COLLEGE CENTRE FOR QUALITY IMPROVEMENT

Accreditation for Acute Inpatient Mental Health Services (AIMS)

PILOT PHASE REPORT

July 2006 - July 2007

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Foreword by Helen Bennett

FOREWORD

In 1998 the Sainsbury Centre for Mental Health published a report regarding problems facing acute inpatient wards [1]. Following this, a number of reviews identified consistent themes in acute care and the need for positive action. New policy and guidance challenged mental health services across the United Kingdom to make meaningful service improvements, in the context of a changing NHS. Development of mental health services has been driven by the need to improve community infrastructures and support networks: this has been an essential move, but to the detriment of inpatient care.

Thornicroft [2] cites the unacceptable experiences of service users who have found admission to hospital a distressing experience, leading to increased social exclusion and stigmatisation. The development of alternatives to admission has improved service user satisfaction, but the need to provide inpatient services for those whose care cannot be safely provided in the community has not gone away.

The AIMS accreditation process provides clear standards which are monitored and externally accredited, and the process commits wards to a programme of continuous service improvement: my own experience is that this can inspire staff to drive through sustained improvements. It also measures the quality of care provided against a national benchmark, and enables the sharing of good practice. AIMS follows on from the success of the ECT Accreditation Service (ECTAS) [3], adopting a similar model of assessment, against a common set of standards, a peer-review visit and follow-up monitoring. The assessment process is robust but also evolutionary, allowing teams to develop and work towards gaining the coveted accreditation. Evidence from the pilot sites, and the interest that followed the formal launch of AIMS, shows that Trusts across the UK want to participate and to gain accreditation.

Of the 16 wards that participated in the pilot phase, 12 have now been accredited, and as of July 2007, a total of 59 wards have signed up. Ward staff and service users have been trained to undertake the peer-review process: this both helps ward staff and service users to better understand the required standards of achievement and helps to spread best practice, by developing a network of accredited inpatient wards with motivated clinical teams.

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[1] Sainsbury Centre for Mental Health (1998) Acute problems: a survey of the quality of care in acute psychiatric wards. London: Sainsbury Centre for Mental Health.

[2] Thornicroft G (2006) Shunned: Discrimination Against People with Mental Illness. Oxford: Oxford University Press.

[6] Caird H *et al* (2004) The Electroconvulsive Therapy Accreditation Service (ECTAS).

It has been a pleasure to have been involved in the AIMS project from the outset, working with service users, carers and staff who want to ensure that acute inpatient care is properly recognised for the important role it can play in promoting positive mental health.

Helen Bennett
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July 2007

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BACKGROUND

The challenges faced by acute psychiatric wards have been extensively reported over the past 15 years. Recent surveys and reviews undertaken by national bodies [4,5,6] suggest that these problems persist. The National Audit of Violence [7], conducted by the Royal College of Psychiatrists' Research and Training Unit (CRTU) between 2003-2005, found that 1 in 3 inpatient service users have experienced violent or threatening behaviour whilst in care. The figure rose to 41% of clinical staff in these units and nearly 80% of nurses.

The key messages arising from the audit were:

- wards are often noisy, unsafe environments with poor ambience;
- service users often have no structure to their day and are bored;
- staff worry about the impact of drug and alcohol use;
- many wards have inadequate staffing levels and rely upon temporary staff;
- many nurses feel poorly trained, particularly to deal with real-life situations.

Despite the challenges, most service users who have experienced inpatient care think highly of nurses and most nurses feel well-supported by their colleagues.

In response to these findings, the CRTU hosted a series of meetings of key professionals from acute wards to discuss how to tackle these problems. It was concluded that the unremitting focus on the problems facing wards has meant that the great amount of excellent work that staff do under difficult circumstances has gone unrecognised. A system for accrediting acute psychiatric wards would help by rewarding and recognising wards that achieve high standards. Accreditation for Acute Inpatient Mental Health Services (AIMS) was established in June 2006, modelled on the ECT Accreditation Service (ECTAS) - both projects are managed by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI).

