The changing face of a high secure hospital intensive care unit

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Overview

- Review of historical archive information
- Small-scale service evaluation data
- Qualitative description of ward milieu
- Potential business model for self-funding

Case for high secure ICU

- Evidence base for intensive care
- Reducing bed numbers in high security
- Relatively higher risk patient population
- Most incidents involve a small percentage of patient population

Review of historical archive information

- No written accounts of situation pre-1970
- Ward daily logs and first hand verbal accounts from long-serving staff
- Assisted by internal communications team to obtain archived hospital newsletters

ICU chronology

- Drake: up to 24 beds
- Usually spare capacity
- Patients utilised courtyard but rarely left ward
- Proposal put forward for ward development in 1998
- Drake decanted out and new Derwent ward opened on existing site in Nov. 2000

	Drake ward (D1)	Derwent ward
Ward purpose	Insular philosophy •Masculine environment •No staff from rest of hospital •No contact with other wards for patients or staff Low turnover of patients	Explicit ward philosophy Mixed staffing (male and female staff)
Ward security	Physical •Location and construction of seclusion rooms (not separate from main clinical area). •Metal cutlery used •Access to everyday objects eg. pens unrestricted •Windows not all shatterproof Procedural •No formal alarm system Relational •7 staff •All patients locked in their rooms overnight	Physical •Re-design of ward •Melamine cutlery •Strict access care plans •Monitoring of interactions between patients •Ensuite seclusion facilities Procedural •Personal panic alarms Relational •9 staff •24 hour therapeutic care
Ward regime	Regimented routine – no therapeutic focus; no off-ward activities Irregular multi-professional contact with the ward No dedicated consultant clinical team	'Derwent programme' in place Regular multi-disciplinary ward rounds, led by a consultant forensic psychiatrist with specific responsibility for the ward

Current service referral criteria

- Mental health, LD and PD Directorates
- Risk: escalating risk of violence towards others, subversive behaviours – increased relational and procedural security necessary
- Re-evaluation of ongoing problematic challenging behaviours

Referral and clinical management

- Referral: nurse to nurse and RC to RC
- Derwent clinical team undertake day to day clinical care though RC and ‘parent’ ward should liaise closely
- Pathway must remain from referring ward
- ‘Day care’ available after discharged from Derwent – facilitates transition

Seclusion data

- Crude but clinically useful data
- But: central hospital database information versus data obtained by hand
- See handout 'Table 2'

Seclusion data

Drake:

- Small core of patients over-represented in episodes of seclusion

Derwent:

- Use of seclusion markedly less but length per episode markedly more

Potential explanations:

- Drake: Less physical security measures
- Derwent: Higher risk patient group

Service evaluation data

- August 2004 – July 2006 (101 wks)
- 31 referrals
- 13 urgent referrals admitted within 48 hrs
- Maximum bed occupancy: 95% of period
- 17 discharges
- Only 7 had joint care plans at discharge

Patients' perspectives

- 22 patients submitted exit questionnaires in 3 yrs
- Preference for gym, watching video, music participation rather than problem solving or anger management group
- 100% felt able to discuss their progress at MDT ward round

Future of Derwent

- Develop cogent business model
  - Service specification
  - Clarify income stream
  - Robust outcome measures
- Pathway development
  - Agreed entry and exit criteria
- Consultative role – see handout ‘Figure 3’
  - Use expertise to advise others