RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

**QNWA**
QUALITY NETWORK FOR INPATIENT WORKING AGE MENTAL HEALTH SERVICES

# Developmental Cycle
## Year 1
*Aggregated data from 2020 – 2021*

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Artwork displayed on the front cover of this report was kindly provided by the patients at Bushey Fields Hospital, Black Country Healthcare NHS Foundation Trust.

# WHO WE ARE AND WHAT WE DO

## Who we are

The Network was first established in 2006 as AIMS-WA (Accreditation for Working Age Inpatient Mental Health Services). We then became the Quality Network for Inpatient Working Age Mental Health Services (QNWA) in 2020 following the introduction of a developmental option for our members. We are one of around 28 quality networks, accreditation and audit projects organised by the Royal College of Psychiatrists College Centre for Quality Improvement (CCQI) working with mental health services to assess and improve the quality of care they provide.

The Network was created as a result of the findings of the National Audit of Violence (2003-2005) which highlighted the concerning high prevalence of violence on acute wards, but also concluded that examples of good practice were going unrecognised. Since the first set of standards were published in 2006, we have grown to include over 140 member wards/units. A full list of member wards and their current accreditation status is available to view on our website.

## What we do

Our purpose is to support and engage wards in a process of quality improvement whereby they are reviewed against a set of specialist standards for acute inpatient wards for working age adults. There are two pathways: accreditation and developmental. The developmental cycle first allows wards to familiarise themselves with the standards and review process before attempting to gain accreditation. By participating in a developmental review wards can see which areas they are doing well in as well as which areas they need to work on. Quality improvement work can then be initiated before the ward begin their accreditation cycle.

The accreditation process provides recognition for wards who meet a set threshold of standards and who are deemed to be operating at a level that achieves accreditation.

## The developmental pathway


All new members are strongly encouraged to start on the development pathway, this enables the ward to familiarise themselves with the standards and review process before attempting to gain accreditation.

The developmental pathway consists of:

**A 3-month self-review period**

Whereby the ward would score themselves as "meeting", "not meeting" or "partly meeting" each of the QNWA standards. The ward can also opt in to collecting feedback from patients, carers and staff via online questionnaires.

**A 1-day peer review visit**

Whereby a team of 4-5 peer-reviewers attend the ward to valid the self-review data.

**A developmental report**

Following the peer-review visit, the ward will receive a report which outlines how the peer-review team think the ward are performing against each of the QNWA standards as well as a summary of areas of achievement as well as areas for improvement.

Following this, the ward can then make the decision whether to proceed onto the accreditation cycle the following year or have a second developmental review. Wards can be developmental members for up to 2 years before having to proceed onto accreditation.

# WHY CHOOSE THE DEVELOPMENTAL PATHWAY?

## Why was it introduced?

The developmental pathway, launched on the Network in summer 2020, was introduced as a supportive measure for wards that were not yet performing at the standard required for accreditation.

It allows wards to familiarise themselves with the standards and review process before attempting to gain QNWA accreditation.

Wards also receive a detailed report which outlines what standards they are currently meeting and not meeting with some local Quality Improvement (QI) ideas being given by the peer-review team. The ward can then use this to implement changes that will prepare them for their accreditation cycle.

The Network currently has 26 developmental members, with the majority joining the Network for the first time. Some previously accredited members have also chosen to have developmental reviews due to the additional demands on their resources caused by the Covid-19 pandemic.

## Who is it aimed at?

The developmental pathway is aimed at:

- All wards joining the Network for the first time
- Newly opened wards
- Wards within Trusts that have recently received a "requires improvement" rating by the Care Quality Commission (CQC)
- Wards that have recently been refurbished or reconfigured, for example, from a mixed-sex to a single-sex ward

If your ward is interested in becoming a **developmental member**, get in touch with the Project Team at:
QNWA@rcpsych.ac.uk
where we can set up an MS Teams meeting or phone call to discuss your ward's requirements

## A word from the Chair of our Accreditation Committee

Dr Rob Chaplin

Whilst data published by the Network in 2020 showed that standards are improving in areas such as patient-centred care and staff health and wellbeing, it remains true that accreditation is not easily achieved. Given this, some wards may feel they need more time to reach this goal, which is why the developmental option was introduced.

The Accreditation Committee regularly see wards with over 20 unmet Type 1 standards following their peer-review visit. With certain standards appearing frequently such as those pertaining to policies, staff training and high-risk medication audits.

Had these wards first undertaken a developmental cycle, many of these unmet standards would have been flagged to them in a supportive report with clear recommendations as to how they could be achieved. The ward could have implemented these improvements at their own pace before undergoing an accreditation cycle.

I have no doubt that wards who fully utilise the developmental pathway will find themselves with less unmet Type 1 standards following their accreditation peer-reviews. In turn, this would increase their chances of being accredited and reduce the resources required to do so.

Artwork kindly provided by patients from the Camden Acute Day Unit, Camden and Islington NHS Foundation Trust

# THIS REPORT

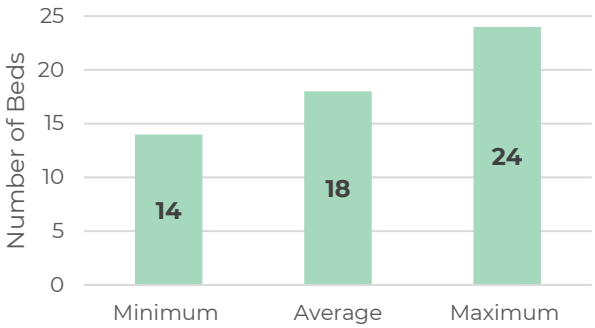
This report uses the data collected from member services who completed their developmental cycle against the Standards for Acute Inpatient Services for Working Age Adults - 7th Edition.