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[4] Mental Health Act Commission (2005) In Place of Fear: 11th Biennial Report 2003-2005. London: The Stationery Office.

[5] Sainsbury Centre for Mental Health (2005) Acute Care 2004: a national survey of adult psychiatric wards in England. London: Sainsbury Centre for Mental Health.

[6] Marshall et al (2004) Safer Wards for Acute Psychiatry: a review of the available evidence. London: National Patient Safety Agency.

[7] Healthcare Commission (2005) National Audit of Violence (2003-2005). London: Healthcare Commission.

AIMS allows ward staff to adopt a common set of national standards and to work to demonstrate adherence to these: the goal of accreditation is the driver to catalyse or lever improvement. Because the British Department of Health is not alone in having expressed concern about acute inpatient care, membership of AIMS is open to all wards in the UK and Ireland.

The principles of AIMS are that it:

- is owned by front-line staff and uses true peer-review;
- engages with all relevant groups, including all staff who work on the ward, senior service managers and local service users;
- applies standards that are explicit and a process that is transparent;
- gives feedback promptly;
- recognises wards that have met the accreditation standards and supports and helps those that have not.

The AIMS Steering Group was a partnership between the British Psychological Society, the College of Occupational Therapists, the Royal College of Nursing and the Royal College of Psychiatrists. It also included service users and carers.

The AIMS standards (available to download from www.rcpsych.ac.uk/AIMS) are drawn from more than 50 authoritative sources to ensure that wards are evaluated against accepted best practice. These include the Department of Health's Policy Implementation Guides [7,8], the findings of the Confidential Inquiry into Suicide and Homicide [9], NICE guidance, recommendations by NHS Estates [10] and by the Royal College of Psychiatrists [11] about ward design, the National Patient Safety Agency's Safer Wards for Acute Psychiatry Initiative [11] and the National Audit of Violence [12]. The standards have also been subject to

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[7] Department of Health (2002) Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision. London: Department of Health.

[8] Department of Health (2004) Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings. London: Department of Health.

[9] Department of Health (2001) Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. London: Department of Health.

[10] NHS Estates (April 2003) NHS Estates Schedules of Accommodation: Accommodation for people with mental illness. London: NHS Estates.

[11] Royal College of Psychiatrists (1998) Not just bricks and mortar: Report of the Royal College of Psychiatrists Working Party on the size, staffing, structure, siting, and security of new acute adult psychiatric in-patient units. London: Royal College of Psychiatrists.

[11] Marshall et al (2004) Safer Wards for Acute Psychiatry: a review of the available evidence. London: National Patient Safety Agency.

[12] op cit.

widespread consultation which has involved front-line staff, service users and carers.

Standards are graded into three Types:

Type 1 Standards must be met for a ward to be accredited. Failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or breach the law.
Type 2 Standards are those that an accredited ward would be expected to meet.
Type 3 Standards, if met, are indicators of excellence.

The process of accreditation starts with a period of self-review. The local multi-disciplinary team evaluates its own ward against the AIMS standards and, if necessary, it makes the changes needed to achieve accreditation. Data collection is aided by simple audit tools that include: questionnaires completed by ward managers, staff, patients and carers; reviews of health records and other documents such as policies and procedures, and; a review of all aspects of the ward environment. When the results have been collated, there is a one-day visit by a multi-professional peer-review team of staff from other AIMS member wards and a service user or carer. The visiting team validates the self-review findings, providing an opportunity for discussion, advice and support. Data collected from both the self-review and peer-review visit are compiled into a summary report of the ward's strengths and areas for improvement. This report is considered by the AIMS Accreditation Advisory Committee which makes a recommendation about the accreditation status of the ward. This is then ratified by the Royal College of Psychiatrists' Education, Training and Standards Committee.

A ward that fails to meet any of the Type 1 standards or a number of the Type 2 standards will have accreditation deferred for up to 6 months to enable it to take corrective action: the ward will not be accredited unless this is done. Accreditation is for a period of up to 4 years, but is subject to regular self-review and affirmation that standards have been maintained. It is also expected that wards that are accredited engage in an ongoing process of improvement, working on areas that were highlighted during the review. The AIMS standards are reviewed annually which will likely result in a "raising of the bar" from year-to-year, and therefore an incremental improvement in wards nationally.

