

AIMS
ACCREDITATION FOR INPATIENT
MENTAL HEALTH SERVICES



Accreditation for Inpatient Mental Health Services-Older People's Services (AIMS-OP)

First National Report 2008-2011

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FOREWORD

Accreditation for Inpatient Mental Health Services for Older Peoples Acute Wards began in 2008. This First National Report is concerned with findings over the first two years of the project and we hope you will find it of interest.

The AIMS process is increasingly recognised to be one of the very best tools available to produce badly needed improvements in today's psychiatric wards, making a meaningful difference to all those that either provide or receive care.

The process provides clear standards which are monitored and externally accredited. It commits units to a programme of continuous service improvement inspiring staff to drive through sustained improvements. It enables the sharing of good practice, identifying the quality of the care provided against a national baseline. AIMS-OP follows on from the success of AIMS for Working Age Adult Acute Wards, adopting a similar model of assessment against a common set of standards, peer-review and follow up monitoring. The accreditation process is robust but also evolutionary, allowing teams to develop and work towards achieving the higher level of accreditation. Since the formal launch of AIMS in 2006, Trusts across the UK have shown themselves keen to participate in the programmes and gain accreditation for their wards.

We would also particularly like to thank the AIMS-OP member wards and their staff, Patients and Carers for their hard work, feedback and patience during the AIMS-OP process.



Joanne Cresswell
AIMS Senior Programme Manager

INTRODUCTION

The Accreditation for Inpatient Mental Health Services for Older People (AIMS-OP) project assures and improves the quality of inpatient mental health services for older people. It accredits short-stay wards for people with functional and organic disorders against best practice standards. It is part of a wider accreditation programme for psychiatric wards called AIMS and is managed by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI).

AIMS enables unit staff to adopt a common set of national standards and to work towards demonstrating adherence to these. The goal of accreditation is to drive forward improvement and enable wards to achieve excellence.

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 who act as peer-reviewers as well as assessing the quality of their own ward;
- 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-OP standards were based on the AIMS Working Age version (both sets of standards are available to download at www.rcpsych.ac.uk/AIMS). The AIMS standards were drawn from more than 50 authoritative sources to ensure that wards are evaluated against best practice. These include the Department of Health's Policy Implementation Guides^{1,2}, the findings of the Confidential Inquiry into Suicide and Homicide³, NICE guidance, recommendations by NHS Estates⁴ and by the Royal College of Psychiatrists⁵ about ward design, the National Patient Safety Agency's Safer Wards for Acute Psychiatry Initiative⁶ and the National Audit of Violence⁷. The standards

¹ Department of Health (2002) *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*. London: Department of Health.

² 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.

³ 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.

⁴ NHS Estates (2003) *NHS Estates Schedules of Accommodation: Accommodation for people with mental illness*. London: NHS Estates.

⁵ 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-patients units*. London: Royal College of Psychiatrists.

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.

have also been subject to widespread consultation which involved front-line staff, service users and carers.

There are three types of AIMS-OP standards:

Type 1 Standards must be met for a unit 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 unit would be expected to meet.

Type 3 Standards are those that an excellent unit should meet, or are standards that are not the direct responsibility of the unit.

The AIMS-OP standards are reviewed at least every two years. This ensures that they fully take into account all current guidance. It allows for a 'raising of the bar' from year to year and therefore an incremental improvement in wards nationally.

The process

There are three main phases to the AIMS process: self-review, a peer-review visit, and the decision about accreditation category and feedback.

Phase 1: Self-review

During the three-month period of self-review the local multi-disciplinary team evaluates its own ward against the AIMS-OP

standards and, if necessary, it makes the changes needed to achieve accreditation. Data collection is via simple audit tools that include: questionnaires completed by ward managers, staff, patients and carers; reviews of health records and policies and procedures; a review of the physical ward environment; and the completion of a training grid and a staff off-duty rota. Most self-review data are submitted online via the project website. To ensure confidentiality, the patient and carer questionnaires are returned directly to the project team using postage-paid envelopes provided by AIMS. The training grid and staff off-duty rota are also returned by post. Minimum targets are set for the number of questionnaires and health record audits required.

Phase 2: Peer-review

The self-review data are collated into a peer-review booklet that forms the basis of the one-day visit by a multi-professional peer-review team. The peer-review day usually takes place between four to eight weeks after the self-review period ends.

Peer-reviewer training

When a ward signs up to the AIMS-OP process, they are asked to nominate two clinicians to act as a peer-reviewer for other member wards. In addition, service users and carers attached to member services are encouraged to join as reviewers to ensure representation of their points of view. It is essential that all potential reviewers complete a training day before they

carry out a review visit. Training days are offered on a regular basis.

Review teams

This team of four comprises three staff from other AIMS member wards, with at least two having experience of an older people's ward, and a service user or carer representative. One team member acts as the lead reviewer, who has additional responsibilities before, on, and after the peer-review visit.

Purpose and benefit of the visits

The purpose of the peer-review visit is to validate the results of the self-review and to discuss any discrepancies that may become apparent. The visits also provide a valuable opportunity for discussion, and for the review team to share ideas, make suggestions, offer advice and give support. During the day, it is emphasised that the review is an opportunity for support and not an inspection. Review teams are encouraged to work alongside the host team to identify areas for improvement and highlight areas of good practice. This enables staff to demonstrate the quality of their service. The visits are structured around a suggested timetable for the day, which ensures that all aspects of the peer-review booklet are covered.