20 acute inpatient working age mental health wards took part in the first year and data used in this report has been gathered from these wards. Data is anonymised per ward/unit using a randomly assigned service code. A list of members can be found in Appendix 1.

## Contextual Data

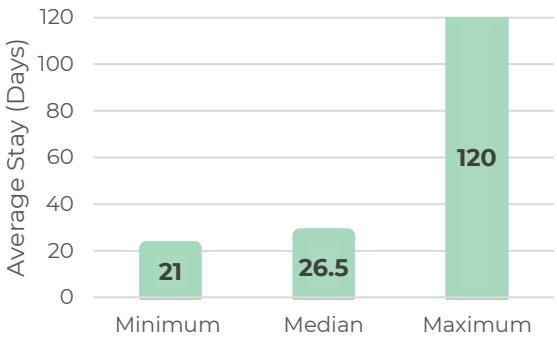
All wards starting a self-review period are asked to provide up-to-date contextual data, including number of beds, bed occupancy (%), and average length of stay. Wards are also asked to provide information on number of restraints, complaints and serious incidents, covering a 12-month period. The following figures are based on data gathered from the 20 wards that undertook the developmental review process during its first year (2020-2021).

### Number of beds



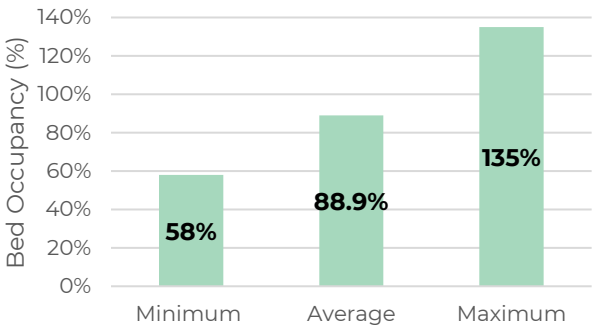

The number of beds varied across the 20 wards. The lowest number of beds was a 14-bed mixed-sex ward. The highest number of beds was a 24-bed mixed-sex ward. The average number of beds across the 20 wards was 18.

### Average length of stay (days)




The average length of stay (in days) varied considerably across the 20 wards. The shortest average length of stay was 21 days. The longest average length of stay was 120 days. The median length of stay was 26.5 days.

### Bed occupancy (%)



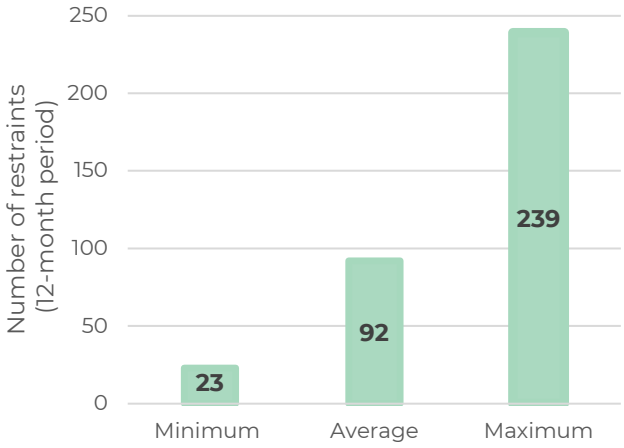

Bed occupancy* (%) ranged from 58% to 135%. The ward with the lowest bed occupancy was a 24-bed mixed-sex ward, with an average bed occupancy of 58%. The ward with the highest bed occupancy was an 18-bed female ward, with an average bed occupancy of 135%. Average bed occupancy across the 20 wards was 88.9%.

Given that the above figures are based on data gathered during the COVID-19 pandemic, it is important to note that bed occupancy was reduced on some wards for infection control purposes.

*A definition of bed occupancy was not provided to the wards and therefore data provided could indicate bed occupancy including or excluding leave. This should be taken into consideration when interpreting the data.

3 of the 20 wards did not provide data on restraints, complaints or serious incidents. Therefore, the following data is taken from the 17 wards that did:

## Number of restraints over a 12-month period

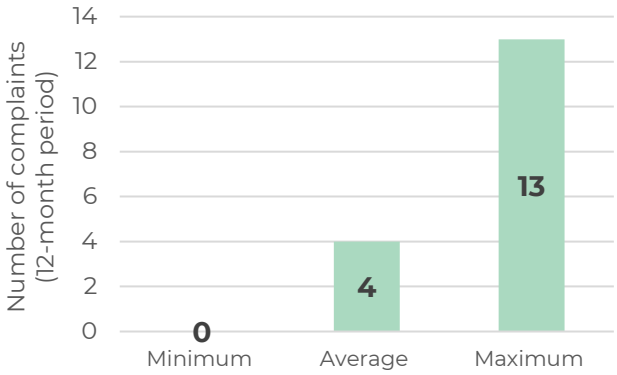



The lowest number of restraints reported over a 12-month period was 23. The highest number of restraints reported over the same period was 239.