In June 2006, 16 acute wards joined the pilot phase of AIMS. By July 2007, a further 43 acute wards had enrolled and were in the self- or peer-review phase of the process: this report summarises the achievements of the 16 wards that took part in the pilot phase. Section 1 gives an overview of the performance of these 16 wards, including the accreditation status that was awarded, and the reasons why some wards were deferred. Themes that arose from the work with the pilot wards are considered in Section 2, and a number of recommendations are made.

SECTION 1

Overall performance of the 16 wards participating in the AIMS pilot

Of the 16 pilot wards, 4 wards achieved accreditation at the first attempt and 12 were deferred because they had failed to meet at least one Type 1 standard: Table 1 shows the number of deferred wards that failed to meet individual Type 1 standards. By July 2007, 8 of the deferred wards had taken the necessary corrective action, and had achieved accreditation.

TABLE 1

Standard	No. wards
Inpatients have access to specialist practitioners of psychological interventions up to one session per week per ward.	7
The referring agency gives clear information as to security of the patients home, whereabouts of children/animals etc.	6
Each patient is invited to meet with a member of staff for one-to-one therapeutic contact for at least fifteen minutes, each waking shift.	5
The ward can demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology professions are developing the necessary skills to provide a repertoire of basic psychological interventions in line with NICE guidance.	5
If a patient is identified as presenting with a risk of absconding, then a crisis plan is completed, which includes instructions for alerting carers and any other person who may be at risk.	4
Any incident requiring rapid tranquillisation, physical intervention or seclusion is recorded contemporaneously, using a local template, which records the use of these interventions and the procedures taken during these interventions and any adverse outcomes.	4
All likely ligature points are removed or made safe.	4
The care plans are based on a comprehensive physical, psychological and social assessment, which includes a comprehensive risk and strengths assessment.	3

All qualified nurses have been assessed as competent in the administration of medications.	3
There is a smoke-free policy for staff, which follows HDA guidance and best practice.	2
Patients have daily 'face to face' contact with a member of the MDT.	2
At all times, a doctor is available to quickly attend an alert by staff members when interventions for the management of disturbed/ violent behaviour are required, according to documented guidelines or within 30 minutes.	2
There are agreed protocols in place with the local police that ensure effective and sensitive liaison regarding incidents of criminal activity/harassment/violence.	2
Admission to an adult unit of people under the age of 18 only happens if: • the local authority is informed of the admission; • the MHAC is informed (if the patient is detained); • all ward staff who have contact with the patient have enhanced CRB checks; • there is access to child and adolescent psychiatric consultation and advice throughout admission.	2
The ward has a strategy for the comprehensive care of patients with dual diagnosis that includes: • liaison between mental health and substance misuse services; • regular drug/alcohol screening to support decisions about care/ treatment options; • liaison between mental health and statutory and voluntary agencies; • staff training (which includes input from the police); • the appointment of key staff who will lead clinical developments; • clear protocols, agreed with the police; • consideration as to the impact on other patients of adverse behaviours due to alcohol/drug abuse.	2
Policies, procedures and guidelines are written and formatted in ways MDT staff find accessible and easy to use.	1
All front-line staff are provided with study facilities and time.	1
Before being asked to carry out any clinical work, all staff receive mandatory training.	1
Communication between the ward and the assessing team enables the ward to prepare for an admission.	1