Working through the booklet

After working through the booklet with the host team, members of the review team discuss whether, on the basis of evidence supplied, each criterion should be rated as 'met' or 'not met'. The lead reviewer collects the booklets from the other team members and is responsible for compiling all reviewer comments into a summary report, before returning it to the AIMS-OP project team. The draft report is then produced and sent to the host team for comment within two weeks of the visit. All parties agree that it is a fair reflection of the self-review and peer-review data before the report is finalised.

This report is considered by the AIMS Accreditation Committee (AC) which is a body of representatives from the British Psychological Society, the College of Occupational Therapists, the Royal College of Nursing, the Royal College of Psychiatrists, and service users and carers. The AC makes a recommendation about the accreditation status of the ward. This decision is ratified by the Royal College of Psychiatrists' Special Committee on Professional Practice and Ethics.

A ward that fails to meet one or more of the Type 1 standards or a number of the Type 2 standards (less than 80% or a substantial number of unmet standards in one domain) will have accreditation deferred for up to 6 months to enable it to take corrective action. Only once the ward has successfully addressed these will the ward be accredited. Deferral can be renewable for up to a year. Currently, accreditation is for a

period of up to four years, subject to a biennial self-review which demonstrates that standards are being maintained. During this period, it is also expected that the wards are engaged in an ongoing process of improvement, working on the areas that were highlighted during the review. This is facilitated by the provision of an action plan which is issued within each ward's final report.

THE CHARACTERISTICS OF THE WARDS

Table 1 summarises the contextual data provided by the 50 wards that completed the AIMS-OP process by 31 March 2011. This data included: size of the ward, staffing levels, bed occupancy, average length of stay, and occupational therapy and psychology input.

Table 1: Aggregated contextual data items across all wards

	Mean	Range
Number of beds	17	5 to 25
Bed occupancy rate	83%	10 to 100%
Length of stay	13 weeks	4 to 43 weeks
Number of qualified nurses	11	7 to 17
Number of unqualified nurses	13	5 to 21

Size of the wards

Three-quarters of the wards had between 15 and 25 beds (see fig. 1).

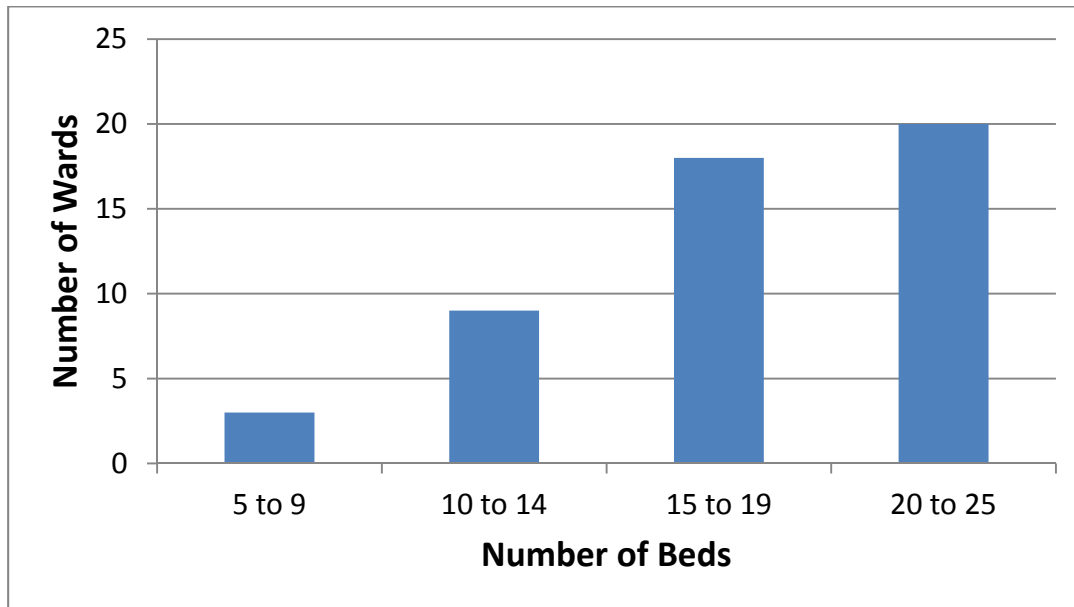


Fig. 1: Number of beds on the participating wards

Staffing levels

Table 2 shows the mean number of qualified and unqualified nursing staff on wards of different sizes.

Table 2: Staffing levels on wards of different sizes

Number of beds	Number of wards	Mean no. qualified nurses (range 1-17)	Mean no. unqualified nurses (range 5-21)
5 to 9	3	8	11
10 to 14	9	9	11
15 to 19	18	11	11
20 to 25	20	12	14

Bed occupancy

Figure 2 shows the percentage bed occupancy levels for the wards. The wards calculated this by averaging their bed occupancy over a one year period, including 'on leave' beds.

