In-patient care for older people within mental health services

Faculty report FR/OA/1

Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists

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Foreword

The Faculty of the Psychiatry of Old Age last made recommendations about in-patient services in its keynote paper *Raising the Standard* (Royal College of Psychiatrists, 2006). In the 5 years since that report was published there have been very considerable changes in the profile of many services across the UK. Further changes are to be expected, partly because of the ever increasing number of older people, partly because of services developing in response to dementia strategies and partly because of the focus on age discrimination, which is acknowledged to affect those receiving mental health services particularly badly.

Because of the variability in service provision across the country, the Faculty cannot recommend a 'one size fits all' model of service provision. In this Faculty Report, some guidance is given about key issues such as age-specific *v*. age-inclusive wards, mixed pathology wards, sectorised or functionalised service models and care home provision, and recommendations are provided about the physical environment, access to physical healthcare, quality and expertise. We hope that this report will assist people in planning services and stimulate further debate about the shape of an 'ideal service'.

I would particularly like to thank my colleagues, Gill Pinner, Jonathan Hillam, Tim Branton and Anand Ramakrishnan, for the considerable time, effort and specialist knowledge they provided to complete the report, and to colleagues in the Faculty Executive for their comments and agreement.

Peter J. Connelly
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Faculty of the Psychiatry of Old Age

1 Introduction

Older people with mental health problems are cared for in a variety of in-patient settings, both within dedicated mental health services and in general hospital settings. This report will relate entirely to the former – there are a number of national initiatives addressing the issue of managing older people with mental health problems in more general settings.

Current provision of in-patient services falls broadly into assessment beds and longer-term care beds. In-patient assessment may occur in organic/dementia wards, functional wards, mixed dementia and functional wards or indeed on adult mental health wards. There is great variation in provision and practice (Audit Commission, 2000). Longer-term care had traditionally been provided in so-called continuing care wards. Following changes in funding rules (Social Care Policy and Innovation, 2007), much of this provision has moved to independent sector nursing homes. National Health Service (NHS) trust beds are now focusing more keenly on older people with very challenging behaviour that independent homes are not fully equipped to manage.

Mental health in-patient care for older people is highly specialised, focused on the most vulnerable, those with greatest need and complexity. In-patient care costs a large proportion of the mental health budget, employing the greatest number of staff (Department of Health, 2002). It is surprising then that there is little focus and guidance on how this care should best be delivered. It is with this in mind that this Faculty Report has been prepared.

2 Key overarching and guiding principles

Although key documents for mental health services for older people make little, if any, reference specifically to in-patient services as they are heavily community care focused, there are generic principles that must be applied to all settings, including in-patients. Dignity and privacy, patient centeredness, respecting and valuing diversity, respecting patients and carers, ensuring access to the best and most effective treatments are key fundamental elements of good quality care (National Collaborating Centre for Mental Health, 2006; Cass *et al*, 2009).

Purpose of admission to older peoples' in-patient services

> 'Hospital admission is needed for people with psychiatric and behavioural problems that cannot be managed in any other setting, with close links to physical health care services – with admissions limited by effective community services.' (Audit Commission, 2002: p. 30)

This statement highlights three key principles.

1. In-patient care provides specialist expertise, with intensive levels of assessment, monitoring and treatment, unable to be provided elsewhere.
2. It is imperative that there is good access to physical healthcare, with robust arrangements for geriatric medical liaison.
3. Community services must be developed to allow proper alternatives to in-patient care to avoid unnecessary admission.

Additionally, it is important to consider:

- the quality of such care and how this can be measured and improved
- the potential problem areas that arise such as prolonged hospital stays
- risk to patients and others.

Specialist expertise

Psychiatric in-patient care provides specialist expertise, with intensive levels of assessment, monitoring and treatment that is not possible in other settings.

Inclusion of all disciplines as part of the multidisciplinary clinical and management team is essential to provide psychological, occupational, recreational, physical and spiritual activity. Equally, there is increasing recognition as to the enabling impact of a good therapeutic environment, including building design and decor (Waller & Finn, 2004; Care Services Improvement Partnership, 2005*a*). However, to reach such high-quality specialist units, people may have to travel further to more centralised in-patient areas, which must be recognised as potentially problematic for some older people.