All assessments are documented, signed and dated by the assessing practitioner.	1
The patient is given a copy of a written aftercare plan, agreed on discharge, which sets out: • the care and rehabilitation to be provided; • the name of the care co-ordinator (if they require further care); • the action to be taken should signs of relapse occur or if there is a crisis, or if the patient fails to attend treatment; • specific action to take in the first week.	1
The nurse in charge of the ward is the point of contact for consultation, negotiation, and decision making for all ward operational matters.	1
There is a written mutual code of conduct for ward behaviour.	1
A crash bag is available within 3 minutes. This equipment must include: • an automatic external defibrillator; • a bag valve mask; • oxygen; • cannulas; • fluids; • suction; • first-line resuscitation medications.	1
The crash bag is maintained and checked weekly or after use.	1
There are clear and comprehensive policies and procedures regarding positive risk taking and illicit drug use within the inpatient unit based on the relevant Department of Health guidance (2002).	1
Patients have a comprehensive, ongoing assessment of risk to self and others with full involvement of client and their carer (if the patient gives consent).	1
Findings from risk assessments are communicated across relevant agencies and care settings, in accordance with the laws relating to patient confidentiality.	1
There are written policies on the use of restraint of which all staff are aware.	1

SECTION 2

Themes and recommendations

These 16 wards volunteered to participate in the pilot and so might not be representative of all wards in the UK. With this caveat, we have examined the themes that arose and make some tentative recommendations. Next year's report will include the results for many more wards and will present a more accurate and complete picture. The information sources that contributed to identification of the themes and subsequent recommendations for this section are:

- an audit of 294 health care records (a mean of 18 per ward);
- an inspection of the facilities and equipment of each ward by local staff and by the visiting peer-review team;
- a checklist of important policies, protocols and procedures, completed at a team meeting involving core ward staff, and confirmed by the visiting peer-review team;
- questionnaire returns for 298 ward staff (a mean of 19 per ward). Staff that completed the questionnaires included 131 qualified nurses, 95 nursing assistants, 17 occupational therapists, 15 doctors and 8 administrators;
- questionnaire returns from the Ward Manager of each ward;
- questionnaire returns from 83 carers (a mean of 5 per ward);
- questionnaire returns from 173 service users (a mean of 11 per ward).

All questionnaires were completed confidentially and anonymously, and returned directly to the CCQI by the person who completed it. The themes identified are drawn from the results that were presented initially to the Accreditation Advisory Committee. The 8 wards that were initially deferred have addressed many of these deficits and were subsequently accredited. Quotes from service users, staff and carers, made in the free-text sections of the relevant questionnaires, are used to illustrate the themes derived from the numerical data. Inevitably, the quotes selected to illustrate themes are mostly negative, and it is important to start by saying that service users also made many positive comments:

> "The care and support I have received has been of the highest standard. The staff were excellent in every way, nothing seemed to be too much trouble for any of them. I believe that I have left here with a better understanding of my problems. To be committed was very daunting, but I was put at ease right away by all the members of staff. I cannot ever thank them enough. Many, many thanks."

"I feel I am very well looked after and appreciate it."

"I was treated very well and as a human being. Very good."

"Although there are quite a few 'no' answers, I feel that many of the questions are quite trivial compared to the importance of having my wishes taken into account, which has happened (and is by far of most importance)."

"I think the ward today is something that is well respected by staff and service users. It has changed for the better in the mental health system over the years I have used the system."

THEMES

Theme 1:
The availability of psychological therapies on the inpatient ward

The Type 1 standard that wards failed to meet most frequently concerned the provision of psychological therapies. Patients on 7 out of the 16 wards had no access to specialist practitioners capable of delivering the repertoire of psychological therapies recommended by practice guidelines. Only 1 ward could offer access to specialist practitioners more than once per week. The qualified staff on 4 wards lacked the skills to provide even basic psychological interventions and on only 3 wards was each service user offered supportive counselling, active listening or problem solving for 1 hour each week.

"Frustration that medication is the main priority of my care to the extent that I can't discuss my reservations about it with anyone other than the psychiatrist who works with a medical model only which I don't fully agree with." (service user)

"Received no counselling or therapy." (service user)

"An interesting questionnaire, it would be fabulous to receive training in talking therapies." (service user)

Theme 2:
Contact time with staff

On some wards, service users spend little therapeutic time with ward staff. As such, 5 wards had accreditation deferred because they could not offer service users 15 minutes of one-to-one time each shift. Just over one-third of service users reported that they spent this amount of time with staff, and only 54% that they met with their primary nurse on more than one occasion during the week.