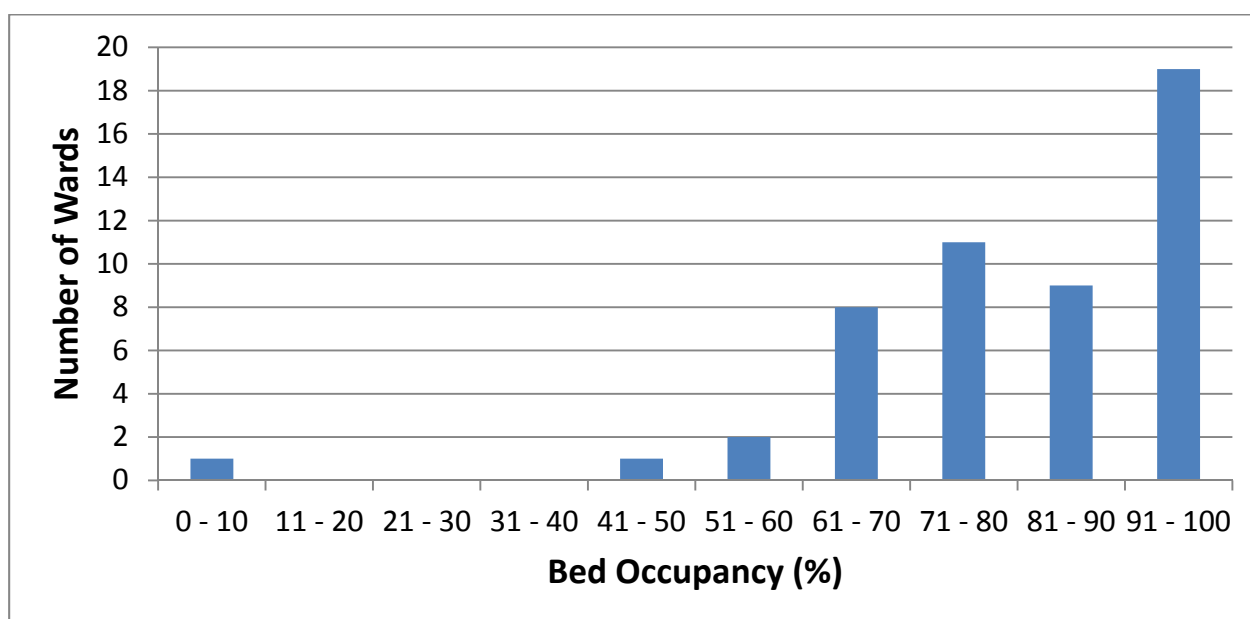


Fig. 2: Percentage of bed occupancy levels.

The outlier in Fig. 2 relates to one 5-bedded ward, which is part of a larger ward so beds may not always be filled.

Average length of stay

The median length of stay was 6 to 10 weeks (Fig. 3).

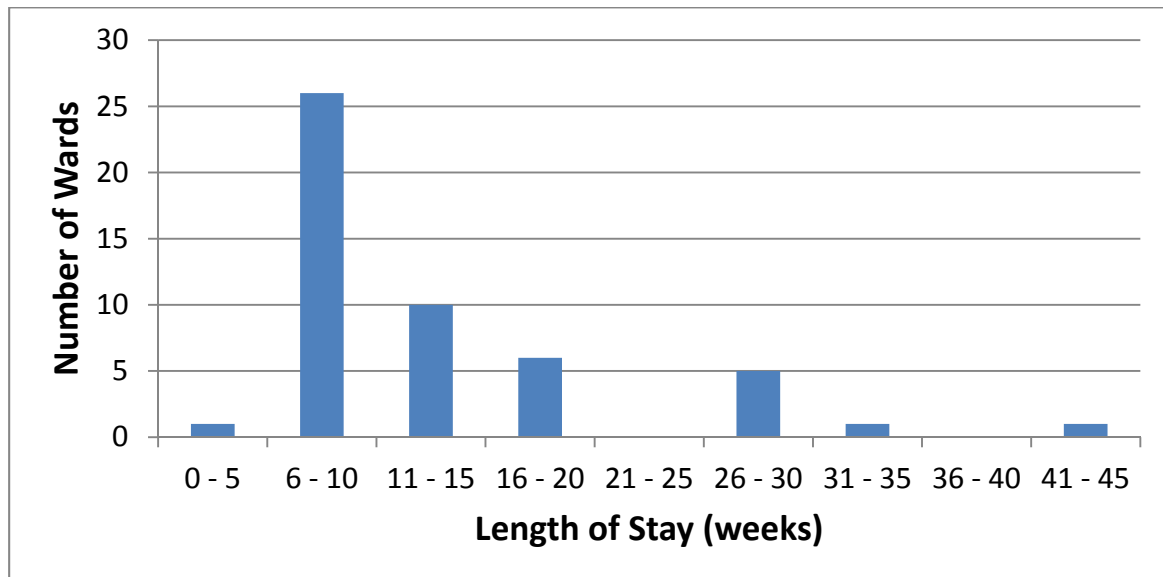


Fig. 3: The distribution of length of stay of patients

Occupational therapy and psychology input

45 of the 50 wards provided all the required information. 29 (64%) have input from occupational therapy on a regular sessional basis and 16 (36%) have regular input from a psychologist.

