The introduction of an innovative system known as ‘zoning’ is helping to transform the care being delivered in one trust’s acute inpatient units. Catherine Gamble describes how the system is freeing up staff to offer individual service users the ‘protected time’ that they so desperately need.

Concerns about standards and quality of care in acute inpatient wards (AIWs) have been well documented (Sainsbury Centre for Mental Health 1998, Moore 1998, Rose 2000, Department of Health 2002). Clients report boredom, feeling unsafe (Barker 2000) and dislike being offered pharmacological, rather than psychological interventions, as a first treatment option. Meanwhile ward nurses report dissatisfaction with the difficulty they have in forming therapeutic relationships (Lelliott and Quirk 2004) and often clients’ needs are often either misunderstood or not anticipated by ward staff. As a result, psychiatric intensive care units (PICU) report clients being transferred before alternative management options have been exhausted (Bowers et al 2003).

The AIWs within South West London and St George’s Mental Health Care Trust were no exception. Staff were crisis managing, preoccupied with office duties and there was limited input from multidisciplinary team members (MDT). Service users and their carers complained that minimal therapeutic activities were available. Indeed, internal trust surveys of these people’s experiences replicated those identified by Mind (Barker 2000), which found that only 37 per cent of inpatients received adequate time from staff.

Ward teams also expressed frustration that the fundamental principles of care – keeping people safe, assessing their problems, treating their mental illness and providing physical health care (Bowers et al 2005) – were not implemented routinely. Ward managers wanted to reduce the amount of time nurses, in particular, spent on ‘non-clinical’ bureaucratic activity. Instead, they wanted to incorporate evidence-based interventions, such as cognitive behavioural therapy (CBT), family intervention, medication management and relapse prevention (NICE 2002) into routine activity and thus provide a service where patients could receive optimum standards of care.

To achieve this, it would be necessary to implement a ‘protected time’ system (Nursing Standard 2004). The ward would effectively ‘shut down’ to non-therapeutic activity so that the nurses and other team members could work with service users to assess their needs formally; draw up collaborative evidence-based treatment plans and observe individual abilities within group activities without interruption.

To ensure standards of good practice permeated across the trust’s eight acute inpatient wards a benchmark assessment tool was constructed. This included a preparation for implementation checklist to identify if key stakeholders had been provided with a rationale for instigating protected time and an overview of the likely consequences. For example, the implications of not responding to phone calls imme-
diately or visitors being unable to access wards at certain times were appraised.

During this preparation phase it became clear that to promote whole system ways of working and adhere to national guidelines (Acute Care 2004) team members would have to meet more frequently as sharing risk and the burden of care requires team effort and an effective communication strategy (Gamble 2006). Also, good practice principles would be required to promote equitable access to nurses’ time and help staff identify who would do what, when and with whom. Without doing so, protected time might be monopolised by a minority of patients and/or based on their knowledge and experience. Staff could cherry pick who they spent their time with. This could result in other patients’ needs being further neglected. Additionally, the shift from a ‘drop everything, crisis management’ culture would challenge traditional working styles and thus would not only require robust leadership, team commitment and operational management support, but it would also have to be part of an ongoing supervisory support structure.

**Principles of zoning**

Zoning is primarily a system for managing casework and targeting resources in delivering care. Research has demonstrated that it can enhance operational management and ensure clinical knowledge and expertise is organised and consistently shared within and between disciplines. In doing so, it reduces the likelihood of unilateral decisions being made through the use of problem solving, team approach strategies (Ryne et al 1997).

The generic model of zoning involves team meetings daily to plan their clinical activity and categorise patients’ needs into red, amber, green or black zones, using a large whiteboard. This provides a rapid indication of how resources might be targeted and how different patients’ priorities can be met. The colours represent the following: The red zone represents those who are considered to be currently at risk or in crisis and whose care requires frequent review; amber represents those who are unwell but do not present major risk factors; green zone contains stable people receiving maintenance care, who may be in the process of being transferred to a less intensive sector of the service; black zone 1 represents those who are currently outside the direct care of the service (e.g. they may be receiving treatment in a general hospital); black zone 2 is used to represent who they spent their time with. This could result in other patients’ needs being further neglected. Additionally, the shift from a ‘drop everything, crisis management’ culture would challenge traditional working styles and thus would not only require robust leadership, team commitment and operational management support, but it would also have to be part of an ongoing supervisory support structure.