Consistent with this finding, only 58% of service users reported having

been told the name of their primary nurse on the day that they were admitted and just 40% of service users reported that they had been informed about how to arrange to meet their primary nurse. On 13 of the 16 wards, patients did not have the opportunity to meet with their consultant outside ward rounds.

"Doctors hand out medication because they can't be bothered to invest time in treating service users properly." (service user)

"Lack of conversation between staff and service users (esp. with v. depressed service users weeping, etc)." (service user)

"I felt isolated and lonely. I stayed in my room and did not leave it. Every so often staff would knock and open the door. No-one took the time to sit down and really find out my problems. It was only after my CPN visited that staff really talked to me. My Primary Nurse was allocated the day I left. For 3 days I had nothing to eat because I didn't want to go into the dining room. No-one offered to bring food to my room or talk to me about this. It was my CPN who sorted this out when she visited." (service user)

"Due to staff shortages [and] service user observations we have little or no time to practice 1:1 time; we as nursing assistants have little time for self-improvement." (staff member)

"They (staff) should spend more time with service users talking to them." (carer)

"Don't see the doctor enough. Poor communication with medical staff." (carer)

Theme 3:
Safety on the ward

4 wards were deferred because they had not removed or made safe potential ligature points. This had not been apparent to the ward staff at self-review but had been picked up by the peer-review team which found that ligature points still remained, for example on fire doors, where collapsible door hinges are recommended, and in bathrooms.

Of the healthcare records reviewed, only 1 in 3 contained crisis plans for those service users at risk of absconding (e.g. with contact details for persons who may be at risk from absconding service users).

3 wards had not assessed the competence of nurses in the administration of medication. On 2 wards, doctors were not available to attend a crisis within the recommended 30 minutes and a crash bag was not available within 3 minutes on one of the wards. Staff on 4 wards did not record adequately the management of psychiatric emergency measures such as rapid tranquillisation and seclusion.

Theme 4:
The provision of activities on the ward

Consistent with national surveys that show that many wards lack structured days, leading to service users becoming bored, 5 wards provided no activities at weekends and 8 provided none in the evenings. Staff on 9 wards had been given no planned and protected time to ensure that activities and interventions are provided regularly and routinely.

"At weekends agency staff are used. They don't know you. I don't know what the OTs do. They sit in the office all day. There are no activities." (service user)

"[Want] more activities during evening & weekends. More staff working on the ward. Continuity of regular staff instead of bank staff." (service user)

"There is a marked lack of activities to activate & engage from the morning onward. Like many other service users I resort to smoking too many cigarettes." (service user)

Theme 5:
Numbers of qualified staff

As the box above shows, some service users make a link between having nothing to do on the ward and problems with staffing and, in particular, the lack of qualified staff in the evenings and at weekends and reliance on agency staff. There was no strategy to improve staff recruitment and reduce the use of bank and agency staff on 4 of the wards, and for only 3 wards did the human resources department advertise staff vacancies at the earliest opportunity.

Theme 6:
Control of admissions, case-mix and bed occupancy levels

Previous surveys suggest that the role of the ward in the system of mental healthcare is ill-defined and that ward staff have little control over admissions. In keeping with this, on only 6 wards was the current case-mix of patients on the ward taken into account when a decision about whether to admit a new patient was made. The pressure on beds is illustrated by the finding that staff on 12 wards could not guarantee that a service user would return to the same bed when they came back from leave.

RECOMMENDATIONS

1. Low staff numbers and high use of non-permanent staff contribute directly to 4 of the 6 themes. Human resource departments must be more proactive in ensuring that wards are adequately staffed. The AIMS team should explore the possibility of developing a set of simple indicators (e.g. of levels of use of agency and bank staff, delays in recruitment and absences through sickness) that might be used routinely as markers of the quality of human resource support provided to ward managers.

2. It should be a national priority that action is taken to increase the availability of psychological therapies to people receiving inpatient care. AIMS should work actively with its partners from the British Psychological Society to develop guidance about this issue.