OVERALL PERFORMANCE OF THE WARDS

Table 3 shows the accreditation status of the 58 wards that had enrolled with AIMS-OP by 31 March 2011. 52 wards were located in England and 6 in Wales.

Table 3: Accreditation status of member wards as of 31 March 2011

Accredited as excellent	10
Accredited – first time	17
Accredited – having first been deferred	16
Accreditation currently deferred	5
In self/peer-review stage	10
Total	58

Accredited as excellent

There are currently 263 AIMS-OP standards. It is therefore a significant achievement for a ward to be accredited as excellent, as it would need to meet all Type 1 standards, 95% of Type 2 standards and a majority of Type 3 standards in order to attain this. The 10 wards that had achieved this status as of 31 March 2011 are listed in the table overleaf.

Table 4: The 10 wards accredited as excellent as of 31 March 2011

NHS Trust	Ward	Hospital
Northamptonshire Healthcare NHS Trust	Brookview Ward	Princess Marina Hospital
Northumberland, Tyne and Wear NHS Foundation Trust	Hauxley Ward	St George's Park
Cheshire and Wirral Partnership NHS Foundation Trust	Cedar Ward	Bowmere Centre
Berkshire Healthcare NHS Foundation Trust	Jasmine Ward	Prospect Park Hospital
East London NHS Foundation Trust	Ivory Ward	Newham Centre for Mental Health
	Ruby Ward	
South London and Maudsley NHS Foundation Trust	Chelsham House	Bethlem Royal Hospital
Dudley and Walsall Mental Health Partnership NHS Trust	Cedars Ward	Bloxwich Hospital
	Linden Ward	
Cornwall Partnership Trust	Garner Ward	Bodmin Hospital

Reasons for deferral

Wards that fail to meet all Type 1 standards or the majority of Type 2 standards are deferred so that they can take the necessary corrective action to meet that requirement for accreditation. 21 of the 50 wards that had completed the self and peer-review stages by 31 March 2011 were deferred. A deferred ward cannot subsequently be accredited as excellent.

Table 5 lists standards that caused three or more wards to be deferred – some wards were deferred for more than one reason. 16 of the deferred wards had successfully addressed the problems and went on to achieve accreditation by 31 March 2011.

Table 5: Type 1 standards that three or more wards failed to meet, resulting in deferral.

STANDARD⁸		NO. WARD
Environment and facilities audit		
26.1	A crash bag is available within three minutes. This equipment includes: <ul style="list-style-type: none">- an automatic external defibrillator;- a bag valve mask;- oxygen;	5

⁸ Note that these standards refer to the current First Edition AIMS-OP standards. Those not in the current set of standards are marked at the end of the table as 'Old Standards.'

	<ul style="list-style-type: none"> - cannulae; - fluids; - suction; - first-line resuscitation medications. 	
26.2	The crash bag is maintained and checked weekly or after use.	4
29.3	Male and female patients have separate sleeping accommodation in separate areas of the ward.	10
24.3	Facilities ensure routes of safe entry and exit in the event of an emergency.	4
Checklist		
5.2	All qualified nurses have been assessed as competent in the administration of medications.	14
23.1	There are clear and comprehensive policies and procedures regarding positive risk-taking, including self harm and risk of harm to others and illicit drug use within the inpatient unit.	7
19.3	There are written policies on the use of restraint of older people, of which all staff are aware.	3
19.5	There is a policy on the use of rapid tranquillisation in older people.	3

20.1	There is an agreed falls prevention and intervention procedural guideline in place for the service.	3
17.7	<p>The ward has an agreed protocol for the transfer or discharge of vulnerable patients.</p> <p>This includes:</p> <ul style="list-style-type: none"> - consideration of the need for nurse escort/handover of patient; - affirmation of medical assessment prior to transportation of the patient's medical stability for transfer/discharge; - information on treatment outcomes, ongoing care requirements and diagnoses and prognosis; - communication of risk assessment and risk management approaches; - 'do not resuscitate (DNR)' status; - body map of wounds or injuries, with an explanation for how they were acquired; - communication of infections; - communication of medication prescription. 	3
16.1	There is a daily handover between the nursing staff, doctors and other relevant members of the MDT.	5

2.6	A member of staff is assigned to maintain general observation in patient day areas at all times, including during personal care, to observe for risk behaviour and intervene or call for assistance to maintain patient safety.	3
39.1	There is a system in place to ensure that, where required, all patients are able to use an appropriate and well-maintained hearing aid.	4
8.1	There is a smoke-free policy for the ward which follows HDA guidance and best practice.	3
2.17	There is a policy and procedure on the recruitment and use of volunteer staff on the ward.	5
2.4	At all times, a doctor is available to attend an alert by staff members within 30 minutes.	4
Health record audit		
13.9	On admission, patients who require staff to carry out personal care of an intimate nature are asked their preference for the gender of staff providing such care, and this is recorded.	19
9.3	The ward ascertains from the referring agency information as to the security of the patient's home, the wellbeing of dependents, the whereabouts of animals etc.	7

