Acute Problems

A survey of the quality of care in acute psychiatric wards

BRIEFING 4

The Sainsbury Centre for Mental Health is a registered charity, working to improve the quality of life for people with severe mental health problems. It aims to influence national policy and encourage good practice in mental health services, through a co-ordinated programme of research, training and development. The Centre is affiliated to King's College London (School of Health and Life Sciences).

Copies of Acute Problems are available from The Sainsbury Centre @ £9 plus 10% p&p.
Tel. 020 7827 8352 (Publications),
134–138 Borough High Street, London, SE1 1LB.

Acute psychiatric units have been subjected to a range of pressures and criticism in recent years. However, they play a key role in the response to severe psychiatric crises and they absorb a large proportion of the money available for mental health services. In recognition of the importance of this element of mental health services, The Sainsbury Centre has undertaken a major piece of research which followed over 200 people through their experience of inpatient care.

The report *Acute Problems* describes the results of the research and makes ten key recommendations about the way forward. This Executive Briefing summarises the report and highlights the key issues for commissioners and providers.

What was the research about?

Despite the central role of acute psychiatric care we have only limited information about its effectiveness and quality. The purpose of the Sainsbury Centre research project was to:

- describe people's experiences on the wards
- develop a picture of life on today's acute psychiatric wards
- assess the key issues surrounding acute care
- track pathways into and through acute care
- examine the extent of discharge planning.

It was carried out in two stages:

- the first was a census of a significant proportion of all acute psychiatric units
- the second was a more intensive study of nine wards and 215 patients. It is this part of the research that is reported in detail in the report.

What are the current issues around acute care?

Despite the lack of evidence about the effectiveness of acute care it is used, and used intensively, because it is there, and because there are rarely readily available alternatives which provide safe care either at home, or elsewhere. Acute care is a neglected area of mental health services in terms of current thinking and research.

What we do know is that pressures on acute care have increased significantly with the reduction in long stay beds, the failure to provide adequate community services, and other social pressures. Many units report occupancy rates of over 100% (possible because beds of patients away on leave are used for others) and high levels of pressure on staff, inevitably resulting in a poor quality experience for patients. This study aimed to follow patients right through their experience of acute care in hospital to find out what happened at each stage.

The research methodology

A representative sample of nine wards was selected from the 38 services studied in the first part of the research programme. 20-25 patients admitted consecutively to each ward were recruited to the study, totalling 215 people in all. Information was collected on their personal characteristics, why they were admitted, what care they received and how effective it was, and on the discharge process.

The researchers visited the wards weekly, collecting information on admission, then following patients through to discharge. Patients themselves were also interviewed and described their satisfaction with services.

Pathways to acute care

The study found that the large majority of patients were admitted for emergency psychiatric treatment, usually for the relapse of an existing illness. 89% were unplanned 'emergency admissions'. However, more than one in ten patients were admitted for social reasons or for respite care. 40% of patients had been admitted to the same service within the last 12 months and 20% within the last 90 days.

There was evidence that a significant proportion of admissions were avoidable, and that current community services are failing, or are unable, to predict or prevent admission. In some cases this is due to a lack of alternatives in the community. A&E Departments are a major access point to acute care – the most important in the South East – and many patients arriving in A&E had not received previous input from mental health services during their crisis.

Patients' experiences of acute care

Most patients leave acute care in a better mental state than when they came in. However, people's long term, underlying needs are not being met during their hospital stay; and in particular social needs are not being addressed. In some cases staff and patients disagree about the patient's most pressing needs. Nearly half of all patients said that they had not received enough information about their illness and the possible treatments.

Many patients receive only limited therapeutic input and multi-disciplinary care is absent for the majority. Patients had remarkably few contacts with staff other than doctors and nurses, and there was little evidence of the timely and effective use of psychologists, occupational therapists or social workers. There was also little evidence of community staff being involved on a systematic basis. Patient contact with all staff other than hospital doctors or nurses only averaged one contact per patient per stay.

Most patients are bored during their stay and few if any are involved in planned programmes of social activity. 40% of all patients undertook no social or recreational activity.

The study uncovered a small, but serious, risk of violence to patients and staff on acute wards. During the study 18 incidents causing no detectable injury were recorded and a further 10 which caused minor injury. No major incidents occurred. There were 16 cases where patients harmed themselves during their stay, but there were no suicides.

