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Commentary

Psychiatric intensive care accreditation: The development of AIMS-PICU

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Abstract

This commentary outlines the need for a PICU accreditation system, its development and initial use. The development of a framework that includes clinical outcomes in conjunction with accreditation to measure quality of care is discussed.

Keywords

Psychiatric intensive care; accreditation; quality; governance

WHY?

Within the UK, publication of the 'Darzi report' (Department of Health, 2008a) placed renewed focus upon quality of healthcare provision. Although this document and subsequent publicity gave impetus and focus to the quality agenda, members within the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) have been striving to provide clinical excellence since its foundation in 1994. Through clinician, managerial, service user and carer involvement, it has striven to advance distinction of care within psychiatric intensive care and low secure settings. The publication of national standards in 2002 (Department of Health, 2002) provided a springboard for development of structures surrounding systematic clinical governance within our specialty (Dye & Johnston, 2005). This occurred alongside the introduction of further initiatives pertaining to quality not only within psychiatry but also in the wider health economy (such as the NHS Institute for Innovation and Improvement and ultimately, the regulator of services: the Care Quality Commission).

In 2000 Lelliott commented upon need for monitoring of quality within general adult mental health services (Lelliott, 2000). The challenge of evaluating clinical effectiveness by measures of audit and improvement was made. Lelliot stated: ''Clinical standards cannot be separated from the political policy and service management agenda for the NHS'' and ''The setting, application and monitoring of explicit standards will be unavoidable.'' The fact that mental health was one of the first National Service Frameworks helped with the choice of factors that could or should be measured. However, exact performance indicators need careful selection and methods of measurement need to

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be transparent as well as effective. In the climate of demand for value for money, self-regulation needed to be questioned but the introduction of centralised monitoring and inspection systems can lead to disempowerment and disillusionment amongst clinicians. Surely, as Darzi has concluded, clinicians alongside service users should be involved with the formulation of such standards and lead both in the monitoring of them and in subsequent service improvement.

Enablement and empowerment of organisations and the staff within them to determine quality interaction between staff and patients is potentially lost when agendas are set centrally. Recognising this, the then National Institute for Mental Health in England (NIMHE) helped fund NAPICU to deliver a clinical governance network process which specifically focused upon development of quality within four specific spheres of PICU / low secure care (Dye et al., 2005). Participating units were able to demonstrate improvements via a project that was chosen and owned by their own service. This demonstrated that local quality initiatives can improve local services but the small numbers of units involved in the network, the specificity of projects and questions surrounding sustainability of improvements inevitably meant that variation in levels of practice within PICU / low secure care continued. This has been highlighted by the results of a recent multi-centre survey which involved mainly units that participated in the network process (Brown et al., 2008; Brown et al., 2010; Dye, Brown & Chhina, 2009; Dye, Chhina & Brown, 2009). Thus there is a need for a more uniform process to ensure quality improvements. This need has been met within general acute inpatient psychiatry by the development of an accreditation process: Accreditation for Inpatient Mental Health Services (AIMS) (Lelliott et al., 2006; Cresswell & Beavon, 2009). In developing this process, the aspiration was for it to "become a permanent feature of the landscape, unlike most national initiatives driven by the Department of Health and regulators, which are time limited." Also to: "create an incentive for provider organisations to undertake a sustained programme of improvements to their wards," as well as enabling "sharing of good ideas between staff in different parts of the country." These are similar to NAPICU's ideals and the governance network had aimed to do this but in a less systematic and more concentrated manner and fashion.

A set of principles outlined in Table 1 underpins AIMS and differentiate it from centrally imposed inspection agencies and systems. In England, AIMS has working links with (but is independent of) these agencies and in this way it is hoped that participation in AIMS will provide evidence of adherence to the requirements of national regulators. Indeed, involvement within the AIMS process was a measure that was assessed in the Healthcare Commission review of inpatient services in 2008 (Healthcare Commission, 2008).