13.8	<p>If a patient is identified as presenting with a risk of absconding, then a crisis plan is completed, which includes:</p> <ul style="list-style-type: none"> - instructions for alerting carers and any other person who may be at risk from the patient, or - instructions for alerting carers and the police if the patient is at risk of significant harm when outside a safe environment alone. 	3
13.3	<p>The immediate risk assessment of the patient includes:</p> <ul style="list-style-type: none"> - identification of whether they may have been subject to abuse or inappropriate care; - potential psychological and social risks to themselves and/or others; - potential physical risks, including falls risk, malnutrition/ dehydration risk, pressure ulcer development risk, risk of self-harm or suicide; - absconding risk, as well as risk of harm if the patient absconds; - consent or refusal of consent to treatment. 	7

38.3	Patients have minimum documented sessions with their primary/ allocated nurse to review their progress, in accordance with their care plan but not less than once a week.	6
Staff questionnaire		
5.3	All new staff are allocated a person who oversees their induction, such as a mentor or preceptor.	3
Ward manager questionnaire		
40.4	All patients are offered specific psychosocial interventions appropriate to their presenting needs and in accordance with national standards (i.e. NICE).	7
Patient and carer questionnaire		
12.4	<p>On the day of their admission or as soon as they are well enough, patients and/or carers are given a “welcome pack” or introductory booklet that contains the following:</p> <ul style="list-style-type: none"> - a clear description of the aims of the ward; - the current programme and modes of treatment; - a clear description of what is expected and rights and responsibilities; - a simple description of the ward’s philosophy, principles and rationale, and 	12

	<p>the ward team membership, including the name of the patient's consultant psychiatrist and key worker/named nurse;</p> <ul style="list-style-type: none"> - visiting arrangements; - personal safety on the ward; - ward facilities; - ward programme of activities; - what practical items patients need in hospital and what should be brought in. 	
12.5	<p>On the day of their admission or as soon as they are well enough, detained patients are, in accordance with section 132 of the MHA, given written information on their rights, rights to advocacy and second opinion, right to move hospital, right of access to interpreting services, professional roles and responsibilities, and the complaints procedures.</p>	5
18.3	<p>There is a policy and procedure for staff and patients to confidentially report or 'whistle-blow' on abuse or inappropriate care.</p>	3
Training grid		
5.5	<p>All qualified clinical staff are trained in adult protection, which includes local policies and procedures.</p>	18

5.21	All staff have received training in relation to confidentiality.	4
5.4	Before being asked to carry out clinical work, all staff receive mandatory training in fire safety, manual handling and basic life support, and a record of this is kept	7
Old standards (no longer in current edition)		
	All staff are trained in the prevention of C.Diff (Clostridium Difficile) and MRSA (Methicillin Resistant Staphylococcus Aureus)	7
	All qualified staff are trained in adult protection	5
	Patients have minimum twice-weekly documented sessions with their primary/allocated nurse to review their progress.	5
	There is a policy and procedure that supports the work of volunteer staff in the ward/service	4

QUALITY IMPROVEMENT: CHANGE OVER TWO YEARS IN 9 PILOT WARDS

As of 31 March 2011, seven of the nine wards that participated in the initial pilot of AIMS-OP had completed the full repeat of the self-review that is required two years after accreditation has been awarded. The remaining two had not submitted

enough data to be considered for a report after a repeat of the self-review.

The table overleaf shows the percentage of standards met at the original self-review and at the repeat self-review that was undertaken two years later.

Table 6: Percentage of the three types of standards met at the initial self-review in 2008 and at the repeat self-review in 2010 for 7 wards that took part in the pilot.

Ward Number	% Type 1 ⁹		% Type 2		% Type 3		% All	
	2008	2010	2008	2010	2008	2010	2008	2010
OP1	94	97	84	80	78	86	87	91
OP4	93	92	82	90	67	79	85	90
OP6	100	100	95	97	78	100	95	98
OP7	98	91	83	91	76	93	86	92
OP8	100	100	91	99	89	93	94	99
OP9	88	96	84	88	75	100	83	92
OP11	86	95	85	96	65	100	79	97
MEAN % MET	94	96	86	92	75	93	87	94

⁹ Please note: wards would have demonstrated that they met all Type 1 standards by the time they were awarded accreditation.