Discharge planning

Acute care should form part of a planned and integrated programme, delivered in conjunction with community services. This ideal is, in practice, rarely achieved. Most patients stayed longer than necessary, because of a lack of (usually less expensive) alternatives in the community. Staff believed that nearly one in five patients no longer needed inpatient care at the end of the first week of their stay, rising to 45% by the end of the second week and 70% after 8 weeks. The main reasons for inability to discharge were lack of accommodation and lack of home-based support.

Discharge is often unplanned with inadequate involvement of community staff, patients and carers. Use of the Care Programme Approach (CPA) is variable and is often resented by staff. Only 34% of patients had a discharge planning meeting and most patients had no idea that they were to be discharged until a few days before they left, and had little involvement in discussions about their future. Half of all patients' case notes did not identify the level or intensity of care they required under the CPA.

Patients' views

112 patients were interviewed around the time of their discharge about their care and the environment on the wards. The main findings were that:

- inpatient care is unpopular
- wards lack many basic amenities. 55% of patients had no separate bedroom, 71% no secure locker for personal possessions and 47% no quiet area
- many patients feel unsafe
- women are particularly dissatisfied – they are very concerned about privacy and cleanliness; and also about personal safety
- conditions are especially poor in deprived areas
- the main aspects of care which were liked were respite from everyday problems and contact with staff or other patients.

Discussion

The study is a sobering one, reinforcing the current poor image of acute psychiatric care. This should come as no surprise. Many acute wards are operating with excessive occupancy levels in accommodation which is out of date and not designed to deal with large numbers of patients in crisis. Care is being delivered by pressured and often scarce staff and the report should not be taken as a criticism of committed staff who are battling with what must often seem a hostile environment.

One feature of the report which is perhaps surprising is that the wards which were sampled are located across England and Wales in areas having differing levels of deprivation, yet the similarities between users' experiences were much greater than the differences. Tackling the issues raised needs therefore to be on the agenda of all commissioners and providers, not just those in inner cities.

The core problems seem to be that:

- there are no clear goals for acute care
- the setting is neither pleasant nor therapeutic
- staff are not delivering targeted programmes to improve users' health or social functioning, based on individual needs
- acute care is not seen as part of a system of mental health care – connections with community services are poor.

These problems are not going to be easy or cheap to address. However, unless acute services start to be treated as part of an overall system of care, it is unlikely that the problems will be solved.

Conclusions

Consideration of the research project generated 6 key findings and 10 recommendations which commissioners and providers in all areas will need to grapple with:

No individualised approach is offered, sensitive to the needs of patients.

RECOMMENDATION 1:
Patient-centred care should be adopted as the fundamental principle underpinning the planning and delivery of acute care.

Acute mental health services need to be patient-centred so that response to crisis is tailored to individual patient's needs. In planning and delivering care, staff need to be sensitive to patients' specific individual needs, and to their gender, sexuality, culture, ethnicity and religion.

Specifically, this principle requires that services develop care plans when someone known to services enters crisis. Care planning must involve consideration of the range of options for responding to the crisis and listening to the views of the user and their immediate carers. If inpatient care is the most appropriate option a plan for the inpatient episode must be developed with the user, which covers all aspects of their care and life. Discharge planning needs to start immediately on admission.

Hospital care is a non-therapeutic intervention.

RECOMMENDATION 2:
Care should be individualised, comprehensive and continuous.

RECOMMENDATION 3:
A range of therapeutic resources must be available within acute care, based on the needs of patients.

This study has shown that care provided on acute wards is often unplanned and ad hoc from admission to discharge. The problems are three-fold:

- the care offered is not meeting individual patients' social and therapeutic needs
- there are serious deficiencies in basic amenities
- the needs of specific groups of patients – such as people from ethnic minorities – are not separately addressed.

Patients need to receive a comprehensive assessment on admission, addressing psychological, medical and social problems, and followed by an agreed detailed care plan. This plan should regularly be adjusted to changing circumstances, and discussed with the patient and community services to address outstanding needs before discharge.

It must be recognised that the responsibilities of community services do not end with a hospital admission and recommence on discharge. Contact must be maintained during the hospital stay. Care needs to be seen as a continuous process for as long as a person requires any level of mental health services, and the key worker needs to stay in touch throughout.

In order to support individualised care providers need to:

- review the range of therapeutic resources available including, for example, occupational therapy, psychotherapy and behavioural interventions, group activities and planned recreational activity
- set standards for access to and the quality of these resources, and monitor them.

There needs to be an overhaul of the care and amenities on acute psychiatric wards.