Recommendation

- All in-patient areas should have access to a full range of disciplines to provide assessment and treatment in an environment that has been designed to care for the specific needs of that patient group.

Good access to physical healthcare

It is imperative that there is good access to physical healthcare. For example, there should be reciprocal arrangements with acute trusts for geriatricians to assess and advise on the physical health needs of in-patients. Consideration should also be given to the development of jointly managed assessment units as part of a comprehensive liaison service (Royal College of Psychiatrists, 2005). The *Forget Me Not* report (Audit Commission, 2000) recommended that, ideally, mental health beds should be based on the same site as a general hospital.

Recommendation

- There must be clear and robust arrangements for urgent medical interventions and regular expertise available from geriatric medicine services. This may be facilitated by locating in-patient assessment beds on general hospital sites.

Alternatives to in-patient care

Community services must be developed to allow proper alternatives to in-patient care to avoid unnecessary admission. Services such as crisis intervention and home treatment are all too often exclusive to adult mental health services, but arrangements should be made within trusts to provide equally relevant services for older people. This is an area which is clearly age discriminating and contravenes the Age Discrimination Act that will be enforceable by 2012.

Recommendation

- Community services should be developed and designed to provide real alternatives to in-patient admission. This should include crisis intervention and home treatment that is focused on the needs of the elderly.

Improved quality care

There have been some initiatives to improve standards of care in in-patient settings, including older peoples' wards, such as the Royal College of Psychiatrists' Accreditation for Acute Inpatient Mental Health Services (AIMS) process (Cresswell *et al*, 2009); the 'star wards' initiative (www.starwards.org.uk); and Releasing Time to Care™ programme (National Nursing Research Unit, 2010). National accreditation such as AIMS can be used to inform good-quality service development and practice and drive up standards of care, and should be used by trusts as a quality indicator. We would also wish to see quality indicators reflecting the importance of enriching the spiritual and therapeutic activity specifically on offer to older in-patients rather than just reduced lengths of stay and delayed discharge.

Recommendation

- Trusts should utilise quality indicators specific to in-patient mental health services for older people to inform and develop their services. These can include quantitive measures such as length of stay to drive change, but not be limited to them. External accreditation schemes such as AIMS should be utilised.

Avoid prolonged admissions

The negative impact of prolonged in-patient admissions must be recognised across all agencies. Significant numbers of mental health beds have been reportedly occupied by people whose discharge has been delayed: 13.3% of functional mental illness beds and 28.6% of organic assessment beds in a national survey by the Faculty of Psychiatry of Old Age (Barker & Bullock, 2005). More recent findings by the Mental Welfare Commission for Scotland (2010) show very similar results, reporting that on average 2.5 patients on dementia assessment wards and 0.75 patients on functional assessment wards are there because of delayed discharges at any one time, the main delay being patients waiting to move into a care home. This suggests that this is an area where little improvement has been made and change is much needed (Mental Welfare Commission for Scotland, 2010).

Length of stay varies enormously both across the country and within local services. The reasons behind such variability are highly complex, with many factors specific to a particular service coming together, so no singular solution can be suggested. This requires local understanding and solution. However, there are some generic principles that must be adhered to.

Recommendation

- In-patient services require defined admission and discharge care pathways, and this requires close working relationships with Social Services departments and an understanding of how to manage delayed discharge policies (Community Care (Delayed Discharges etc.) Act 2003). This should be stated as a risk shared across mental health trusts and Social Services departments.

Risk

Nowadays, many admissions to psychiatric care involve significant risk: self-harm, self-neglect, abuse, psychological or physical harm to others. Some patients will be detained under the Mental Health Act and some may be subject to restriction under the relevant capacity legislation. Additionally, staff caring for elderly patients with mental health problems in in-patient areas are subject to high levels of assault – higher than their counterparts in adult mental health services – and very often have poor levels of training and support to manage this (Royal College of Psychiatrists' Centre for Quality Improvement, 2008).

Recommendation

- All staff should receive regular training across these risk areas and trusts should have specific policies and procedures in place to support this.

Best practice and provision

We have identified a number of key areas that should be addressed when considering best practice and provision in in-patient mental health services for older people. These will be outlined on the following pages.