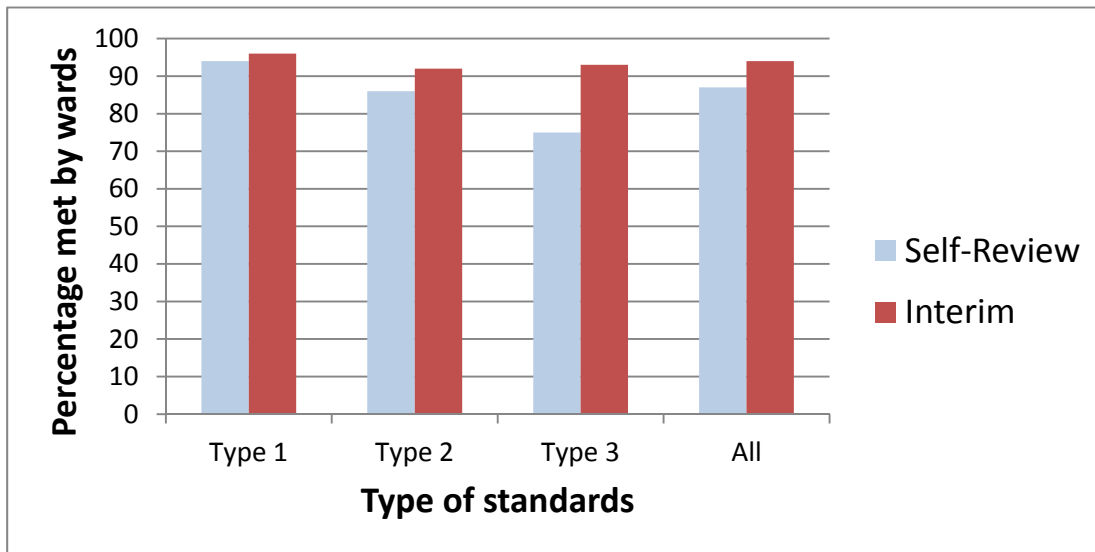


Fig. 3: Mean percentage of standards met at self-review and interim review

The overall trend is that the wards improved during the two years between the initial self-review and the repeat self-review, as measured by the percentage of standards that were met. OP11, in particular, improved significantly. The majority of the wards improved slightly.

Five of the wards failed to meet at least one of the Type 1 standards at the repeat self-review. Table 7 lists these standards and the number of wards that failed to meet them in 2008.

Table 7: Type 1 standards that the 7 pilot wards failed to meet at the repeat self-review in 2008

STD NO.	STANDARD ¹⁰	NO. WARD
Environment and facilities		
None.		
Checklist		
6.1	The ward provides access to an advocacy service that includes IMCAs where appropriate.	2
2.7	The ward has its own dedicated lead consultant psychiatrist who can provide expert input into key matters of inpatient service delivery, staff support and decision-making, and overall service co-ordination.	1
12.4	<p>On the day of their admission or as soon as they are well enough, patients and/or carers are given a “welcome pack” or introductory booklet that contains the following:</p> <ul style="list-style-type: none"> - a clear description of the aims of the ward; - the current programme and modes of treatment; - a clear description of what is expected 	1

¹⁰ Note, these standards refer to the Pilot Edition of the OP standards. These were later adapted for the current First Edition of the OP standards.

	<p>and rights and responsibilities;</p> <ul style="list-style-type: none"> - a simple description of the ward's philosophy, principles and rationale, and the ward team membership, including the name of the patient's consultant psychiatrist and key worker/named nurse; - visiting arrangements; personal safety on the ward; - ward facilities; ward programme of activities; - what practical items patients need in hospital and what should be brought in. 	
Health record audit		
13.9	On admission, patients who require staff to carry out personal care of an intimate nature are asked their preference for the gender of staff providing such care, and this is recorded.	2
17.1	Transfer/discharge documentation is communicated to key personnel, including the care co-ordinator, receiving care setting, GP, etc. on the day of discharge.	2

9.3	The ward ascertains from the referring agency information as to the security of the patient's home, the wellbeing of dependents, the whereabouts of animals etc.	1
13.3	<p>The immediate risk assessment of the patient includes:</p> <ul style="list-style-type: none"> - identification of whether they may have been subject to abuse or inappropriate care; - potential psychological and social risks to themselves and/or others; - potential physical risks, including falls risk, malnutrition/ dehydration risk, pressure ulcer development risk, risk of self-harm or suicide; - absconding risk, as well as risk of harm if the patient absconds; - consent or refusal of consent to treatment. 	1
13.8	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 from the patient, or instructions for alerting carers and the police if the patient is at risk of significant	1

	harm when outside a safe environment alone.	
14.1	The patient's main carers/nearest relatives are identified and contact details, including emergency contact numbers, are recorded.	1
Ward manager questionnaire		
	None.	
Staff questionnaire		
	None.	
Patient and carer questionnaire		
31.10	Patients can wash and use the toilet in private.	1
12.5	On the day of their admission or as soon as they are well enough, detained patients are, in accordance with section 132 of the MHA, given written information on their rights, rights to advocacy and second opinion, right to move hospital, right of access to interpreting services, professional roles and responsibilities, and the complaints procedures.	1
Training grid		
5.4	Before being asked to carry out any clinical work, all staff receive mandatory training in line with Trust guidance, e.g. fire safety, manual handling and basic life support	4

5.21	All staff have received training in relation to confidentiality.	4
22.2	All staff are trained in hand-washing techniques.	4
5.5	All qualified clinical staff are trained in adult protection, which includes local policies and procedures.	3

In most instances, the Type 1 standards that wards failed to meet at repeat self-review were different from those that had caused the wards to be deferred following the initial review.

Seven of the 9 wards that failed to meet Type 1 standards at the repeat self-review took simple corrective action and continued to be accredited. However, two wards did not submit enough information at the repeat self-review, and therefore had their accreditation suspended pending receipt of this data.

THEMES

The themes highlighted below are those that occurred across all three types of wards: organic wards, functional wards, and mixed organic and functional wards. However, we highlight any issue that particularly affected a specific type of ward.