Thus, development of an accreditation system to monitor quality of care has become vogue and potentially this aids commissioners, regulatory inspectors and providers alike (as the development of the national minimum standards also aimed to do!). The manner in which such a system is implemented is crucial, as accreditation needs to be performed in a robust and transparent fashion

Table 1. *Principles underpinning AIMS*

Local ownership	Wards only participate if front-line staff and local service users agree. The local review process must be owned by front-line staff and must incorporate true peer review.
Engagement	The system engages all relevant groups, including all staff that work on the ward, senior service managers and service users.
Credibility	The accreditation process is transparent and the standards that underpin it are explicit. The steering group for AIMS includes service users, carers and representatives from the professional bodies whose members are most involved in inpatient care.
Responsiveness	Feedback to participating wards is prompt and includes advice and support about how to meet standards. Networking is encouraged through newsletters and an email discussion group.
Focus on development	Although accreditation is only awarded to wards that demonstrate that they meet minimum standards, the purpose of the process is to support and help wards to achieve this.

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with meaningful results that will also aid the most important stakeholders: patients and carers.

Shortcomings of ratings have been highlighted by various difficulties within Foundation NHS Trusts (with some being criticised for woeful shortcomings of care quality). This indicated a confusing integration / separation of roles between Monitor (an independent regulator of NHS Foundation Trusts) and the Care Quality Commission (an independent regulator of health and social care) and measures that are used within these organisations.

AIMS-PICU has therefore been established as a joint initiative between NAPICU (an organisation with a credible history within the PICU community) and the Royal College of Psychiatrists (an organisation with a track record of producing a credible accreditation system). Both have commitment to the improvement of standards and quality of care, and the need for this process implies the time is ripe for development of AIMS-PICU. Small audits and surveys of practice have indicated differences in practice between units and the demand for consistent improvement has highlighted the need for monitoring of practice at a national as well as an individual unit level – perhaps accreditation can go some way to achieving this.

DEVELOPMENT OF (YET MORE!) STANDARDS

The AIMS-PICU standards (Cresswell et al., 2009) have been developed by the Royal College of Psychiatrists in consultation with a variety of stakeholders including NAPICU, and by reviewing the published literature. As well as the timing of their introduction being politically fashionable, practically it has provided an opportunity to, in part, review the existing national standards and give some 'teeth' to what was, in essence, only guidance and in no way enforceable.

NAPICU and staff from the Royal College of Psychiatrists, College Centre for Quality Improvement (CCQI) used a series of face to face and internet meetings to produce the first draft of the AIMS-PICU standards. Existing AIMS Acute Ward standards were compared with the Mental Health Policy Implementation Guide (Department of Health, 2002), ensuring that all relevant components were incorporated into AIMS-PICU. A review of the evidence base for each standard was undertaken and noted, ensuring that standards remained consistent with current evidence-based practice. The CCQI then circulated the draft standards to the wider group of stakeholders before publication.

AIMS-PICU standards cover 5 areas:

- General standards
- Timely and purposeful admission
- Safety
- Environment and facilities
- Therapies and activities.

It is anticipated that AIMS-PICU will be sustainable and continually updated: users are encouraged to contribute to the ongoing development of the scheme by giving feedback to the College. The cycle of reviewing both one's own service and that of others on an annual basis, should lead to a high degree of critical analysis of the scheme, which can only lead to greater refinement in future versions. Figure 1 illustrates one PICU's involvement within the process.

Standards are graded into those that are essential if accreditation is to be achieved (type one), those that are expected to be met by an accredited ward (type two) and those that, if met, are indicators of excellence (type three). A period of self-review is followed by a peer-review visit by staff from other participating PICUs. Service users are involved, both as sources of information about the quality of the ward and as reviewers. Data collection is aided by carefully designed audit tools and results are compiled into a report for the ward concerned. The report recommends actions where necessary and is the basis of the decision about accreditation status.