The average number of restraints reported over 12 months was 92.

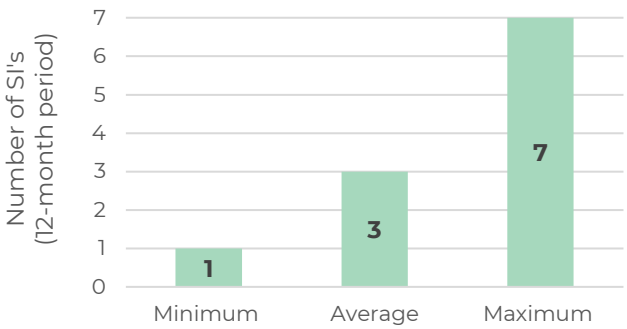
*2 outlier results have been removed from this data set due to distinct features of the ward that make them non-comparable.*

## Number of complaints over a 12-month period




2 wards reported no complaints and 3 wards reported just 1 complaint over a 12-month period. The highest number of complaints reported over the same period was 13. The average number of complaints was 4.

## Number of serious incidents (SI's) over a 12-month period




The lowest number of serious incidents* reported over a 12-month period was 1 (6 out of 17 wards) and the highest number of serious incidents reported over the same period was 7. The average number of serious incidents was 3.

*A definition of serious incidents was not provided to the wards and therefore data provided could vary based on how each individual ward/Trust categorises their SI's. This should be taken into consideration when interpreting the data.

**Summary of the wards who took part in the first year of the developmental cycle (2020-2021):**

- 20 wards from 8 different Trusts
- 2 mixed-sex
- 10 female
- 8 male
- All based in England
- Peer reviews took place between March 2020 and November 2021

**Recommendation based on the contextual data:**

Whilst analysing the contextual data the QNWA team recognised the need for greater specificity when defining certain measures, namely bed occupancy and serious incidents.

Going forward, clearer definitions will be provided which will allow for more reliable data comparison in the future.

# KEY FINDINGS

This section provides an overview of the findings from the 20 wards who undertook a developmental peer-review in its first year.

It explores key findings identified in terms of how services performed against the QNWA standards, which can be split into 7 main areas: admission and assessment; care planning and treatment; referral, transfer and discharge; patient and carer experience; staffing and training; environment and facilities; and governance.

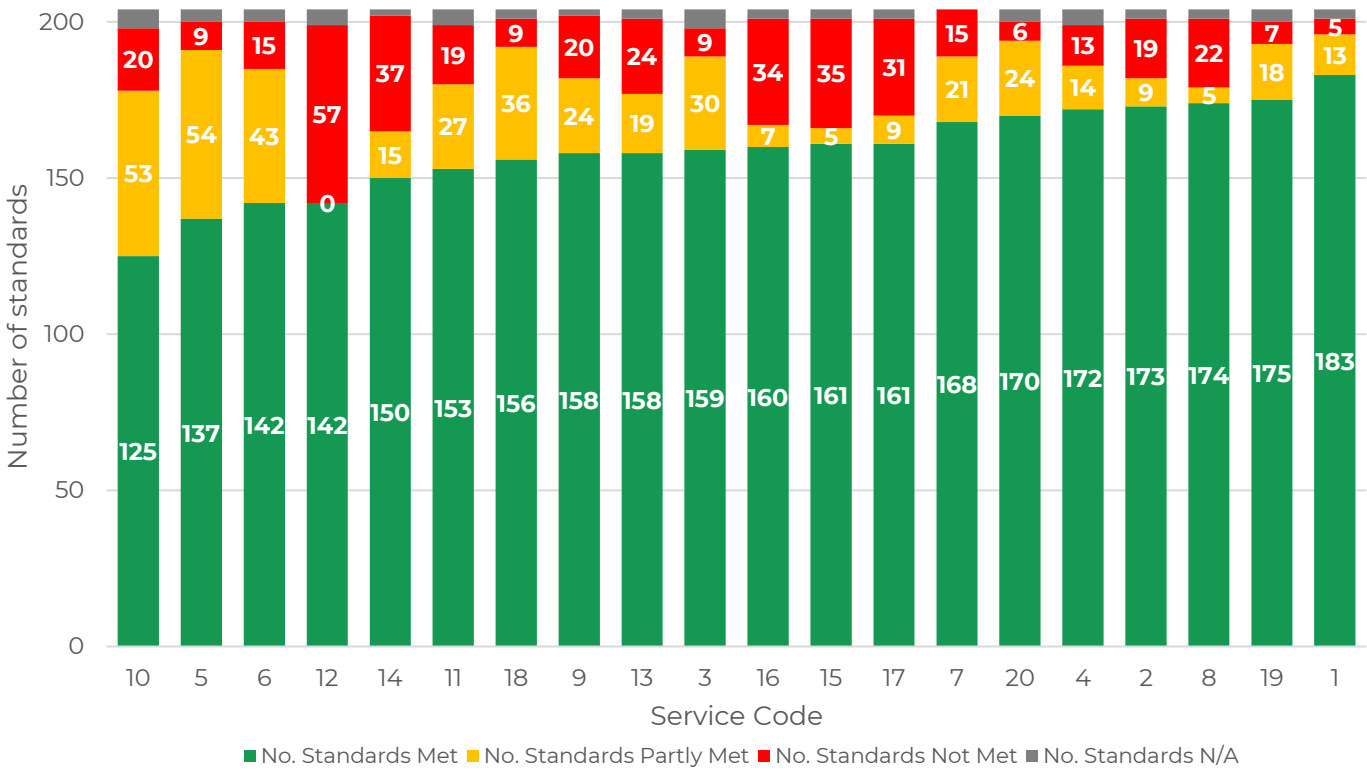
## Overview

On average, member services who took part in the first year of the developmental process were found to be fully compliant with **70%** of standards for acute inpatient services for working age adults. The table below demonstrates the overall score for each service according to their individual service code.