RECOMMENDATION 4:
The hospital environment must be designed to deliver a relaxed and secure atmosphere.

RECOMMENDATION 5:
Wards should be organised as optimally therapeutic units.

RECOMMENDATION 6:
Providers must review their provision to ensure that it meets the needs of women.

For patients the experience of staying on an acute ward can be unpleasant. Although they clearly value the relationships they develop with staff and the respite from their daily problems, this study shows they are deprived of some of the most basic amenities, such as privacy and security. This would be hard enough to tolerate for patients recovering from a brief physical illness, but it seems particularly unacceptable for people in mental distress.

An adequate environment should include sufficient space, privacy, an atmosphere conducive to calmness, safety for patients, security for their belongings, and opportunities for relaxation. It should also protect individual dignity and be designed to allow people to observe their own religious or other practices. There needs to be an urgent review of the facilities and environment on acute psychiatric wards in an effort to improve privacy, security and general amenities:

- there should be separate rooms for all patients, with access to high-standard washing and toilet facilities
- there should be quiet spaces for people to enjoy privacy or take visitors, and a separate smoking room
- everyone should have access to somewhere secure to keep their belongings.

The needs and resources of staff and patients should be considered more creatively, and units should be identified functionally for maximum therapeutic benefit. This may mean separating wards or areas within wards in order to focus on groups of people with distinct needs, whether on the basis of age, gender, social problems, diagnosis, severity of symptoms, treatment plans, or user choice. This would also facilitate the organisation of therapeutic and recreational programmes.

Special consideration must be given to the needs of women. Their concerns about safety and privacy, and the high level of reported sexual harassment in other studies, is unacceptable and hardly conducive to a therapeutic milieu. Equally unacceptable is the frequency of mixed sleeping areas, toilets and bathrooms, and the absence of women-only areas.

Staff are currently poorly equipped in terms of numbers, roles and skills, to offer effective care.

RECOMMENDATION 7:
Staffing levels and skill mix must be geared to the provision of effective care.

RECOMMENDATION 8:
Training in evidence-based practice is required for all clinical staff.

Wards can only be therapeutic (and safe) if sufficient staff with the right skills are available. No simplistic recommendation prescribing numbers and skills can be given, it depends on:

- numbers and characteristics of patients
- the atmosphere of the ward and
- the quality of staff.

The allocation of staff should not be rigid but offer flexibility, taking into account the fit between case and skill mix and the care environment and seasonal fluctuations in demand.

The role of staff on acute wards needs rethinking. In the light of evidence about the most effective forms of treatment and poor present availability, the skills required by staff need to be adjusted. Both pre- and post-registration training need to be adapted to make good any gaps in staff skills. This training should focus on ensuring staff offer a patient-centred, evidence based and holistic approach to acute care.

Individual providers should carry out regular analyses – say every 18 months or 2 years – of patients' needs and staffing skill mix to ensure that there is a sufficient match between the two.

Bed management is currently poor, with large numbers of patients currently remaining in beds when they do not require inpatient care.

RECOMMENDATION 9:
Each provider must designate a senior lead clinician or manager to take overall responsibility for bed management.

There needs to be better management of acute beds at every stage: at admission, throughout the patients' stay and at discharge, to ensure available beds are used in the most efficient and effective way. Issues which need to be addressed include:

- gatekeeping
- liaison with community services
- facilitating quick discharge when patients are ready to leave
- help with benefits and social problems
- involvement of patients and carers in care planning
- audit of 'revolving door' patients to try to meet their needs more effectively
- alternatives to hospital care to be put in place.

Acute 24 hour care should be viewed as one component of a comprehensive and integrated service.

RECOMMENDATION 10:
A range of crisis services should be available of which hospital-based care is one component.

Mental health care for people in crisis needs a fundamental reorganisation to develop a range of services, offering people seamless and comprehensive treatment and support tailored to individual needs. Acute wards should form one component in this range of care. Such services need to be owned by users, therefore they must be involved in planning and developing the range of crisis care. (See Sainsbury Centre Briefing on *Open All Hours* available free of charge.)

Questions or comments on this Briefing should be directed to Dr Andrew McCulloch at The Sainsbury Centre for Mental Health.

The Sainsbury Centre for Mental Health

Published by The Sainsbury Centre for Mental Health, 134-138 Borough High Street, London SE1 1LB.
Tel: 020 7403 8790 Fax: 020 7403 9482 www.scmh.org.uk

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