- Single-gender accommodation – implications and potential solutions
- Age-specific *v*. age-inclusive wards
- Separate organic and functional *v*. mixed pathology wards
- Traditional sectorised service *v*. functionalised service models
- Continuing care
- Physical environment
- Staffing complement

Single-gender accommodation

All new NHS facilities must now comply with single-gender accommodation rules and existing services must make necessary adaptations. This was set out in *Privacy and Dignity* – a report by the Chief Nursing Officer into mixed-gender accommodation in hospitals (Department of Health, 2007).

Single-gender accommodation can be achieved in a number of ways and its application must be flexible and based on local need. Older people may be more sensitive to mixing with members of the opposite gender and having same-gender wards is one approach, but it will not allow the flexibility required to maximise bed occupancy for most services. A recent report highlights the lack of strong views against mixed-gender wards and indeed benefits of such arrangements were identified (Mental Welfare Commission for Scotland, 2010). It could be argued that single-gender accommodation has a negative impact on normalisation, ignoring the beneficial effect of having some contact

with members of the opposite gender. However, same-gender units should be considered most appropriate in challenging behaviour dementia care where there is a clear need to protect vulnerable women from potentially aggressive and disinhibited men (NHS Executive, 2000).

Within mixed-gender wards, many newly built units are designed with all single en-suite rooms or a mix of small bays that can accommodate either men or women, not both, with adjacent same-gender toilet and washing facilities.

Patients should be able to have a choice of day areas, with protected women-only space.

Small units need to consider ways in which they can be flexible to accommodate differing ratios of men to women at different times, with appropriately trained staff. The use of partitions, of full height, rigid and fixed to the building structure that can be relocated at differing points can be used to facilitate this.

Recommendation

- The requirement for single-gender accommodation can be achieved in a number of ways and should not be interpreted as requiring all single-gender wards. Its application must be flexible and based on local need.

Age-specific *v.* age-inclusive wards

The care of frail older adults with complex needs on wards for younger adults is usually inappropriate (Audit Commission, 2002): it would place them at risk from robust, behaviourally disturbed younger adults and deprive them of the specialist nursing, medical and other care that they require. Specialist in-patient old age psychiatry wards will have access to and links with other investigative, treatment and management services, alongside which a palliative model of care should operate for people with advanced dementia (Royal College of Psychiatrists, 2006).

Despite this, some trusts are discussing the adoption of all-age functional (i.e. non-organic) teams and in-patient services. This appears driven by cost savings, rather than the provision of good clinical care, and clearly disadvantages the vast majority of elderly vulnerable patients who have complex and specialist needs.

So-called ‘graduate’ patients, who are managed primarily within adult mental health services due to the enduring nature of their mental illness and physical robustness, may be better suited to an adult mental health in-patient environment, but this may change with advancing age and changing need. Such patients may need to be managed on an older persons’ functional ward under a trust's transition protocol. Services should have agreed transition protocols in place for the interface between mental health services for older people and adult mental health services, including patients of working age

with dementia specifically, and where those patients may best be managed in an in-patient area. Good transition management includes the need for flexibility of working and willingness to share resources between mental health services for older people and adult mental health services, and emphasises consideration of patient needs rather than using chronological age as the one and only yardstick (Royal College of Psychiatrists, 2009).

Recommendation

- Specialist in-patient old age psychiatry wards should be provided and the move towards all-age functional in-patient wards is not supported. Every trust should have an agreed transition protocol in place to facilitate the most appropriate needs-led care for patients within adult mental health services who may benefit from in-patient care on an older persons ward and vice versa.

Separate organic and functional *v.* mixed pathology wards

Traditionally, two main groups of older people with mental health problems have been identified depending on diagnosis: those who have an 'organic' brain disorder such as dementia; and older people with so-called 'functional' disorders, the most common of which is depressive illness, but also including people with schizophrenia and other psychoses. This categorisation has largely remained despite its limitations, as it provides a proxy for the different needs that patients may have.

Across the country there is variation of practice in the provision of in-patient wards relating to primary pathology – some services providing separate in-patient wards for functional and organic disorders and others having no such definition, providing care for all older people with mental health problems. Opinion is divided among old age psychiatrists regarding which model is most appropriate. Given this, local services will need to consider the possible pros and cons before implementing any change.