| Service | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Score | 90% | 85% | 78% | 84% | 67% | 70% | 83% | 85% | 77% | 61% |

| Service | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|---|---|---|---|---|---|---|---|---|---|---|
| Score | 75% | 70% | 77% | 74% | 79% | 78% | 79% | 76% | 86% | 83% |

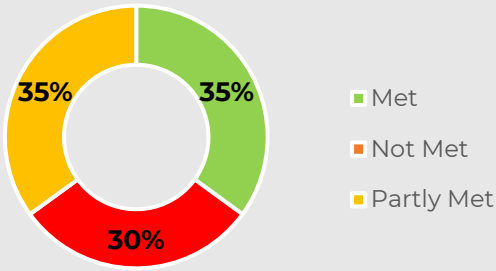
The graph below demonstrates how many standards each individual service is meeting, partly meeting, and not meeting, according to their individual service code. The graph shows the service meeting the fewest standards and the service meeting the most standards, in increasing order.



# ADMISSION AND ASSESSMENT

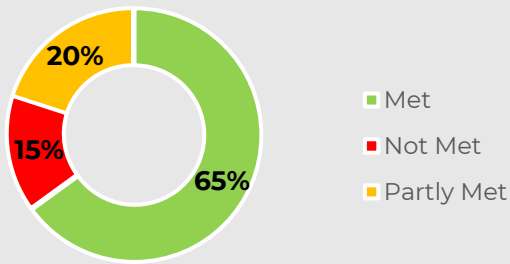
**On average, services met 86% of standards within this category.**

The **most commonly unmet standard** within this section was Standard 17 [1]. This refers to patients being given an information pack on admission which includes things like the therapeutic programme and key service policies.




**Almost two thirds of services (65%) were either not meeting (30%) or partly meeting this standard (35%) indicating that those wards were either not giving out information packs on admission, or that the information pack did not include all the requirements outlined in the standard e.g., the therapeutic programme, key service policies, the unit code of conduct, etc.**

The **second most commonly unmet standard** within this section was Standard 18 [1]. This refers to patients being given accessible written information on admission. This information should include their rights under the Mental Health Act and how to access advocacy services.




**Over a third of services (35%) were either not meeting (15%) or partly meeting this standard (20%) indicating that those wards were not providing patients with accessible written information on admission, covering all the requirements of the standard e.g., rights under the Mental Health Act, how to access advocacy services, how to get a second opinion, etc.**

**There were 3 standards in this section that all services met. These were:**

- **Standard 1 [1]:** The service provides information about how to make a referral to the ward.
- **Standard 16 [1]:** Where the patient is found to have a physical condition which may increase their risk of collapse or injury during restraint this is: clearly documented in their records; regularly reviewed; communicated to all MDT members; evaluated with them and, where appropriate, their carer/advocate.
- **Standard 21 [1]:** Patients admitted to the ward outside the area in which they live have a review of their placement at least weekly.

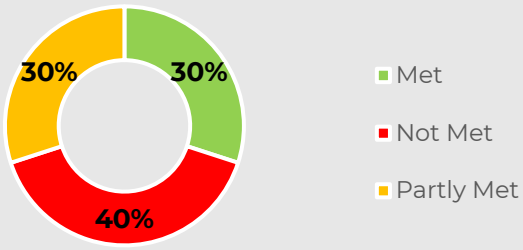
**Ideas for local QI:**
It might be useful to keep a copy of the information pack in patients' bedrooms. For example, on one peer review, the review team heard that this was kept in a folder/directory in patients' bedrooms, which contained important information about the ward; staff would direct patients to this on admission.

Accessible written information should be included in the information pack and displayed on noticeboards, for example posters advertising PALS or advocacy services.

# CARE PLANNING AND TREATMENT

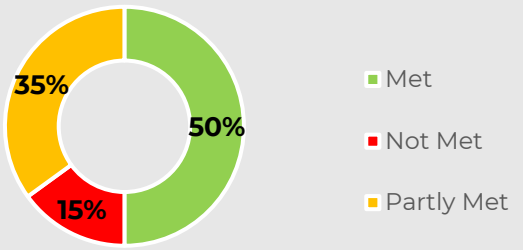
**On average, services met 82% of standards within this category.**

The **most commonly unmet standard** within this section was Standard 45 [1]. This refers to patients being provided with a 7-day personalised therapeutic timetable of activities.




**70% of services were either not meeting (40%) or partly meeting (30%) this standard. Less than a third of services (30%) were meeting this standard. It was found that services were having difficulties providing a regular timetable of activities on weekends/evenings. There were also difficulties running group activities due to social distancing requirements.**

The **second most commonly unmet standard** within this section was Standard 24 [1]. This refers to patients having a written care plan, which reflects their individual needs and is written in collaboration with them.




