requirement to make someone a specified person. The administrator will supply the paperwork to the ward and ensure a copy is filed in the patient's notes when completed.

Focussed visit summary: Visits to individuals with learning disability

Number of visits 2

Number of recommendations 6

We only undertook two focussed visits to units for people with learning disability. This was because of the large themed visit. For more information, see our learning disability themed visit report.

Example of improvements after our visit

We used our focussed visits to follow up on some issues raised when we conducted our themed visits. On one of these visits, we looked into the needs of ten individuals who appeared to need ongoing care and support but not in hospital. We were concerned that they did not feature in the NHS Board's actions to reduce "delayed discharges" because this was mainly targeting acute general hospitals. There were no clear plans for the people we visited. We made recommendations and followed the situation up.

By April 2012, three individuals had been discharged to supported accommodation, a further three were in the process of being discharge to specific accommodation for individuals with forensic histories who needed a higher level of support. We are still following this matter up to make sure that plans in place for the other four individuals result in their discharge from hospital.

Focussed visit summary: Visits to individuals in mental health continuing care and rehabilitation facilities

Number of visits: 5

Number of recommendations: 16

We had recently completed a national themed visit to these facilities. There were fewer focussed visits as a result. We used focussed visits to return to facilities that caused us greatest concern. For more information, see our “Left Behind” report.

Recurring themes and areas for improvement

- **Personalised care planning including activities (6 recommendations)**
- **Rehabilitation environment (6 recommendations)**

1. Personalised care planning including activities

In our visits to individuals in continuing care and rehabilitation wards we want to see evidence that people’s individual background, beliefs and abilities are being recognised and that the full range of options for care are being considered . We want to ensure that environments, facilities and activities are focused on recovery; maintaining and enhancing existing skills and developing new skills required for more independent living.

Example of improvements following our visit

We visited a hospital continuing care ward where we noted that a number of care plans and activity plans showed marked similarities to each other. We felt they did not adequately capture the strengths or needs of the individuals for whom they were compiled.

We recommended that care plans and treatment plans be reviewed to ensure that they reflect individual needs.

As a result of our recommendation individual activity plans are now in place. The hospital has taken the following steps to ensure this outcome benefits patients:

- *Discussion of preferences where possible with patients and relatives and incorporated into plans. To include life histories and likes and dislikes.*
- *Nursing and OT staff now working jointly on activity plans with special emphasis on individuality.*
- *Activity volunteers in place to assist in supporting individualised activity work*.

2. Rehabilitation environment

People in continuing care/rehab settings should have the opportunity to maintain or regain living skills. We used the principle of benefit to make recommendations for improvements following a visit to an NHS rehab ward where we were concerned that service users were being denied the opportunity to develop the self care skills necessary for more independent living outside hospital. Although we commended the staff creativity in improving the patients' environment within stringent resource constraints, we felt that the centralised catering and laundry provision did not support a rehabilitation ethos.

We recommended the development of a supported self catering programme which would maximise opportunities for residents to develop and practise their cooking and budgeting skills. We also suggested the consideration of in-house domestic style laundry facilities and more personalised towels and bedding to further enhance the homely atmosphere and provide additional opportunities for patients to develop their self care skills.

Unfortunately, despite two follow up reminders to the hospital, we had not at the time of writing this report received a response from the service concerned. As is our practice, we are prepared to escalate this matter if no response is forthcoming.

Focussed visit summary: Visits to older people in hospital

Number of visits 30

Number of recommendations 117

Recurring themes and areas for improvement

- Environment (38 recommendations)
- Personal care planning, including activity (33 recommendations)
- Capacity, consent and treatment (23 recommendations)

1. Environments

We used the principles of benefit and least restriction of freedom and the right to privacy and dignity to make recommendations for improvements. It was disappointing that so many hospital wards specifically designated as being for people with dementia were badly designed.

It can be difficult if the hospital is old. We understand the financial constraints and that the ideal solution of building a new unit may not be possible. But a lot can be done to improve older wards.

