

Improving the quality of acute inpatient care

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Abstract. Over the past ten years, the National Health Service in England has introduced home treatment teams throughout the country. Despite this, and the fact that England now has the fourth lowest number of beds per capita in Europe, no mental health service has been able to dispense with acute admission beds altogether. One unintended consequence of new investment in community alternatives to inpatient care is that the threshold for admission has risen and acute wards now accommodate a patient group that is more severe with regard to levels of disturbance and social disadvantage. This has compounded the challenge of providing high quality inpatient care and repeated national surveys suggest that acute admission wards are the weakest link in the English mental healthcare system. In response to this, the Royal College of Psychiatrists has established an accreditation scheme for acute admission wards. Only 22 of the first 132 wards to have completed the review process so far are considered to be excellent. Although 59 wards (45% of the total) failed to meet one or more essential standard, 43 of these were able to rectify the problem.

Declaration of Interest: None.

INTRODUCTION

In some respects, the changes in inpatient psychiatric services in England over the past fifty years mirror those in the United States; as described by Lloyd Siderer in his editorial. Bed numbers in England have fallen by about 80% and the last asylum finally closed its doors more than a decade ago. By 2007, England had the fourth lowest number of beds per 100,000 population of countries in Europe (World Health Organisation, 2008).

Unlike the situation in the United States as described by Siderer, more recent reduction in bed numbers in England has been part of a coherent national strategy. Since 1999, a 'National Service Framework' (Department of Health, 1999), accompanied by additional funding, has driven the systematic development of a range of new community services across the National Health Service in England. These include the establishment of home treatment teams in every part of the country whose explicit purpose is to provide an alternative to admission for working age adults. However, despite this commitment to diverting people from inpatient care, as in the United States, no English mental health service has

yet been able to dispense with beds altogether.

Although they remain an essential component of a comprehensive service, psychiatric admission wards are perhaps the weakest link in the English mental healthcare system. A number of national surveys and inquiries have reported problems with the quality of care provided on psychiatric wards and patients often report negatively on the experience of being an inpatient (Healthcare Commission, 2005; Sainsbury Centre for Mental Health, 2005; Mental health Act Commission, 2009). Table I lists the problems highlighted by these reviews (taken from Lelliott *et al.*, 2006).

As can be seen, many of these problems are, at least in part, unintended consequences of the developments in community care. The focus of strategic planners and of those with responsibility for local services has been on establishing the new community teams. Although not explicit, these developments seem to have been driven by a mistaken belief that, if only community services can be perfected, beds will not be needed. Money and staff released from bed closures have been invested in new alternatives to inpatient care and not in improving the quality of the remaining stock of beds. At the same time, the diversion from admission of patients who can be treated at home has had a concentrating effect on the ward casemix; which now comprises only the most disabled, disturbed and disadvantaged group of patients. Many of these patients have co-morbid problems of drug and alcohol abuse and severe social problems, such as homelessness.

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Table I – Summary of problems affecting the quality of care on acute psychiatric wards in England (taken from Lelliott et al., 2006).

The focus has been on community developments

- jobs in community teams are more glamorous and better paid
- wards are seen as recruiting grounds for staffing community services
- senior managers' attention is on developing community services
- under-investment in the physical environment of wards

The role of the acute ward is ill defined

- 'dumping ground' for people whose community care has broken down
- very diverse casemix
- function of wards is an ad hoc mix of care, containment and accommodation

The environment is not therapeutic

- staff manage problems day-to-day and have little time to deliver talking therapies
- the emphasis is on pharmacotherapy
- little input from therapists from outside of the ward
- no structure to the patients' day and limited access to day hospitals
- poor physical health care

Wards are dangerous and chaotic

- violence and absconding are everyday occurrences
- staff are always 'fire-fighting'
- zero tolerance to violence cannot be enforced
- substance misuse causes major problems

There is a lack of leadership

- the ward manager has little authority
- multiple senior psychiatrists often admit to the same ward – none take a lead

Trust management is obsessed with bureaucracy

- paperwork takes staff away from patients
- risk management consists of filling in questionnaires

There is a staffing crisis

- problems with recruitment and retention; over-reliance on agency and bank staff
- difficult to release ward staff for training
- low morale/high sickness rates

Bed management systems cause a problem

- ward staff have little control over admission decisions
- preoccupation with reducing costs rather than increasing quality

USING ACCREDITATION TO DRIVE UP QUALITY

The President of the Royal College of Psychiatrists was cited by the Press as having stated that 'many inpatient units are unsafe, overcrowded and uninhabitable, adding: "I would not use them, and neither would I let any of my relatives do so" (Hill, 2008). It is therefore perhaps not surprising that in 2006, in response to the persisting and apparently intractable problem of poor quality, the College piloted an accreditation scheme for acute psychiatric wards in the United Kingdom. The Accreditation for Inpatient Mental Health Services (AIMS) was developed in collaboration with the national professional bodies of the other clinical disciplines that comprise the core ward team – nurses, psychologists and occupational therapists. A set of standards was drawn from national guidance about the organisation of services, and from clinical practice guidelines, and was subject to extensive consultation with staff working on wards and with patients and carers of patients who had experienced inpatient care (Royal College of Psychiatrists, 2010). In addition to defining good practice in relation to

staffing and organisational procedures, the AIMS standards cover four domains that encompass many of the quality problems listed in Table I:

- i. ensuring a timely and purposeful admission;
- ii. maintaining safety on the ward;
- iii. the quality of the environment and facilities and
- iv. the availability of therapies and activities for patients on the ward. These standards are categorised into:
 - i. those that must be met;
 - ii. those that most accredited services would expect to meet and
 - iii. those that are more aspirational and/or that would denote that a ward is excellent.