**Half of services (50%) were either not meeting (15%) or partly meeting (35%) this standard indicating that those wards were not actively involving patients in the development of their care plan.**

**There were 5 standards in this section that all services met. These included:**

- **Standard 27 [1]:** The team knows how to respond to carers when the patient does not consent to their involvement.
- **Standard 38 [1]:** Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime.
- **Standard 44 [1]:** If needs are identified that cannot be met by the ward/unit team, then a referral is made to a service that can.

**Ideas for local QI:**
Wards could employ an activity worker/s to run activities on weekends/evenings. Alternatively, nursing staff can be trained to deliver activities. Some wards also have an activity box, for example containing arts and crafts materials, that patients can access on weekends/evenings.

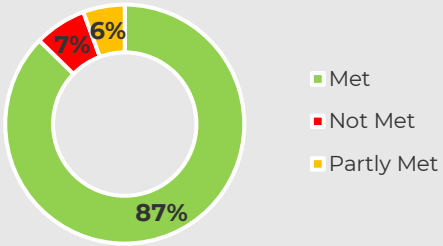
If it is not viable to run activities in big groups, it could be beneficial to split sessions so that they run at different times during the day.

*"The ward is very helpful, and all the staff are absolutely brilliant, no bad words about any of the staff, if you need anything they are there or you."*

# REFERRAL, TRANSFER AND DISCHARGE

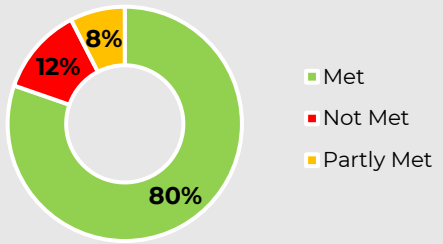
**On average, services met 89% of standards within this category.**

The **most commonly unmet standard** within this section was Standard 51 [1]. This refers to a discharge summary being sent within a week to the patient's GP .




**13% of services were either not meeting (7%) or partly meeting (6%) this standard indicating that those wards were not sending discharge summaries to the patient's GP within the required timeframe as outlined in the standard.**

The **second commonly unmet standard** within this section was Standard 57 [1]. This refers to teams providing specific transition support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP.




**20% of services were either not meeting (12%) or partly meeting (8%) this standard indicating that those services were not providing adequate support for patients to prepare for transition of care, whether this was to another unit, to a community mental health team, or back to the care of their GP.**

**There were 3 standards in this section that all services met. These included:**

- **Standard 53 [1]:** When patients are transferred between wards/units or from/to the community there is a handover which ensures that the new team have an up-to-date care plan and risk assessment.
- **Standard 58 [1]:** The inpatient team makes sure that patients who are discharged from hospital have arrangements in place to be followed up within 3 days of discharge.

**Ideas for local QI:**
Wards should implement processes that ensure that the discharge summary is sent within a week to the patient's GP. For example, the review team heard from one ward that they use an auto prompt to remind them to send the letter within 1 week of discharge. A template could be created to use as a point of reference.

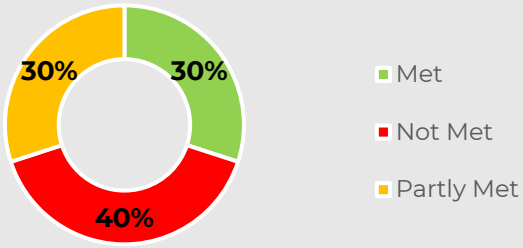
One way wards can ensure continuity of care is to encourage community teams to visit and attend ward rounds and to ensure the care coordinator is involved in discharge planning. This would ensure patients are aware of who will be taking over their care and treatment when they are discharged. A comprehensive handover between teams will allow for smooth transition of care.

*"Staff are amazing, they make you feel comfortable on the ward even when they have to deal with different issues [on] the ward, they are always polite to you."*

# PATIENT AND CARER EXPERIENCE

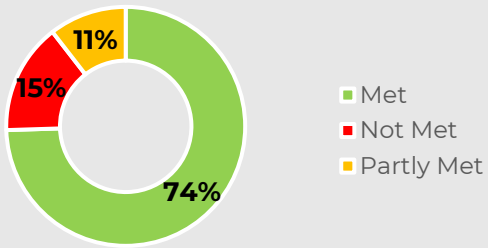
**On average, services met 73% of standards within this category.**

The **most commonly unmet standard** within this section was Standard 65 [1]. This refers to patients being supported to prepare for formal reviews of their care and during their review they, along with their carer (where consent has been given), are able to express their views.




**Over two thirds of services (70%) were either not meeting (40%) or partly meeting (30%) this standard indicating that those wards were not providing patients with adequate support to prepare for reviews of their care, and/or the patient (and/or carer where consent was given) did not feel able to express their views.**

The **second most commonly unmet standard** within this section was Standard 67 [2]. This refers to patients being able to meet with their consultant outside of reviews.




**26% of services were either not meeting (15%) or partly meeting (11%) this standard indicating that for those services the consultant was either unavailable, or that patients were unaware of how to arrange a meeting, outside of reviews.**

**There were 4 standards in this section that all services met. These included:**

- **Standard 79 [1]:** The team supports patients to access support with finances, benefits, debt management and housing.
- **Standard 81 [1]:** The ward/unit uses interpreters who are sufficiently knowledgeable and skilled to provide an accurate and full translation. The patient's relatives are not used in this role unless there are exceptional circumstances.
- **Standard 82 [1]:** Patients who are involved in episodes of control and restraint, or compulsory treatment including tranquilisation, have their vital signs including respiratory rate monitored by staff members and any deterioration is responded to.