3. Wards should ensure that their practices and procedures regarding ward safety are subject to external scrutiny on a regular basis. For those wards that are members of AIMS, this might include involving the Trust's own risk management teams during the self-review phase of the accreditation process, as well as receiving the AIMS peer-review visiting team.

4. This report should be sent to the Medical Directors and Directors of Nursing of NHS and independent sector services that provide inpatient psychiatry facilities.

APPENDIX 1

The AIMS Project Team between July 2006 & July 2007

Name	Position
Ms Joanne Cresswell	Programme Manager/Nurse Advisor
Mr Mark Beavon	Project Administrator
Dr Robert Baskind	SpR Psychiatrist
Ms Diana Chan	Programme Manager (until Dec 06)

The AIMS Accreditation Advisory Committee (Membership as of 1st July 2007)

Name	Job Title/Designation	Trust/Organisation
Mr Godwin Calafato	Carer Representative	-
Ms Joanne Cresswell	AIMS Programme Manager/Nurse Advisor	Royal College of Psychiatrists
Mrs Rachel Christian-Edwards	Head Occupational Therapist/ Therapies Manager	Dorset Healthcare NHS Foundation Trust
Ms Samantha Dewis	Clinical Lead Occupational Therapist	Wolverhampton City Primary Care Trust
Dr Leonard Fagin	Consultant Psychiatrist/ Honorary Senior Lecturer	London Metropolitan University/University College London
Mrs Tracy Flanagan	Nurse Consultant/ Senior Lecturer	Humber Mental Health Teaching NHS Trust/ University of Hull
Mr Angus Forsyth	Nurse Consultant	Northumberland, Tyne & Wear NHS Trust
Dr Sarah Gledhill	Consultant Clinical Psychologist	Surrey & Borders Partnership NHS Trust
Ms Sarah King	Service User Representative	-
Mr Nick Nalladorai	Carer Representative	-
Dr Mark Salter	Consultant Psychiatrist	East London & The City Mental Health Trust
Dr Trevor Turner	Consultant Psychiatrist	East London & The City Mental Health Trust

The AIMS Steering Group

Name	Job Title/Designation	Trust/Organisation
Ms Helen M Bennett (Co-Chair)	Head of Mental Health Nursing	Cardiff & Vale NHS Trust
Ms Anna Burke	Clinical Lead - Mental Health	North West Regional Offender Health Team Bury PCT
Mr Godwin Calafato	Carer Representative	-
Dr Rob Chaplin	Research Fellow	Royal College of Psychiatrists
Mrs Rachel Christian-Edwards	Head Occupational Therapist/ Therapies Manager	Dorset Healthcare NHS Foundation Trust
Mr Ian Gallon (until Dec 2006)	Project Manager	Centre for Clinical and Academic Workforce Innovation/Royal College of Nursing
Dr John Hanna	Consultant Clinical Psychologist	Camden & Islington Mental Health & Social Care Trust/ British Psychological Society
Ms Marion Janner	Service User Representative	-
Dr Peter Jarrett	Inpatient Consultant	Oxleas NHS Foundation Trust
Ms Sarah King	Service User Representative	-
Dr Paul Lelliott	Director, College Research and Training Unit	Royal College of Psychiatrists
Mrs Elizabeth Moody	Associate Director of Nursing	Northumberland, Tyne & Wear NHS Trust
Mr Terry Randles	Head of Mental Health	North East Lincolnshire Primary Care Trust
Ms Yvonne Stoddart	Director, National Acute Mental Health Project	Care Services Improvement Partnership (CSIP)
Ms Dawn Talbot	Carer Representative	-
Dr Trevor Turner (Co-Chair)	Consultant Psychiatrist/ Clinical Director	East London & The City Mental Health Trust
Mr Adrian Worrall	Head, College Centre for Quality Improvement	Royal College of Psychiatrists
Mr Norman Young	Nurse Consultant	Cardiff & Vale NHS Trust/ Royal College of Nursing (from Jan 2007)

Accreditation for Acute Inpatient Mental Health Services (AIMS)

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