<u>Example of improvements following our visit</u>

We visited a hospital ward for people with dementia where little had been done to make the environment dementia friendly. We made several recommendations, including personalisation of bedrooms, alternative sitting space to relieve the burden of activity on the current sitting-room and clearer and more helpful signage to help individuals find their way around the ward. As a result of our recommendations, the improvements included:

- *A more homely atmosphere using input from individuals and their relatives: stencils and pictures on display, memory boxes ordered for bedside and relatives encouraged to bring in photos;*
- *Patiio & Garden area improved to ease sitting room problem, Awning purchased for bad weather. Inside space was more of a problem, but a Consultant has been brought in to review the ward area;*
- *Specialist Dementia signage meeting University of Stirling Dementia Standards being purchased and a "Talking Mat System" was bought.*

2. Personal care planning and activity

Meaningful activity is important in any care setting. Older people need to be engaged in activity that is relevant to their individual needs and interests. We used the principles of participation, past and present wishes and the range of options available to make several recommendations.

Example of improvements following our visit

We visited a hospital where many amenities had been closed. Activity was poor, especially for older people who had been in hospital for many years. We made recommendations about the need for increased activity provision and better involvement of individuals in designing their own plans.

We were very impressed with the way the service responded. Actions included:

- *Care plans were reviewed and activity programs are now contained within care plans.*
- *Nursing and OT staff have developed a range of additional activities including patients running their own shop and library as these facilities were no longer available on site.*

3. Capacity, consent and treatment

For people with dementia, we routinely look to see that capacity to consent is recorded. For people who lack capacity, treatment must be in line with mental health or incapacity law. We will be producing a special report on this. It was a frequent problem on our focussed visits to older people's wards. Most of our recommendations were aimed at better legal documentation and involvement of welfare attorneys or guardians. There were a few occasions where we found that decisions on resuscitation were not being made in line with best practice.

Example of improvements following our visit

We found a ward where prescribed medication did not comply with certificates and treatment plans. We made recommendations about improved documentation and better prescribing and recording of "as required" medication. This resulted in the ward taking action to:

- *Ensure that the ward doctor compiles treatment certificates and plans. Code of practice provided to ward doctor with guidance on examples of correct completion. To be monitored by the consultant at each review. Review dates to be inserted on ward board.*

- *Audit “as required” prescriptions. Outcome of audit will be shared with prescribers*

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Focussed visit summary: Visits to individuals in prison

Number of visits: 3

Number of recommendations: 11

Recurring themes and areas for improvement

- **Access to therapeutic interventions (6 recommendations)**
- **Staff training and development (4 recommendations)**

1. Access to therapeutic interventions

Prisoners with mental illness, learning disability or related conditions have the same right to assessment and treatment as anyone else. The transfer of health provision from the Scottish Prison Service to NHS Boards took place within this visiting year. In our visits we were keen to explore the arrangements in place for transition of care to ensure access to a full range of treatment options and that the principle of maximum benefit was being observed.

We also took the opportunity to follow up the recommendations that had been made in our themed visit to report to prisons published last year.

Example of improvements following our visit

On one of our visits to individuals in prison we followed up a previous recommendation that activities and therapeutic interventions should be developed.

The responses highlighted the following improvements:

- *Development of a range of interventions which will be available to vulnerable prisoners. The intention is that these interventions provide diversion/distraction for prisoners with significant mental health issues and/or learning disabilities and can reduce the risk of preoccupation eg deliberate self harm, delusions/ hallucinations and of conflict issues with individuals which can result in episodes of challenging behaviour. It is hoped that these interventions will reduce the risk of boredom and increase motivation to participate meaningfully*

Examples of planned interventions included*:*

- *Arts and Crafts*
- *Use of gym facilities*
- *Facilitated discussion groups*

- *Addictions awareness session*
- *Sexual health awareness sessions*
- *Personal hygiene awareness sessions*
- *Relaxation group*
- *Use of sensory room.*

2. Staff training and development

We visited a detention facility and raised the need for additional staff training, regular clinical supervision and support for nursing staff as part of their ongoing continuing professional development. Our recommendations in this regard were informed by equalities legislation and are intended to promote the principle of benefit. The prisoners we visited should receive the same quality of professional nursing care as their counterparts in non custodial settings.