Key themes: staff perspective

The AIMS-OP review process engages actively with staff of all disciplines who work on the wards that are undergoing accreditation. The ward manager completes a detailed questionnaire and other ward staff complete an anonymous survey as part of the self-review. Members of the peer-review team then have structured meetings with ward staff during the one-day peer-review visit. The staff survey was completed by 1119 ward staff working on the 50 wards that had completed the AIMS-OP review process by 31 March 2011. Of those, 446 worked in organic wards, 202 worked in mixed wards and 471 worked in functional wards.

The main themes that emerged from analysis of this feedback from ward staff were about: appraisal, supervision and staff support; staff education and training; and allocation of breaks.¹¹

¹¹ Appendix 3 (available on www.rcpsych.ac.uk/AIMS under AIMS resources) to this report gives the detailed, aggregated results from which the themes have emerged. The results for organic, mixed and functional wards can be found in Appendices 4, 5 and 6 respectively.

Appraisal, supervision and staff support

18% of ward staff and 7% of the ward managers reported not having received an annual appraisal. 12% of all staff reported not to have received professional supervision or felt they could not access supervision on an ad hoc basis.

With regards to staff support, only 71% of staff reported having been allocated a mentor/preceptor to oversee their induction. This result conflicts with the findings from the audit which reported that 100% of all new staff are allocated a mentor/preceptor.

Staff education and training

There appears to be a discrepancy between ward managers' position on this issue and the actual experience of staff. Whereas one-third of staff reported that training opportunities were refused due to staff cover, only 7% of ward managers reported that they had refused requests. 15% of staff reported having been refused training due to it being deemed inappropriate, compared with 2% of ward managers. Finally, despite having 98% of ward managers reporting that there is a training budget which enables all staff to attend training relating to CPD and KSF, 20% of staff reported that they had experience of training being refused due to lack of funding.

Allocation of breaks

Only 73% of staff felt that they were able to take allocated breaks off the ward. Reasons for this included insufficient staffing levels and heavy workload.

Key themes: patient experience

From 2008 to 2011, 350 people who were patients on the wards returned patient questionnaires. Of those, 42 were from organic wards, 82 were from mixed wards and 226 were from functional wards.

Many of the comments reported by these patients showed that in general, they were content with the care they received.

Examples of these comments are shown below:

“I am impressed by the kindness and care I have received, thank you all”.

“I am overwhelmed with the care [I have] received with the staff on the ward”.

“The care I received was always first class. The staff at all times treated me with kindness and consideration”.

“Felt reassured that I was going to get well here”.

In addition to this, the main themes that emerged from the patients' feedback were around the admission process, communication and engagement in care, and ward activities.

Admission process

Although 95% of patients reported that they were greeted by a member of staff when they arrived on the ward, 16% stated that they were not introduced to the member of staff who would be their first point of contact for the first few hours, and 13% reported that they were not shown around the ward and their bedroom area within the first hour of admission.

Only half of the patients reported that they were given written information on their legal status and rights. Just over half (51%) of patients reported having received a welcome booklet or introductory booklet on the day of admission or as soon as they were well enough. Moreover, only 54% of carers stated they had received one. According to the staff, more than 90% of wards provided patients with this information.

Communication and engagement in care

At initial assessment, 96% of staff compared with 86% of patients reported that patients could involve people they rely on during care planning. Less than half (46%) of patients reported that they had received a written copy of what had been agreed. 87% of staff stated that this was done routinely.

Throughout their care on the ward, 13% of patients reported that they were not asked for their permission before physical treatments or investigations were carried out. 99% of staff disagreed with this.

Although 91% of patients stated that they were comfortable with the way in which meetings to discuss their care were conducted, 30% of patients reported that the results of these meetings were not discussed with them afterwards.

Furthermore, 34% of patients stated that they did not feel able to meet with their consultant psychiatrist outside of these times.

According to the results from the health record audit, in 80% of cases the choice of medication was made jointly by the patient and responsible clinician, based on an informed discussion of the relative benefits of the medication, the side effects, and alternatives. 84% of patients felt they could discuss their medication with staff.

More generally, 91% of patients felt they were able to spend time with staff during the day and the majority (88%) felt that staff made time to explain important information to them.

Ward activities

About three-quarters of patient responses stated that their wards provided timetabled activities from Monday to Friday. However, only 44% of patients stated that they had access to activities in the evenings and weekends.

Furthermore, nearly a quarter of patients reported not to have the freedom to choose which therapies and activities they did during the day.

With regards to accessing complementary therapies, only 30% of patients stated that this was an option.

Comparison of organic, functional and mixed wards

The most salient difference between the wards was that of communication and engagement in care. The organic wards, compared to the mixed and functional wards, showed higher rates of patients reporting:

- awareness of advocacy services (67% compared to 34% mixed and 48% functional)
- having received a welcome pack or introductory booklet (64% compared to 33% mixed and 54% functional)
- having received written information on their legal status and rights (69% compared to 40% mixed and 50% functional)
- having been allowed to involve the people they rely on for support in care planning (86% compared to 70% mixed and 79% functional)
- having received a copy of the care plan once agreed (60% compared to 39% mixed and 45% functional)
- having been asked permission before physical treatment or investigation is carried out (95% compared to 81% mixed and 87% functional)

In addition, there were differences in the reported evening and weekend activities available to patients on organic wards compared to mixed and functional:

- 76% of patients in organic wards reported to have activities provided to them in the evenings, compared to 21% and 37% of patients from mixed and functional wards respectively.
- 79% of patients in organic wards reported to have activities provided to them at weekends, compared to 28% and 42% of patients from mixed and functional wards respectively.