Potential benefits regarding separate provision

Having separate in-patient beds for these two groups has been consistently regarded as good practice (Audit Commission, 2000, 2002; Royal College of Psychiatrists, 2006). People with severe depression, for example, may find that sharing their living space with other people with behavioural problems can make them feel worse. The effect on people with dementia of sharing a ward with people with severe depression may also be unhelpful. The type of supervision needed for the two groups may be quite different (Audit Commission, 2000). This was reiterated in the document *Everybody's Business* (Care Services Improvement Partnership, 2005*b*).

The Mental Welfare Commission for Scotland (2010) report *Where Do I Go From Here?* also highlighted problems associated with mixed pathology wards. The main problem was that some patients with dementia tended to interfere

and invade the personal space of other people. Also, providing activities that would be stimulating and meet the needs of each individual was cited as challenging. The National Audit of Violence highlights the increasing risk of incidents on so-called mixed pathology wards (Royal College of Psychiatrists' Centre for Quality Improvement, 2008). An additional consideration is that highlighted by the National Institute for Health and Clinical Excellence (National Collaborating Centre for Mental Health, 2006): the need for good palliative care – this would be more difficult to address if old age services were either mixed or indeed integrated with younger adults.

Potential concerns regarding separate provision

Some have supported their local trusts in having chosen to provide mixed pathology older peoples' wards, as the alternative real choice, given limited resources, was perceived to be more detrimental to patient care (i.e. having only dementia wards and the elderly with functional disorders being looked after within adult mental health wards). Also, given certain geographical dispersion it may be impossible to provide two separate wards if bed numbers are small. It must also be recognised that the distinction between organic and functional illness is often neither clear nor absolute and many people may have a mixture of both. Thus it becomes quite arbitrary for many patients to provide services on this basis.

Recommendation

- Recognising these issues, the Faculty recommends that in-patient areas should be separate and dedicated where possible. If separate wards cannot be provided because of detriment to either functional or organic patient groups, then mixed pathology wards should be provided with clear separate living spaces available on wards for those with dementia and those with functional mental illnesses as recommended in previous reports (Audit Commission, 2000). If separate functional and organic wards are provided and there is uncertainty regarding which is most appropriate for an individual patient, then ultimately it is an issue of assessment of need rather than one led inflexibly by diagnosis (e.g. a patient with early dementia who is suicidal or displays predominately psychotic symptoms may be better placed on a functional ward).

Traditional sectorised service *v*. functionalised service models

Many adult mental health services have adopted functionalised service models, with medical staff dedicated to either in-patient ward areas or community services. Some have developed an acute care model, linking crisis and home treatment teams with an admissions or triage unit for brief (1–2 weeks) admission, patients subsequently being discharged back to community services or transferred to locality or treatment wards (Inglis & Baggaley, 2005). Evidence for the rational and successful outcome of this model is limited even in an adult mental health context. This model would be difficult to replicate in

mental health services for older people and would not be appropriate. Ultra-brief triaging admissions would be clinically inappropriate for dealing with the complexities of multiple needs, comorbidities and pathologies almost always associated with older people; multiple moves are best avoided for older people and it is a very fragmented model of care.

However, in-patient mental health services for older people do need updating in terms of wider service changes and demands. Over time, services have become increasingly community-focused, and will continue to do so with services such as crisis intervention and home treatment being adapted for the needs of older people. Community mental health teams (CMHTs) and memory assessment services have developed, with an improved culture of promoting independence, and the elderly population in geographical areas has continued to rise proportionally, with some modest increase in consultant posts. At the same time, assessment bed numbers per sector have reduced and this change needs to be managed.

There is divided opinion among consultants in old age psychiatry as to whether services should remain completely comprehensive and sectorised, or whether all or part of the service should be functionalised (e.g. with dedicated separate services for liaison, working-age dementia, dementia outreach, CMHTs and in-patient areas). Again, given this variation of opinion, local services will need to consider the impact that the benefits and pitfalls of any proposed changes have on their patient population.