Example of improvements following our visit

- *Two RMNs will liaise with the local forensic mental health service to undertake refresher training*
- *The senior nurse has made links with the Mental Health Nurse Forum Scotland and has attended the recent Forensic Nurses' Conference*
- *Regular supervision has been established.*

Focussed visit summary: Visits to individuals in registered care homes

Number of visits 22

Number of recommendations 91

Recurring themes and areas for improvement

- Capacity, consent and treatment (33 recommendations)
- Personal care planning (19 recommendations)
- Activity (13 recommendations)

It was interesting to compare this with our recommendations on older people in hospital. Regulation by the Care Inspectorate has, in our opinion, led to improved environments and better care planning and activity. Knowledge and observance of incapacity legislation remains less good. We will discuss our overall findings with the Care Inspectorate. We send them each report on a registered care home and let them know of any specific concerns.

1. Capacity, consent and treatment

Two major issues emerged here. We found that medical treatment was sometimes not in line with part 5 of the Adults with Incapacity (Scotland) Act 2000. We are compiling a special monitoring report on this. We also found that care home staff often lacked clear records of which residents had attorneys or guardians with welfare and/or financial powers. We made recommendation on one or both of these topics on 19 of our 22 visits to care homes.

<u>Example of improvements following our visit</u>

We visited a care home that was part of a larger group. We found that many residents' care plans had a mention of there being a welfare or financial attorney or guardian. There was no record of the actual powers granted and sometimes no clarity whether the powers related to welfare, finance or both. The managers of the home discussed this with the overall company managers. This resulted in improvements in this care home and others owned by the same company. Their actions were:

- *A letter was sent to all next of kin requesting a copy of the documentation. Documentation was received in 20 cases; a further 12 remained outstanding at the time of writing this report.*

- *The copies are kept within the care plans. The recommendation has also been cascaded to our sister Scottish Homes and is being implemented as good practice.*

2. Personal care planning

We looked at the personal care plans of the individuals we visited. Our focus was mostly on dementia. In our joint report with the (then) Care Commission in 2009, "Remember, I'm Still Me", we commented on the lack of life story information for many of the people we saw. This remains a concern. How can a person with dementia have a personalised care plan without there being a good understanding of the person's life, work, interests and family? This was the most frequent focus for our recommendations on care planning.

Example of improvements following our visit

Generally, care plans in one particular home were good but would be enhanced by better life stories. The managers acted on our recommendations:

Life story work will be undertaken within the home, the first approach will be to work with the resident, key workers and/or families to complete. We have decided to use the National Association for Providers of Activities for older people (NAPA) document All About Me. This will be added to until a living history is established.

3. Activity

Overall, we found good availability of activities, but they were not always tailored to individual need. Sometimes, they were not recorded well. We often raised this alongside life story work.

Example of improvements following our visit

In the above case where life story work needed improvement, we also recommended an increased range of activities. We wanted to see individual activity plans in place for each resident. The home's response was:

The activity organiser is currently working with the residents in compiling a general list of their specific interests, this will be used to provide in the short term, whilst the longer term initiative of life history work is ongoing a programme that reflects needs, desire and aspirations of the residents.

Focussed visit summary: Visits to individuals in secure units

Number of visits 10

Number of recommendations 26

Recurring themes and areas for improvement

There was quite a broad range of recommendations. As with acute and continuing care units, the quality of care plans, range of activity, amount of participation and environmental issues were recurring themes. Because of particular importance for secure units, we wanted to report on three particular issues.

Activity and time out of the ward

- Environment
- Risk assessment and management

1. Activity and time out of the ward

We used the principles of benefit and least restriction of freedom to make recommendations for improvements. The small number of people receiving care in secure units may present a significant risk to others. It is understandable that they have restrictions placed on their freedom, but these should be the minimum necessary. We found that lack of staff escorts sometimes prevented individuals having time out of the ward, especially for therapeutic activities.

Example of improvements following our visit

In one secure unit, we found that individuals had some activities cancelled because there were no staff available to escort them to other parts of the hospital or outside the hospital. We asked managers to review this. Their response was encouraging. We will be visiting again to make sure that these changes are benefiting individuals

- *A system has been implemented which collects activity data on a daily basis from the wards. A report is generated from this and is included as necessary as an agenda item at operational manager's governance meeting.*
- *The provision of activity and the expected uptake will increase significantly from May 2012. This is a result of the new workforce models being implemented.*
- *Nursing, psychology and occupational therapy workforce will increase significantly in line with revised clinical models. An activity nurse who will be super-*

numerary and whose activity will be managed by the OT department has been identified for each ward in the new service.