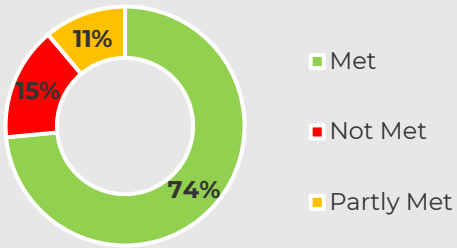
**Ideas for local QI:**
Wards should ensure that patients are allocated 1:1 time with a member of staff and could introduce a review preparation sheet to help patients prepare for their ward rounds/reviews. During the reviews, wards should provide patients with autonomy to choose who they would like to be present in the meeting to encourage them to freely express their views.

Where possible, wards should ensure that patients are able to access the consultant outside of ward rounds via staff who can facilitate a meeting between the patient and consultant.

# STAFFING AND TRAINING

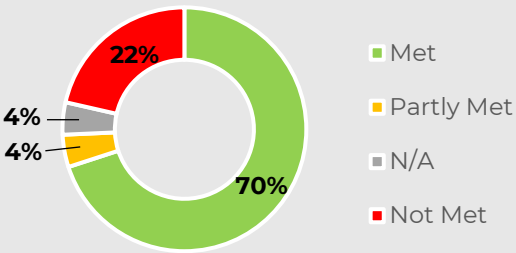
**On average, services met 75% of standards within this category.**

The **most commonly unmet standard** within this section was Standard 127 [2]. This refers to the team having protected time for team-building and discussing service development at least once a year.




**26% of services were either not meeting (15%) or partly meeting this standard (11%). It was found that services were having particular difficulties arranging away days due to social distancing requirements.**

The **second most commonly unmet standard** within this section was Standard 160 [1]. This refers to the agreed response to fire drills being rehearsed at least 6 monthly.




**26% of services were either not meeting (22%) or partly meeting this standard (4%) indicating that those wards were not rehearsing their fire drills at least 6 monthly. Some services were having difficulties carrying out fire drills due to social distancing requirements.**

**There were 4 standards in this section that all services met. These were:**

- **Standard 103 [1]:** *"There is a psychologist who is part of the MDT. They contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence based psychological interventions."*
- **Standard 104 [1]:** *"There is dedicated administrative support which meets the needs of the ward/unit."*
- **Standard 108 [1]:** *"There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the ward/unit."*
- **Standard 109 [2]:** *"There is visible and accessible leadership at ward/unit level."*

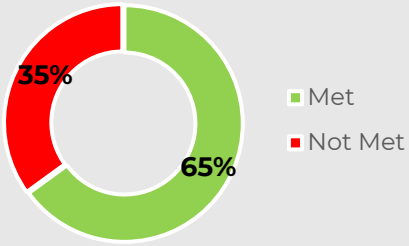
**Ideas for local QI:**
Wards should ensure that they incorporate team away days to encourage team building and to improve staff well-being. Wards should allow staff to provide suggestions of what they would like this day to involve. Where in-person away days would not be possible, for example due to COVID-19 precautions, these could take place online instead.

Wards should ensure that fire drills are carried out at least 6 monthly where staff follow the fire evacuation procedure and this should be documented in a report.

# ENVIRONMENT AND FACILITIES

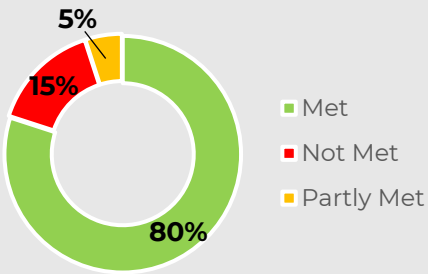
**On average, services met 86% of standards within this category.**

The **most commonly unmet standard** within this section was Standard 172 [2]. This refers to patients having single bedrooms.




**Over a third of wards (35%) were not meeting this standard indicating that dormitories were still present on those wards.**

The **second most commonly unmet standard** within this section was Standard 168 [2]. This refers to facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day.




**Over a fifth of wards (20%) were not meeting this standard (15%) or partly meeting this standard (5%) indicating that on those wards patients were either unable to independently prepare drinks and snacks, or that the facilities were not available 24 hours a day. In some services this would have been restricted due to infection control procedures.**

**There were 17 standards in this section that all services met. These included:**

- **Standard 74 [1]:** Patients have access to safe outdoor space every day.
- **Standard 116 [1]:** Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.
- **Standard 132 [2]:** Ward/unit-based staff members have access to a dedicated staff room.
- **Standard 166 [1]:** Patients are supported to access relevant faith-specific materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room.

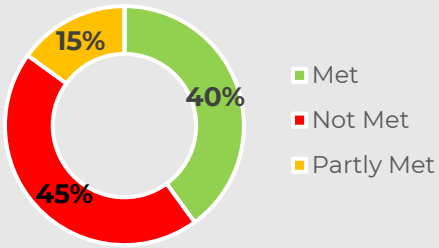
**Ideas for local QI:**
The report of the review of the Mental Health Act recommended that *'all existing dormitory accommodation should be updated without delay to allow patients the privacy of their own room'*. Therefore, wards/unit with pre-existing dormitory style rooms should be making plans, where possible, to have these updated to single bedroom accommodation.