Inpatient services that participate in AIMS evaluate themselves against the standards using a range of systematic approaches – casenote review, surveys of patients and their carers, feedback from staff and formal review of procedures and of the ward environment. A one-day peer-review visit is then undertaken to validate the self-review. The peer-review team comprises staff

from other admission wards participating in the accreditation scheme. Peer review teams also include a patient, or a carer of a patient, who has experienced acute inpatient care.

Participation in AIMS is voluntary. It is a requirement that the ward staff team are willing and active participants in the process of review and that members of staff themselves act as peer-reviewers of other wards in the scheme. The review is intended to be rigorous, but at the same time supportive. The model is one that encourages reflection and honest reporting of strengths and weaknesses by the staff team of the ward under review; rather than one of externally imposed inspection. It is also an

ongoing process with repeated annual reviews that encourage wards, including those that have been accredited, to continue to improve and to work towards becoming considered excellent.

At May 2010, 156 acute admission wards had enrolled for AIMS and 132 of these had completed the whole review cycle. Seventy-three (55%) were evaluated as having met all essential standards; 22 of these (17% of the total) were considered to be excellent, having also met many of the more aspirational standards. Table II lists the most frequent reasons why fifty-nine of the wards (45% of the total) failed to be accredited.

Table II – The most frequent reasons why 59 admission wards failed to be accredited.

| Problems | Number of wards affected ¹ |
|---|---------------------------------------|
| Unsafe ward environment including: layout that does not facilitate patient observation, presence of blind spots, insufficient separation of male and female areas, potential ligature points (from which suicidal patients might hang themselves) | 27 |
| Inadequate training of staff in, for example, administration of medicines, basic life support, patient confidentiality | 18 |
| Inadequate practice with regard to assessment of patients' clinical status and risk | 22 |
| Failure to provide basic information to patients about rights, treatment and care | 25 |
| Failure to provide a basic level of one-to-one therapeutic contact between patients and staff | 14 |
| Poor communication within staff group or with other agencies | 11 |
| Inadequate procedures for managing violence and other risky behaviours | 32 |

¹Some wards failed accreditation for two or more reasons

At the time of writing, the staff team on 43 of the 59 wards had rectified the problems identified during the review and provided documentary evidence that they now met all essential standards.

During the course of the review, a total of 3366 patients have given structured feedback on their experience of care by the ward undergoing accreditation. This is in the form of a paper questionnaire completed anonymously and returned directly to the central team managing the accreditation scheme. Patients can report honestly because ward staff never see the questionnaires completed by individual patients and are only given the aggregated result for their ward.

The main theme to emerge from the patient feedback was that of poor communication by ward staff. This included not being given basic information about the ward on admission (reported by 49% of patients), not receiving the recommended minimum of 15 minutes of one-to-one time with a staff member (39% of patients) and not being asked about adverse effects of prescribed medication (38% of patients).

WHAT MORE MIGHT BE DONE?

Given the bleak picture painted by previous national surveys, and the pessimistic view expressed by the President of the Royal College of Psychiatrists, it is encouraging that as many as one in six of the wards that have completed the review process have been accredited as excellent. However, because the scheme is voluntary, it is likely that wards that have joined AIMS early in its existence are among the better wards in the country. AIMS has also demonstrated that at least some of the problems facing admission wards can be both identified by a process of systematic review and addressed by the ward team. The latter is helped by the attention given by senior managers in the mental healthcare provider organisation facing the risk of their ward failing accreditation.

The AIMS standards consider mainly ward structures and processes. Thus, although the review process elicits patient feedback, it is quite possible that the scheme is accrediting wards where treatment decisions do not

always follow best practice guidelines and/or where the clinical outcome of admission is sub-optimal. This could be addressed by the accreditation decision being informed by standard measures of patient outcome, collected routinely as a condition of ongoing membership of AIMS, and by performance on a carefully selected set of indicators of good clinical practice. The latter might include the rate of prescribing of antipsychotic drugs at doses above those recommended by national clinical guidelines – a practice that applies to about one-third of all patients on acute admission wards in England (Paton *et al.*, 2008).

These are early days. Only a minority (perhaps 25%) of all English admission wards have so far enrolled for AIMS. However, the Department of Health has acknowledged that such professionally led accreditation schemes should be considered formally as part of the national regulatory and performance management system for the NHS in England. This should create an incentive for more wards to join.

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