HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

Looking into why people with a learning disability are not getting the right medicine in mental health hospitals

Easy Read version of the report ‘Medicine omissions in learning disability secure units’

easy read

What is in this report

This is an Easy Read version of the main report. It doesn't include all of the original information, but it will tell you about the important parts.

In this Easy Read document, hard words are in **bold**. We explain what these words mean in the sentence after they have been used.

About us

We are the Healthcare Safety Investigation Branch (HSIB).

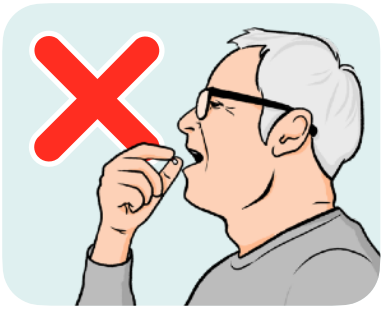
We work to improve safety for patients who use NHS services.

We look into NHS services to check the way they work to keep patients safe.

We write reports about what we find out and suggest what the services need to do to improve.

When someone tells us that they think an NHS service is doing something wrong, we look into what is happening.

What this report is about



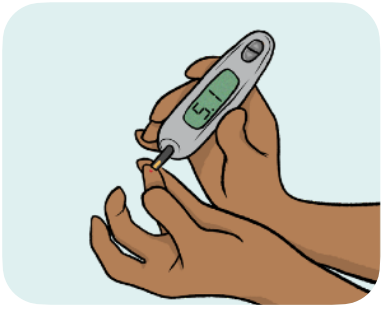
We have been looking into why some patients with a learning disability have not been getting the right medicines in **mental health hospitals**.

A **mental health hospital** is a place where someone stays to get treatment for their mental health condition.

Why we looked into this issue

We were contacted by a mother who has a son called Luke. Luke has a learning disability.

Luke was being kept in a mental health hospital and wasn't always given the medicine he needed to treat his:



- Diabetes - this is where your body can't deal with sugar properly.

- High cholesterol - this is a type of fat in your blood. High cholesterol is when you have too much of it in your blood.

Luke's **medical record** says that he refused to take the medicine.

A **medical record** is where a doctor or nurse writes about your health, illnesses and treatment.

But Luke and his mother say that he didn't refuse to take his medicine. They say there were other reasons that he did not get his medicine.

Luke's mother wanted to know if the same issues were happening for patients with a learning disability in other mental health hospitals.

What we did

We visited different mental health hospitals in different parts of the country. This included new and old hospitals.

We wanted to see how staff and patients behave in the different types of hospitals.

We looked into:

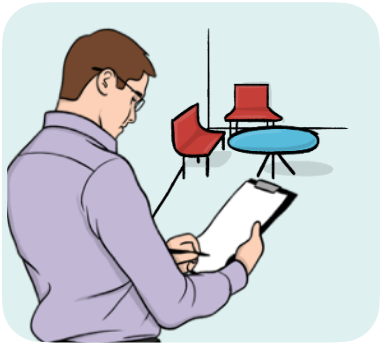
- What the rooms are like in mental health hospitals, where people are given medicine. These rooms are called wards.

- Whether the hospitals have enough learning disability nurses. These are nurses that have been trained to work with people with a learning disability.

- Whether hospital staff know how to support patients with a learning disability to make their own choices about taking medicine.

This is an Easy Read version of our report about what we found out.

What we found out



The wards

We found that the design and layout of hospital wards affected the behaviour of patients.

People were calmer and happier if a ward felt like a place where people lived, instead of feeling like a place of work.

Learning disability nurses

Learning disability nurses are trained to work with people with a learning disability.

They understand about how to communicate with someone with a learning disability.

They have different skills to mental health nurses - who are trained to work with people with a mental health condition.

We found that there are not enough learning disability nurses working in mental health hospitals.

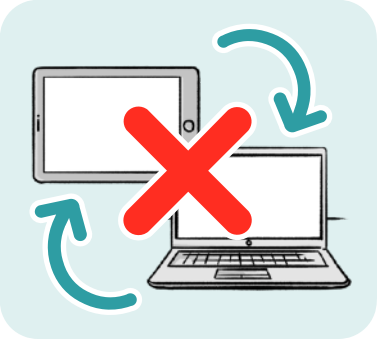
This is part of a bigger problem, because there are not enough learning disability nurses in the whole NHS.

More learning disability nurses are leaving their jobs than starting.

In mental health hospitals, if there are not enough learning disability nurses, a mental health nurse will be asked to work with a person with a learning disability.

Mental health nurses don't always have the right skills to support patients with a learning disability in the right way.

Giving people medicines



We found that the computer system used by nurses to help give people the right medicine does not work with the computer system used for patient's medical records.

So not all of the information about a patient and their treatment is being shared with all of the health staff who give them care.

If a patient refuses to take their medicine from a nurse, the information isn't always being shared with the senior doctor who says what medicine they should take.

We also found that different computer systems and different hospitals have different ways to describe when someone had not taken their medicine.

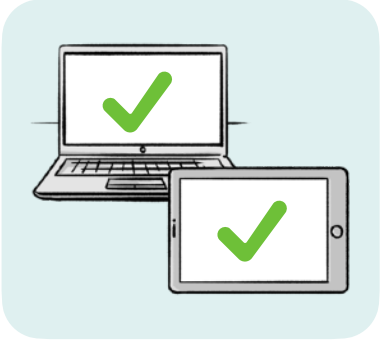
What should happen

We think that these things should happen to improve the issues we found in mental health hospitals:

- NHS England and NHS Improvement should look at the rules for the design of wards in mental health hospitals.

- NHS England and NHS Improvement should do more to keep learning disability nurses in their jobs.

- The computer system used by nurses to help give people the right medicine should be made to work with the computer system used for patient's medical records.



- All computer systems should have the same clear ways to describe why someone has not taken their medicine.

- NHS services that use mental health nurses to do the work of a learning disability nurse should make sure they are trained to communicate with people with a learning disability.

For more information

You can look at our website here:
www.hsib.org.uk

If you need more information please contact us by:

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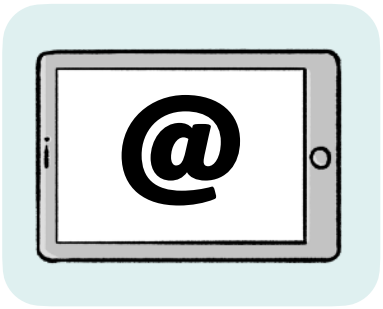

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