PICUs as labs for the development of future psychiatric nursing science: hi-tech psychosocial care

Len Bowers and team,
Professor of Psychiatric Nursing
City University, London
Overview

- The death of the PICU has been greatly exaggerated
- The potential of the PICU
  - A systematic literature review into PICU care
  - What is an effective PICU?
  - Differences between PICUs
    - Three PICUs compared
    - Admission pathways and criteria
    - Containment (seclusion and constant observation)
  - Severity of Psychosis and the NOIIS
  - Interacting with acutely psychotic people
- Some suggestions

East London NHS
NHS Foundation Trust

City University London
Locked doors – the end of the PICU?

- During 2005 and even split: open, partially locked, permanently locked
- Recent study: interviews, surveys, and outcomes
- Patients still abscond from locked wards
- Locked wards have greater violence and self-harm
- Locked wards do not have lower suicide risks
- The era of locked acute wards will soon be over
Acute wards are like PICUs now?

- Evidence?
- Doesn’t tally with my own clinical experience of acute care, but:
  - Geographical variation?
  - Variation between wards?
  - Variation between shifts?
- Taking violence to others as an example, clinical experience of one shift on a ward will be determined 8% by which Trust you are in, 24% by which ward, and 68% by which shift you are on duty
- Generalisations impossible on the basis of personal experience
Literature review on PICUs

- Method:
  - Electronic search of the databases (PsycInfo, CINAHL)
  - Search terms: intensive care, extra care, special care and high dependency and (inpatient or hospital) and (psychiatr* or mental*)
  - In English
  - 1960-2006
  - After the initial papers were drawn from our existing collection and the electronic search, the majority of papers were obtained through chains of references
  - A significant proportion of this work had been done by NAPICU and its members

- Result: 57 papers reporting empirical studies
The studies

- Most were retrospective, descriptive analyses of official records, up to 30 years old
- Six of these have used a comparison group of non-PICU patients so that differences can be identified
- Several surveys have taken place in the UK
- Only three studies have attempted to measure outcome
In comparison to general acute ward patients, the typical PICU patient is more likely to be: male; younger; single; unemployed; suffering from schizophrenia or mania; from a black Caribbean or African background; legally detained; with a forensic history (most commonly for violent offences)

The most common reason for admission to the PICU is for aggression management, followed in rank order by generally disruptive behaviour and suicide risk

Once in the PICU, patients are more likely to be violent, and more likely to be secluded or receive coerced IM medication

Most patients stay a week or less, but there is a smaller group of longer term difficult-to-manage patients who have substantial admissions

No norms for beds/population or staffing levels
Efficacy of PICU care

- PICUs could be effective in two ways:
  - through keeping patients and staff safer than possible on generic acute wards
  - through speeding recovery via more intensive treatment
- One study looked at the impact of opening a PICU on the remainder of the psychiatric unit (Musisi, Wasylenki, & Rapp 1989). For the first 6/12 after: staff accidents 50% down, patient accidents 60% down, nurse absenteeism 38% up, constant observation 90% down, seclusion 92% down
- Two studies conducted at the same unit (Cohen & Khan 1990; Khan, Cohen, Chiles, Stowell, Hyde, & Robbins 1987) have compared the rate of recovery over the first 48 hours of admission, of psychotic patients admitted to either an acute ward or a PICU, finding dramatically faster recovery, BUT....... 
- Using City-128 data I was unable to find differences in conflict rates between wards that had access to a PICU and those that did not
## Three PICUs compared

<table>
<thead>
<tr>
<th></th>
<th>Refuge</th>
<th>Haven</th>
<th>Shelter</th>
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</thead>
<tbody>
<tr>
<td>New patients per bed per week</td>
<td>0.25</td>
<td>0.14</td>
<td>0.16</td>
</tr>
<tr>
<td>Acute beds per PICU bed</td>
<td>5.87</td>
<td>8.22</td>
<td>8.25</td>
</tr>
<tr>
<td>Population per PICU bed (000s)</td>
<td>14.00</td>
<td>21.78</td>
<td>30.50</td>
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<tr>
<td>All incidents per bed per week</td>
<td>0.033</td>
<td>0.138</td>
<td>0.036</td>
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<tr>
<td>Nursing establishment WTE per bed</td>
<td>2.01</td>
<td>3.68</td>
<td>2.71</td>
</tr>
<tr>
<td>Nursing WTE vacancy per bed</td>
<td>0.59</td>
<td>1.24</td>
<td>0.46</td>
</tr>
<tr>
<td>Nursing WTE sick leave per bed</td>
<td>0.01</td>
<td>0.18</td>
<td>0.08</td>
</tr>
<tr>
<td>Nursing WTE bank and agency use per bed</td>
<td>0.48</td>
<td>1.01</td>
<td>0.58</td>
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</tbody>
</table>

Admission pathways and criteria

- PICU patients differ:
  Admissions/week 2.25 0.38 0.78
  Transfers in/week 1.53 0.88 0.53