Wards should allow patients to make their own hot and cold drinks and snacks on the ward. Wards that meet this standard usually have a small kitchenette with a temperature-controlled hot water dispenser to maintain safety.

# GOVERNANCE

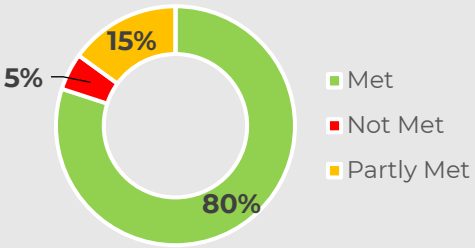
**On average, services met 90% of standards within this category.**

The most **commonly unmet standard within this section** was Standard 198 [1]. This refers to the safe use of high risk medication being audited, at least annually at a service level.




**Over half of services (60%) were either not meeting (45%) or partly meeting this standard (15%). Some services had difficulty producing an audit for 2020-2021 due to pressures from the COVID-19 pandemic.**

The **second most commonly unmet standard** within this section was Standard 189 [2]. This refers to services being developed in partnership with appropriately experienced patient and carers and have an active role in decision making.




**A fifth of services (20%) were either not meeting (5%) or partly meeting this standard (15%) indicating that for those wards appropriately experienced patients and carers were not being actively involved in developing the service.**

**There were 4 standards in this section that all services met. These were:**

**Standard 190 [1]:** Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.

**Standard 191 [1]:** Staff members, patients and carers who are affected by a serious incident including control and restraint and rapid tranquilisation are offered post-incident support.

**Standard 193 [2]:** The ward manager attends business meetings that are held at least monthly.

**Standard 204 [1]:** When mistakes are made in care this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement.

**Ideas for local QI:**
Wards should be regularly auditing their use of high-risk medications to monitor adherence to national and local treatment guidelines.

On wards where this type of audit has not previously existed, managers have worked with their pharmacy colleagues to have an audit cycle created. More information on this audit can be found on Page 17.

# GOOD PRACTICE EXAMPLES

Below are some good practice examples submitted by QNWA member wards on peer-review days or at Accreditation Committees:

## Patient Information Packs

**At a minimum, your patient information pack should include:**

- a description of the service;
- the therapeutic programme;
- information about the staff team;
- the unit code of conduct;
- key service policies (e.g. permitted items, smoking policy);
- resources to meet spiritual, cultural and gender needs.

**What does best practice look like?**

- packs that have been co-produced with patients
- packs that are accessible and easy to read

**An example section on the ward's smoking policy:**

**Smoking**

The law bans smoking in all enclosed public spaces; this includes hospital wards and grounds; therefore, you are not permitted to smoke on the ward. Please let staff know what your usual smoking habits are, they will make sure you are prescribed Nicotine Replacement Therapy (NRT) to help you manage your cravings. You may use e-cigarettes to help you; however, these must be disposable and not the rechargeable variety. If you are unsure or would like more information or support, please speak to a member of staff. We understand this may be very challenging. Once you are admitted, staff are trained to help you.

## Care Plans

**At a minimum, your care plans should be:**

- person-centred, reflecting their individual needs
- written in collaboration with patients and their carers (where consent is given)
- offered to patients in a format that is easy to read and understand
- reflective of the individual's cultural and ethnic background as well as their gender, sexuality, race, economic disadvantage, age, religion/spirituality, and disability
- updated at least weekly or more frequently if the plan changes

**What does best practice look like?**

- using people's own words and phrases – avoiding jargon and abbreviations
- using goals, aims and outcomes identified by the patient

**Examples of a way to write a personalised care plan**

"I will attend emotional regulation groups to increase my understanding of emotions and how to change my unhelpful thoughts"

"My mum will support me with breathing exercises if I have a panic attack"

"Due to having a broken right arm and reduced eyesight I am not able to fully manage my personal care. I would like to be clean and dressed every day in an outfit I choose as this helps with my low mood"

# Activity Timetable

**At a minimum, your activity timetable should include:**

- timetabled activities in the morning, afternoon and evening 7 days a week
- psychological and occupational therapy (OT) led activities in addition to those led by nursing staff
- sufficient activities taking place on the ward for patients who may not be granted leave to attend activities elsewhere

**What does best practice look like?**

- activity timetables dictated by patients' interests and preferences

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Morning | Breakfast Club 9:30-10:30 | Yoga 10:00-11:00 | Healthy Living 9:30-10:30 | Mindfulness 10:30-11:15 | Relaxation 10:00-11:00 | Breakfast Club 9:30-10:30 | Mindfulness 10:30-11:15 |
| Afternoon | Goal Setting 12:00-13:00<br><br>Gym 2:30-4:30 | Cooking Group 12:00-1:00<br><br>Emotional Regulation 2:00 - 3:00 | Benefits and Employment Advisor 12:00-2:00 | Knitting 12:00-1:30<br><br>Community Meeting 2:00 - 2:30 | Wellbeing Walk 12:00-12:45<br><br>Art Club 2:00-4:00 | Make your own lunch 12:00-2:00<br><br>Wellbeing Walk 3:00-4:00 | Baking 12:00-2:00 |
| Evening | Quiz Night 6:30 | Movie Night 6:30 | Pamper Session 6:30 | Music & Singing 6:30 | Games Night 6:30 | Smoothie Making 6:30 | Movie Night 6:30 |

# MDT Review/Ward Round Preparation

There should be a mechanism on the ward that allows for staff to gain feedback from patients on what they would like to discuss during their next ward round or MDT review.