2. Environment

Because individuals have to spend significant amounts of time within a secure environment, we pay particular attention to the environment. We want to see respect for individual privacy and dignity, bearing in mind that some individuals do present a risk and need security and observation. We have found secure facilities in older hospitals that are of a very poor standard and would not be acceptable for any patient group. We regard this as stigmatising and treating these individuals less favourably. We have major ongoing concerns about one particular facility, but we have been able to get significant improvements elsewhere.

Example of improvements following our visit

We visited an intensive psychiatric care unit is an old hospital. Roads and disused buildings were in a state of neglect. Nobody seemed to be doing anything about it. The ward internal environment was not ideal, but was acceptable given that there was a plan for reprovision. There was a fenced-in smoking area that was in full view of the public and, in our view, breached privacy and dignity and was stigmatising. We raised this at a high management level. As a result:

- *Potholes in roads etc repaired, litter patrol every 2 days, contractors have removed graffiti. Grounds to be maintained by contractors. Entrance areas repaired.*
- *Action plan and risk assessments are in place to improve environment. The fencing around the smoking area was removed immediately and the shelter put out of use. Individuals are escorted into the grounds until relocation to new premises.*

3. Risk assessment and management

This is a major issue in secure settings and usually managed well. We found two units where it could be improved.

Example of improvements following our visit

In one secure unit, we found that risk assessments had been completed but were kept separately from the main case file. This meant that care plans documenting important clinical decisions did not incorporate the risk assessments. As a result, management plans were not up to date. Recovery was hindered as specific risks were not being addressed. Following our visit:

The procedure has been tightened up and the paperwork has been amended to reflect points raised and in action planning. The risk documentation has now been amalgamated into each individual's clinical file.

Focussed visit summary: Visits to young people

Number of visits 5

Number of recommendations 16

Recurring themes and areas for improvement

- Access to a full range of services (four recommendations)
- Communication with and between child and adolescent mental health services (CAHMs) (three recommendations)
- Communication with parents (two recommendations)

Our five visits were all very different and included specialist young people's NHS wards and secure residential units. Apart from the above most common recommendations, we dealt with a variety of other issues brought to our attention including locked door policy, individual risk assessments and transition to adult services.

1. **Access to full range of services**

This was a particular issue for specialist regional mental health units. We found that access to education and some physical health services was difficult for some young people if their home was outside the area covered by the NHS Board or local authority. This was also an issue for young people in residential care whose home address was outside the area covered by the local CAMHS team. These were difficult issues to resolve and needed to be taken to a higher level.

<u>Example of improvements following our visit</u>

We visited an individual in a specialist residential unit. We found that the local CAMHS would only see referrals from their own area. It was difficult to get input from the team responsible for the young person's home area to provide input. We had some discussions and the individual case was resolved. The problem was likely to recur, however. Although the young person was not subject to the Mental Health Act, we still applied the principles of maximum benefit and reciprocity when making a recommendation about resolving this problem. We were partially successful in getting some changes. The response was:

CAMHS in the local NHS Board will provide urgent care, if this is required, but the expectation remains that the NHS Board of origin of the young person is responsible for routine CAMHS support and review, which as you know rarely happens. We are taking this up with the Scottish Government.

2. Communication with and between CAMHS teams

This was an issue in young people's NHS units. The in-patient teams had to deal with a variety of community CAMHS teams from different NHS Board areas. Arrangements for referral, liaison and discharge varied greatly.

Example of improvements following our visit

One regional in-patient unit had a particularly good pathway agreed with one of the referring NHS Boards. We recommended that they used this model to agree a similar process with other Boards.

This is an ongoing negotiation but the unit is making good progress.

3. Communication with parents

This is another problem facing regional units. Parents and family may live some distance away. This can make visits and communication difficult.

Example of improvements following our visit

We heard from young people and their parents in one regional in-patient unit that communication between staff and parents was patchy. We asked manager to address this. We received the following response:

Staff update families weekly by phone. Specialist "family link worker" (a nurse) meetings now set up. Frequency of meetings is agreed with family. Individual communication request mechanism in place.

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