- The interface with forensic services, medical assessment in police custody, court diversion and S.136 practices vary

- Custom and practice around criteria for transfer from acute wards also varies
Admission pathways and criteria

- Seven London PICUs in 2002:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>No of beds</td>
<td>10</td>
<td>15</td>
<td>14</td>
<td>12</td>
<td>16</td>
<td>14</td>
<td>12</td>
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<tr>
<td>Female admissions</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Informal patients</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Take admissions from community</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Take admissions from prison</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Discharge to community</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Seclusion used</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Nursing pre-admission assessment</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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Admission pathways and criteria

- A PICU is not a single uniform service across the country – it means different things in different places
- The underlying causes of that variation needs surfacing and debating, aided by further research
- What a PICU is for determines how its efficacy is to be judged by research
Use of containment - seclusion

- The three PICUs in one Trust:
  1) No seclusion room at all
  2) A seclusion room, but it has never been used
  3) A seclusion room which is used for time out (unlocked) as well as seclusion (locked) for patients on the PICU and for those on acute wards in the same unit
Use of containment – constant special observation

Observation hours

Graphs by Ward pseudonym
Seclusion and constant observation in the PICU

- So, do we need either of these interventions at all?
Severity of psychosis
(with Winship, Brennan, Ransom and others)

The Nursing Observed Illness Intensity Scale (NOIIS)

- Severity conceptualised as the extent to which symptoms interfere with normal daily living and social interaction, and the degree of social rule breaking
- Sensitive to change, especially at the acute (more severe) end of the scale
- Able to be completed on the basis of observation and usual interaction with nursing care during a shift (i.e. not requiring a formal interview)
- Adjusting for the effect of medication/sleep during the shift
# NOIIS

- Six subscales and one total: sleep/sedation; agitation/activity; psychological distress; cognitive accessibility; apathy/withdrawal; conflict
- Currently in clinical use on Sorrel ward in Reading
- Preparing for validity and reliability testing
Clinical uses

- Is the patient’s condition improving or deteriorating? Are they better this week than they were last week?
- Does the patient respond to changes in medication?
- Does the patient get better or worse after leave? Or after family visits? Or after seclusion? Or on special observation?
- Is this episode worse or better than the last admission?
Interacting with acutely psychotic patients

- Interviewed 28 experienced and expert staff, and seven well and insightful patients
- Aim: to describe nurse interactions with acutely psychotic patients, with a view to providing a typology
- So far we have identified 186 different interactional tactics and three overarching themes/dilemmas
  - Whether, when and how to talk about symptoms or not
  - Judging the best psychological and physical distance
  - Risks vs rewards of increasing the coercion ratchet
- More analytic work required before we can declare results
Medication refusal

- A primary cause for manual restraint – at least as much as if not more than violence
- The type of conflict most strongly associated with total containment use on acute wards
- Medication adherence a special skill of PICU nurses?
- Tony Leiba and the Villa: increasing patient choice – flavours, colours, drinks, cups, timings, accompaniments, snacks, etc.
The PICU as a lab - 1

- Intensive care for patients at a stage when they are most ill, disturbed, awkward, risky and difficult to manage
- Hard to communicate, engage with and develop rapport and a therapeutic relationship
- Difficult to persuade to accept the care and treatment they need
- Often irritable, angry, poorly oriented, low in self control and prone to aggression
The PICU as a lab - 2

Thus PICU staff are experts by experience in:
- Interacting with acutely ill patients
- Persuasion, negotiation, ambiguity, diplomacy, dissembling, de-escalation and the avoidance of force
- Medication adherence

They could also be (and maybe some are) experts in:
- Defining and describing such skills
- Teaching such skills to student nurses and doctors
- Developing new tactics and strategies
- Monitoring and assessment of illness severity, recovery and response to treatment
- Low confrontation practice

“We swim in the mobile seas of ambiguity, and try to keep everyone’s eyes off the cliffs of compulsory reality”
PICU potential

- The end is nowhere near nigh for PICUs
- Could be a source of:
  - Expertise in practice and in the education of professionals in the clinical care and management of acutely ill people
  - Developments in new ways to care for people effectively, with dignity and respect
- But desperately need: clarification of role (and mission), research on efficacy, containment minimisation, and many other aspects of practice
Some suggestions

- Clinical case studies written by individuals and teams
- Exploit internet opportunities to share and accumulate expertise
- Published clinical audits of interventions, outcomes, progress
- Clinically focussed research projects as part of Masters degrees
- Commissioned PhD studentships in PICU research
- Lobby for the funding of a research program, focussing on outcomes
www.citypsych.com

- Research reports
- Details of our research programme
- List of published research papers
- Masterclass video clips on acute psychiatric nursing
- A short story about inpatient care
- Details of the international internet psychiatric-nursing mailing list
- Availability of anti-absconding package
- Further information: L.Bowers@city.ac.uk