Potential benefits regarding dedicated in-patient consultant provision

Given the reduction in overall bed numbers, many services will now have 16- to 20-bedded assessment wards which provide care for patients from at least three or four locality sectors, each relating to corresponding CMHTs. With the traditional sector model, this poses significant practical difficulties in ward management (e.g. multiple ward rounds, multiple different consultant 'styles' of care across the ward, potential problems in terms of clinical leadership – an area heavily emphasised in the Rowan Report (Commission for Health Improvement, 2003)), who take responsibility for standards/governance and giving a voice for appropriate resources for in-patients. Adult mental health services have been clear to recommend that ideally one consultant psychiatrist per ward will ensure good clinical leadership and avoid multiple ward rounds. Patients assessed in the community but later admitted to an in-patient area will automatically be assessed by a new clinician, which can be a helpful 'second opinion' in some circumstances. Considering the need for personal and staff development, this model gives consultant staff the opportunity to develop expert skills in specific areas, which can be rotated over time.

Potential concerns regarding separate provision

The overwhelming concern with this model of care is the lack of continuity of care for the patient having to move between different consultants. This poses a significant challenge to ensure excellent communication between services,

the lack of which is often the root of many patient complaints. The majority of consultants in old age psychiatry prefer a traditional sector model, valuing the continuity of care that this naturally facilitates above all. There is huge concern that directly adopting adult mental health service models of care are unlikely to be successful for the older patient group. Also, many staff have expressed concern that their own development and practice might be too restricted if clinically working in a very specific area.

Recommendation

- The Faculty acknowledges that new service models need to be developed as wider services change. However, there is significant concern regarding the potential for overfragmentation and loss of continuity of care. If local circumstances dictate that a functionalised model be developed, then it must be done with the collaboration/leadership of the consultant body. To support the model of service functionality (i.e. in-patient consultant specialists, community consultant specialists), services would have to have clear mechanisms in place to ensure continuity of care (e.g. dedicated time and processes for liaising between community and in-patient areas). If not the consultant, then a designated professional must maintain involvement with the patient at all points, whether in the community or in-patient areas, that can be explicit in Care Programme Approach care plans. There must be close working relationships between ward staff/in-patients, and community care coordinators from CMHTs, intensive support teams, older peoples' crisis resolution/home treatment teams, etc. Continuity may be more difficult to achieve with a non-sectorised model, but with added resourcing it could be assured. Whichever service model is applied, excellent liaison at the interface of wards and community is crucially important to prevent inappropriate early discharge or inappropriate readmission.

NHS trust-provided continuing care v. independent home provision

The provision of NHS continuing care needs some consideration. Although NHS continuing care may be provided in in-patient settings, it is increasingly provided in care homes. However, there is a lack of genuine specialty provision for severely challenging behaviour in the private sector and many trusts have disposed of their continuing care beds. There is a clear need for specialist mental health services to develop challenging behaviour services for older people. Without significant investment in this area, we are likely to see a concentration of individuals who are difficult to treat/place remaining 'long stay' within services that are designed to provide short-stay assessment and treatment, to the detriment of all patients in that environment. Such dedicated units have recently opened with investment from local primary care trusts.

Recommendation

- Although independent homes will be able to provide NHS continuing care for many patients, there must remain some provision of specialist in-patient beds by mental health trusts for those patients with highly challenging behaviour.

Physical environment

For in-patient assessment wards it has been previously recommended that the suggested number of beds for acute care should be 1–2 per 1000 elderly persons and that wards should be no larger than 20-bedded (Royal College of Psychiatrists, 2006). These figures need to be adjusted according to local resources and demands (e.g. availability of home treatment, day hospital, local authority provision; service age cut-off; whether mental health services for older people are responsible for 'graduate' patients or patients of working-age with dementia). Since this recommendation was published, many trusts have reduced their numbers of assessment beds further. For example, it has been reported to the Faculty that some services have reduced acute beds to 0.8 and even 0.67 per 1000 elderly population. In some instances this has been possible due to the reallocation of resources to support improved community care and subsequent reduced need for in-patient admission. However, this is not always the case and has caused significant rise in bed pressures, resulting in some patients not getting access to the in-patient assessment that they would have benefited from or excessive delay in access to that. Quirk & Lelliott (2001) state that

> 'high bed occupancy rates mean that quality of care is compromised. Some people have to be admitted to distant hospitals with subsequent loss of continuity; nurses spend most of their time managing crises rather than giving care'.