This is usually in the form of a "preparation sheet" which asks the patients a number of questions that they can answer in their own words.

Some of those questions can be seen in the example to the right.

**MDT Preparation**

1. Is there anything from the last week that you want to talk about in the MDT?
2. Are you having any side-effects from your medication?
3. Are there any changes you would like to make to your care plan, for example starting activities, getting help with a drug or alcohol problem, a review of your medication or meeting with a psychologist?

# High Risk Medication Audit

**At a minimum, your high risk medication audit should:**

- be conducted with the involvement of the mental health pharmacist and should clearly indicate activity at service not just Trust level
- include the following groups of patients receiving; Clozapine Antipsychotics in excess of BNF limits [singly and in combination], Lithium, Benzodiazepines. *(The detailed monitoring requirements for each of these can be found in Trust protocols, relevant RCPsych guidance and NICE/SIGN)*
- demonstrate adherence to the monitoring protocols and actions to be taken in the event of deviation

Please note that this is **not** the same as an audit of 'controlled drugs'.

**Below is an example of a results compliance table from a Lithium Baseline Audit**

Target Compliance Rate = 100%

| | Standard / Criteria | Compliance (%) |
|---|---|---|
| 1. | Documented evidence should be available in the clinical records that the following tests or measures were carried out in the 2 months prior to starting lithium? | |
| a. | eGFR (Estimated Glomerular Filtration Rate) | 100% |
| b. | U&Es (Urea and Electrolytes) | 100% |
| c. | Calcium | 100% |
| d. | FBC (Full Blood Count) | 100% |
| e. | TFTs (Thyroid Function Tests) | 100% |
| f. | Weight or BMI (Body Mass Index) | 100% |
| g. | ECG (Electrocardiogram) - within 6 months | 100% |
| 2. | At the time that lithium was initiated there should be documented evidence that the patient was informed of the side effects of lithium? | 25% |
| 3. | At the time that lithium was initiated, there should be documented evidence that the patient was informed of the signs and symptoms of impending lithium toxicity? | 0% |
| 4. | At the time that lithium was initiated, there should be documented evidence that the patient was informed of the risk factors for lithium toxicity? | 25% |
| 5. | Patients should be provided with a copy of the NPSA lithium patient information pack | 80% |
| 6. | For women under 50 only<br>At the time that lithium was initiated, is there documented evidence that the patient was informed of the potential effects on the foetus (teratogenicity) when lithium is taken during pregnancy? | 100% |
| | Overall (average taken of the 6 standards) | 55% |

# APPENDIX 1: LIST OF MEMBERS

This list consists the 20 wards who participated in this report. The wards have been anonymised by an individual service code within this report. The list below is not representative of the order of service codes used throughout this report.

| Ward Name | Trust/Organisation | Location |
|---|---|---|
| **Ward B2** | Nottinghamshire Healthcare NHS Foundation Trust | Nottinghamshire |
| **Bilsdale Ward** | Tees, Esk and Wear Valleys NHS Foundation Trust | Middlesbrough |
| **Bransdale Ward** | Tees, Esk and Wear Valleys NHS Foundation Trust | Middlesbrough |
| **Caburn Ward** | Sussex Partnership NHS Foundation Trust | Hove |
| **Hazel Ward** | Central and West London NHS Foundation Trust | Milton Keynes |
| **Lucy Wade Ward** | Nottinghamshire Healthcare NHS Foundation Trust | Nottinghamshire |
| **Onyx Ward** | East London NHS Foundation Trust | Luton |
| **Orchid Ward** | Nottinghamshire Healthcare NHS Foundation Trust | Nottinghamshire |
| **Overdale Ward** | Tees, Esk and Wear Valleys NHS Foundation Trust | Middlesbrough |
| **Redwood 1** | Nottinghamshire Healthcare NHS Foundation Trust | Nottinghamshire |
| **Redwood 2** | Nottinghamshire Healthcare NHS Foundation Trust | Nottinghamshire |
| **Rowan 1** | Nottinghamshire Healthcare NHS Foundation Trust | Nottinghamshire |
| **Rowan 2** | Nottinghamshire Healthcare NHS Foundation Trust | Nottinghamshire |
| **Stockdale Ward** | Tees, Esk and Wear Valleys NHS Foundation Trust | Middlesbrough |
| **Trinity Ward** | Southern Health NHS Foundation Trust | Southampton |
| **Ward 1** | North Staffordshire Combined Healthcare NHS Trust | Stoke-on-Trent |
| **Ward 2** | North Staffordshire Combined Healthcare NHS Trust | Stoke-on-Trent |
| **Ward 3** | North Staffordshire Combined Healthcare NHS Trust | Stoke-on-Trent |
| **Westwood Ward** | Coventry and Warwickshire Partnership NHS Trust | Coventry |
| **Willow Ward** | Central and West London NHS Foundation Trust | Milton Keynes |

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

**QNWA**
QUALITY NETWORK FOR INPATIENT WORKING AGE MENTAL HEALTH SERVICES

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