The hierarchy of three grading types of standards relate to necessity of the standard being

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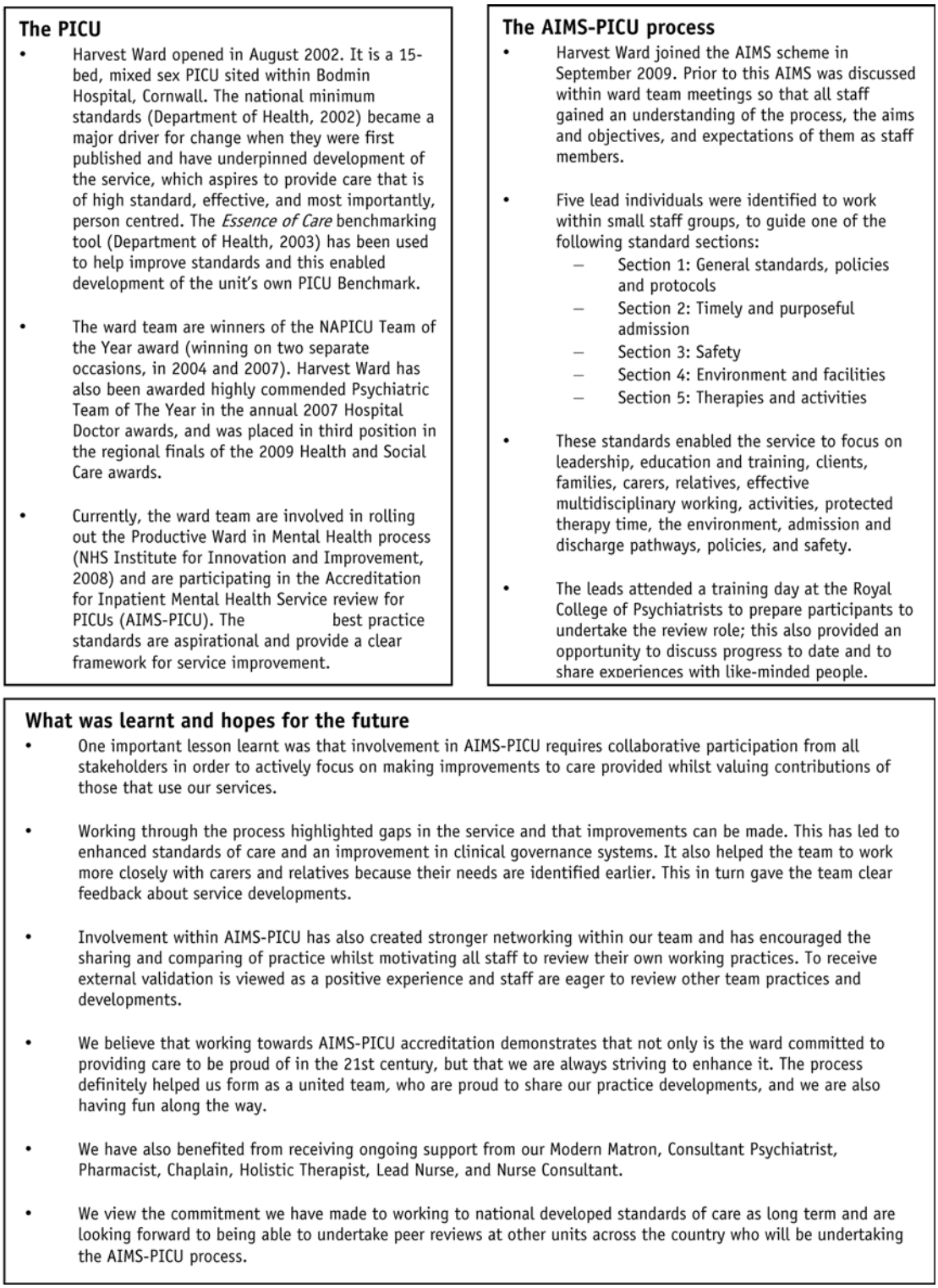