The observation tool

Because many patients in organic wards have cognitive problems, the AIMS-OP team generally receives fewer patient questionnaires. Therefore, during the peer-review visit, the review team uses an observation tool, which includes observing a mealtime, a brief meeting with patients, and a more in-depth meeting with carers. Reviewers are guided by the observation tool. Two professional reviewers must assume responsibility for this section during the peer-review day.

Key themes: carer perspective

The views of carers are elicited by a questionnaire which is returned directly to the AIMS-OP project team. The AIMS-OP team received 321 carer questionnaires from the 50 wards.

The questionnaire gives carers the opportunity to comment on any aspect of their involvement with the ward. Overall, carers reported that they feel their friend/relative received good quality care on the ward (96%).

Examples of the comments reported by carers are shown below:

"I think the staff at the hospital are very caring and put your mind at rest about leaving loved ones."

"I am treated as an old friend by all the staff, who regularly enquire about my welfare and give advice if they think it's needed."

"I attended all the meetings concerning my wife's ongoing treatment and condition. I felt that the reports were frank, honest and factual and that my wife was in the best possible hands."

"A very caring environment has been created, and all the staff are very kind to all the patients. Those who have the misfortune to need their services are very well treated by the staff as friends as well as patients."

"I can't thank all the staff enough, for all the help and understanding they have shown my mum and my family, you truly have saved my mum."

In addition to this, the main themes that arose from the carer questionnaires were assessment of their needs and involvement in their friend/relative's care.

Assessment of needs

Only 41% of carers reported having been offered an assessment of their needs within three days of their friend/relative being admitted and only half (51%) reported to have access to regular carer support meetings on the ward.

Involvement in friend/relative's care

Upon admission, 80% of carers reported that they were asked to share information on the patient's current strengths and needs. 86% of carers, compared with 96% of staff, reported to have been asked to provide background information about their friend/relative. Just over a third of carers, however, stated that they were not offered a meeting to discuss their friend/relative's care within three days of admission.

93% of carers reported that staff members introduced themselves at the first ward round or review.

Throughout the patients' stays on the wards, 84% of carers stated that staff fed back actions and decisions made regarding the care of their friend/relative after reviews. 98% of staff reported that this was done routinely. However, nearly 30% of carers felt that they could not meet with the friend/relative's consultant psychiatrist during times outside of reviews and ward rounds.

Comparison of Organic, Mixed and Functional Wards

The most salient difference between the types of wards was seen in the carers' involvement in their friend or relative's care. The carers from organic wards, compared to those from mixed and functional wards, reported higher rates of:

- receiving feedback from staff on actions and decisions made regarding the care of their friend/relative (95% compared with 75% mixed and 84% functional)
- being asked to share information on their friend/relative's current strengths and needs (85% compared to 71% mixed and 79% functional)
- being asked to share background information on their friend/relative (90% compared to 80% mixed and 85% functional)
- being offered a meeting to discuss their friend/relative's care within three days of admission (72% compared to 55% mixed and 59% functional)

ACTIONS AND RECOMMENDATIONS

Our recommendations relate to the key themes identified from working with the 50 AIMS-OP wards. We will use the AIMS-OP process to support their implementation.

Appraisal, supervision, staff support and staff training

1. **Ward managers** should review appraisals, supervision and training so that they meet the needs of the staff and the ward.
2. **The AIMS-OP peer-review teams** will enquire about implementation of recommendation 1 during peer-review visits.
3. **The AIMS-OP standards development group** will review, and if necessary revise, the standards relating to staff development. It will also consider the typing of the standards (that is which standards should be considered essential for accreditation).
4. **The central AIMS-OP team** will review the self-review data collection process so that more accurate and detailed information is collected about appraisal, supervision and training.

Communication and engagement in care

5. **The AIMS-OP standards development group** will review, and if necessary revise, the standards relating to the patient experience including issues relating to enabling effective communication (specifically with respect to the first few hours on the ward and ensuring written information on legal status and rights is received and understood throughout the person's stay).
6. **The central AIMS team** will work to develop and implement approaches to data collection that increase response rates for the patient questionnaire. The purpose of this will be to increase response rates to a level where patient questionnaire data can have a greater influence on the decision about accreditation status.

Ward activities

7. **Ward managers** should give higher priority to ensure activities occur on a regular basis, including evenings and weekends, and should make fuller use of available resources to ensure a full range of activities are offered to facilitate choice, e.g. Star Wards.

Assessment of the needs of carers and their involvement in care

8. **The central AIMS team** will work to develop and implement approaches to data collection that increase response rates for the carer questionnaire. The purpose of this will be to increase response rates to a level where carer questionnaire data can have a greater influence on the decision about accreditation status.

Note: The appendices to this report are available on www.rcpsych.ac.uk/AIMS under AIMS resources

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