Recommendation

- Services should ensure that in-patient bed provision has adequate capacity to manage the local elderly patient population. Suggested bed numbers are a useful guide, but may be adjusted according to local provision across health and Social Services. Optimal bed occupancy for safe and efficient in-patient bed management is recommended at 85% (Royal College of Psychiatrists, 1998, 2010*a*) in order to have the option of rapid response to emergencies in the community.

Staffing

Medical staff

Over time, due to the reduction of beds and the changing demographics of the ageing population, elderly people being managed in in-patient areas have become more complex in their presentation, are often high-risk with increasingly significant comorbidities. The previous common practice of once-weekly consultant input is no longer sufficient to meet these needs and increased medical staff at all levels are required in these environments. Patients should be reviewed more frequently. In acute assessment areas, regular consultant ward reviews should be held at least twice weekly and additionally the consultant should be available to review urgent cases at any time during the working week.

There has also been a change in the level of junior medical input and the level of their expertise and supervision requirements brought about by Modernising Medical Careers. Many in-patient areas are serviced by junior medical staff on shift systems, adding discontinuity of care. Another issue is that the staff often are at a more junior foundation year level of training. It is imperative that input from both senior and junior medics is available at all times and that there is dedicated time for clinical supervision in consultant job plans to safely train and supervise junior staff. Minimum levels have already been defined and recommended by the Royal College of Psychiatrists (2010*b*). This is an absolute requirement to ensure patient safety.

Nursing

The impact of the high risk and high complexity of individuals presenting to in-patient services as stated before is of course applicable to other professional staff, particularly nurses. The number and balance of qualified nursing and non-qualified care staff necessary for an in-patient ward will vary depending on the number of beds, the dependency levels and specific needs of that patient group. There will be occasions when additional staff are required temporarily to care for very high-risk patients. Strong consideration should be given to some staff holding extended roles such as supplementary or independent non-medical prescribing.

Occupational therapy

It is essential that there are appropriate occupational activities available to patients in in-patient areas throughout the week. These should be diverse and range from the provision of specific ward- and home-based activities of daily living assessments, ward-based targeted therapeutic activities such as relaxation, cognitive stimulation, both individual and group work, to more general occupational activity at other times such as organised games, music, walking groups or breakfast clubs. These can be staffed by a balance of qualified occupational therapists, technicians, activity coordinators and nursing staff.

Psychology services

Each in-patient area should have access to psychology services. This may be dedicated in-patient staff or an in-reach model provided by CMHTs. They should be available for advice and interventions in managing emotional and behavioural difficulties, and in supporting and training other staff in what is difficult work.

Physiotherapy and other allied health professionals

All in-patient areas need to have access to staff in other disciplines who have a particular interest in and expertise with older patients and those in long-term care; for example, a speech and language therapist, pharmacist, dietician, physiotherapist, chiropodist and dentist.

Other services

Each ward should have access to a multifaith chaplaincy and to other voluntary agencies (e.g. Alzheimer's Society, Age Concern). There should also be provision and access to both formal (independent mental health advocates, independent mental capacity advocates) and informal advocacy services.

Recommendation

- Services should have an excellent and wide-ranging skill mix and the balance of staff from different backgrounds is key. The Faculty has deliberately avoided quoting absolute numbers of staff. However, it must be acknowledged by services that if the range and extent of staff across disciplines are limited, this will inevitably reduce the quality of the service provided and will have an impact on the staff that are working in in-patient areas. For example, in areas where services such as psychology, occupational therapy or social work are lacking then there will be an increased workload on medical and nursing staff. Also, the balance between consultant, career grade and trainee medical input will vary, but it is imperative that input from both senior and junior medics is available at all times and dedicated time for clinical supervision in consultant job plans is required to ensure patient safety.

Resources/costs

There has been increasing recognition of the inequalities that have developed across mental health services and discriminatory resourcing for mental health services for older people in particular. To be able to develop improved in-patient services, with a full range of multidisciplinary team specialist staffing, dedicated consultant time, positive therapeutic environment and settings as described in this report, considerable investment is necessary. Where there has been investment in the past for older peoples' services it has largely focused on community care, with subsequent retraction of beds and funds in many in-patient units across the country. This situation needs to be redressed.

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