Figure 1. *One PICU's involvement with AIMS-PICU*

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met. Detail of individual standards in each of the five areas range across the three grading types. The authors acknowledge that full compliance by any unit is unlikely and that many of the standards should be considered to be aspirational, targets on which teams can focus and use to create an action plan (Cresswell et al., 2009). Nonetheless, a good proportion of the standards are 'type one' standards (especially those concerning safety) and all accredited units must be able to demonstrate full compliance in this area in order to be accredited.

The standards provide opportunities for members of unit multi professional teams to focus on achieving a shared and common goal. In addition to the requirements detailed by the AIMS-PICU standards, participation in the review process will also foster and develop multi professional participation whilst ensuring that service user and carer representation is a fundamental component of the ward team. Borrill et al. (2000) established that teams who have clear objectives, high levels of participation with a focus on quality and are well led are more effective. The AIMS-PICU standards reflect the need for effective team working which include mandatory standards requiring a dedicated clinical leader who oversees the unit and a dedicated consultant input into the unit.

WHAT NEXT: MOVING UP A GEAR IN ENSURING QUALITY?

The structure of the AIMS-PICU programme will ensure that standards are regularly reviewed by the key stakeholders. This will make sure that where any omissions are identified or external expectations change these can be included in future versions of the standards. Since publication, the Care Quality Commission has commenced inspection of all NHS Providers as part of the registration process commenced in April 2010. One area of interest relates to infection control – an area not considered within AIMS-PICU standards to date. There has also been significant development in a number of systems which collect and collate real time feedback from service users and this too could be considered to be an essential standard in future versions of AIMS-PICU standards.

If quality is truly to become the 'organising principle' of healthcare (Department of Health, 2008b), then we have a long way to go and a lot to deliver. The problem is not necessarily with poor quality services, but in being able to demonstrate that there is a good quality of service. Mental health services perhaps struggle more than many areas in engaging with this issue and it is perhaps in the most acute area of psychiatric intensive care that this is most difficult. AIMS-PICU's broad spectrum approach will provide a huge reassurance to service managers, commissioners and service users that a PICU is offering a good quality service.

Currently most methods of demonstrating quality are inherently reductionist; service user experience is defined using a very limited range of metrics or even single metrics. Many standards are environmental in nature and do not set quality standards for care satisfaction nationally or locally (hence the need for development of reliable and accurate patient related outcome measures).

The advent of computerised health records has started to provide more opportunities for recording metrics in a reliable way, but the problem of what to record will remain. This technology does now mean that some providers are able to report on performance at multiple levels, across the organisation, services, teams and even individual practitioners. This is doubtless helpful to managers, although it is viewed with some scepticism by certain practitioners!

The NIMHE *Guiding Statement on Recovery* advocates an approach to quality measurement that focuses on outcomes for service users rather than performance of services, and it is perhaps this concept which requires the most investment in the coming years (NIMHE, 2005). The creation of a PICU Outcomes Framework could, if coupled with the right IT solution, lead to a means of measuring quality which truly represents the experience of service users.

Such an innovation utilised with AIMS-PICU accreditation will demonstrate not only the quality of experience of service users while they are in the PICU but also the positive impact this will have on them as individuals not just in terms of symptomatology, but also in terms of vocation, physical health and a range of other holistic factors. Far from being viewed as the result of a process, the introduction of AIMS-PICU should therefore be seen as a further developmental stage in striving to support delivery of clinical excellence in the care of our patients. As an organisation, NAPICU attempts to advance practice within psychiatric intensive care. Over the next few years, it will be the expertise of this body and others like it which will assist in the process of defining and measuring quality, through focusing this framework on 'measures that matter' both to clinicians and patients, increasing efficiency and quality through genuine focus on active care provision.

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