**Fig. 1. Example of 25-bedded acute ward zoning board**

<table>
<thead>
<tr>
<th>Zone and criteria</th>
<th>Team member</th>
<th>Team member</th>
<th>Team member</th>
<th>Team member</th>
<th>Team member</th>
</tr>
</thead>
<tbody>
<tr>
<td>RED: Those at high risk/ in crisis and whose care requires constant review</td>
<td>Sophie</td>
<td>Steven</td>
<td>Ella</td>
<td>Diana</td>
<td></td>
</tr>
<tr>
<td>AMBER: Those who remain unwell but do not present major risk factors</td>
<td>Jim</td>
<td>John</td>
<td>Kirsten</td>
<td>David</td>
<td>Merlyn</td>
</tr>
<tr>
<td>GREEN: Those who are stable and in the process of being discharged or transferred to a less intensive service</td>
<td>Sarah</td>
<td>Catherine</td>
<td>Lynda</td>
<td>Sean</td>
<td>Mohammed</td>
</tr>
<tr>
<td>Black zone (1) Those outside the direct care of the ward</td>
<td>Harold</td>
<td>Beth</td>
<td>Rosemary</td>
<td>Cynthia</td>
<td></td>
</tr>
<tr>
<td>Black zone (2) Families who are receiving support</td>
<td>Sarah;</td>
<td>Stephens;</td>
<td>Ella</td>
<td>Lyndon’s</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sophie’s</td>
<td>Beth and</td>
<td>wife</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jims parents</td>
<td>Kristin’s</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Figure 1 represents a white board in a 25-bed ward. This demonstrates the vulnerability of the majority of patients and the workload of each team member. Furthermore, the systems set criteria links interventions and care programme approaches to each patient, so risk is proactively managed, which helps to promote safety and continuity of care (Green and Hipkiss 2001).*

**Zoning meetings**

Green and Hipkiss (2001) acknowledge that effective Zoning within inpatient services relies heavily on everyone adhering to the set criteria and working to time management principles. Thus, the shift co-ordinator’s role is pivotal, as he or she is responsible for ensuring that everyone involved attends the zoning meeting and stick to these values throughout the shift (Ritter 1997). Prior to the commencement of the zoning meeting everyone ascertains what expectations their allocated patients have for the shift; for example, if they are a detained patient who requires escorted leave, are expecting visitors or need to meet their named nurse or doctor. In doing so each team member gains an overall impression of what zone the patient is currently in and can quickly appraise whether he or she should negotiate a formal meeting during protected time to review this.

The team, including junior doctors and other therapists, then meet. The meeting is chaired by the shifts coordinator. Zoning is reviewed using the board (see Figure 1) and a round robin approach. That is, everyone takes it in turn to share his or her observations regarding patients zone profiles and rapidly appraise the priorities. A shift co-ordination board is constructed so the team’s activities are planned by identifying who will do what, and when. (See Figure 2, for an overview of a morning shift plan.)

By steering proceedings and taking overall responsibility the coordinator can monitor whether: 1) individual practitioners are adhering to care plans and operational policies, and 2) clinical activity is, based on available resources, achievable and realistic within the allocated timeframe. That is, workloads are equitable and no-one has inadvertently agreed to undertake an activity that is too time consuming or overlaps with another so it leaves...
the ward under resourced. These plans are then displayed so everyone knows what is happening and when. So if an emergency arises, it is immediately clear where everyone is.

In line with reflective models and learning cycles, which advocate returning to experiences to gain new perspectives and knowledge (Kolb 1984, Boud et al 1985), and to ensure supervision is permanently available, (DH 2006) review of zoning meetings are held at the end of the protected time. Chaired by the coordinator, the meeting affords the opportunity to debrief, share what has been learnt from interactions, review care plans and initiate further supervision or formal support as necessary.

### References


International Journal of Nursing Studies. 40, 145-152.

McKee 2006)

### Implementation concern

<table>
<thead>
<tr>
<th>Implementation concern</th>
<th>Management plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No-one to answer the phone or the door during protected time.</strong>&lt;br&gt;No one to respond to requests to benchmark.</td>
<td>To ensure these tasks are undertaken professionally appraise skills of team members, review the role of a care assistant, if the ward doesn’t have a ward clerk.</td>
</tr>
<tr>
<td><strong>Limited physical resources to hang a white board and there are concerns that placing names on a board will breach client confidentiality.</strong></td>
<td>In the interim, turn take this role during protected time.</td>
</tr>
<tr>
<td><strong>Coordinator’s role in principle is taken on, however individual practices remain idiosyncratic.</strong></td>
<td>Update existing boards in the ward office, order one with closing doors, only use first names.</td>
</tr>
<tr>
<td><strong>Insufficient staff attend meetings and part-time staff are not able to attend.</strong></td>
<td>The senior members of the team take on the role initially to role model.</td>
</tr>
<tr>
<td><strong>Team fail to engage sufficiently (e.g. do not attend training, fail to respond to requests to benchmark).</strong></td>
<td>Review skills and capabilities through appraisal systems.</td>
</tr>
<tr>
<td><strong>What happens if there are insufficient resources to meet the assessed needs of patients (i.e. majority of clients in red zone).</strong></td>
<td>Incorporate a specific time, for coordinator to handover to part-time staff.</td>
</tr>
<tr>
<td></td>
<td>Review individual team members’ availability and take up individual supervision.</td>
</tr>
<tr>
<td></td>
<td>Conduct a brief meeting with those who are present and appraise situation through project board meetings.</td>
</tr>
</tbody>
</table>

### References


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McKee 2006)
A worthwhile method

Protected time has yet to be formally evaluated. However, initial reports in the chief nursing officer’s review for England (DH 2006) highlight that it is a worthwhile method to ensure individuals receive an inpatient service that is safe, supportive and responsive to their needs. The South West London and St George’s ward nursing staff experiences suggest that zoning, combined with pre and post meetings, complement these recommendations, as formal planning helps staff feel better equipped to deliver a optimum standard of care and manage patients’ needs proactively and effectively.

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McKee E; Harrison A; Smith G (2006) Nursing establishments within acute in-patient mental health units: the need for clarity. Mental Health Practice. 9, 8, 18-21.


