



NHS Clinical
Commissioners

The independent collective voice
of clinical commissioning groups

Guidance for Commissioners of Psychiatric Intensive Care Units (PICU)

2016

National Association of Psychiatric Intensive Care and Low Secure Units

NAPICU is a multidisciplinary, clinician-led organisation committed to developing and promoting the psychiatric intensive care speciality.

Its aims are to improve patient experience and outcome, and to promote staff support and development by: improving mechanisms for the delivery of psychiatric intensive care and low secure care; auditing effectiveness; and promoting research, education and practice development.

The Association uses a number of tools and methods to meet these aims, including local quarterly meetings and academic seminars; training initiatives; the NAPICU website; and an annual national conference. Various committees have been established to take an overview and further develop psychiatric intensive care units (PICUs) and low secure units (LSUs) through research, audit, training and education.

The Executive Committee works with key stakeholders at regional and national levels to shape policy and practice in the area of acute inpatient psychiatry, including psychiatric intensive care and low secure services.

Mental Health Commissioners Network, NHS Clinical Commissioners

MHCN is member-led and managed by NHSCC. It is open to clinical commissioning group (CCG) clinical mental health commissioning leads and senior CCG managers working in mental health commissioning.

NHSCC is the membership organisation of CCGs, providing them with a strong collective voice and representing them in the national debate on the future of healthcare in England. NHSCC facilitates shared learning and delivers networking opportunities for members, so that local clinicians can commission the best possible services for their patients and populations.

MHCN aims to provide a strong collective voice for mental health commissioners, a place to share best practice with peers, and development opportunities and peer support for mental health commissioners.

The network steering group has been consulted throughout the process of creating this guidance, providing comments from a commissioning perspective. The MHCN is keen to continue supporting development of best practice and guidance in commissioning psychiatric intensive care, as part of the network's purpose to enable members in becoming more effective mental health commissioners.

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Foreword

The National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) was established in 1996 to provide guidance on psychiatric intensive care and low secure practice in the UK. The first national minimum standards for psychiatric intensive care units (PICUs) and low secure environments were launched as a Department of Health policy implementation guide in 2002 (Pereira & Clinton, 2002). The general adult PICU standards were revised in 2014 by NAPICU and further supplemented with national minimum standards for PICU for young people in 2015.

In looking back at what has changed over the past two decades, it has been encouraging to see the development of the PICU service model in a standardised manner across the UK, leading to a better experience and higher quality of multidisciplinary care for patients. The learning from PICUs has been driven by the sense of innovation prevalent in PICU teams routinely managing acute and emergency inpatient scenarios, leading to creative ways of supporting patients with serious mental disorder and improving patient safety.

In 2016, PICUs are a critical component of the acute inpatient care pathway, and this progress is testament to the commitment of NAPICU and those who commission and provide these services. More needs to be done to add to the PICU clinical evidence-base, to improve the patient experience, to deliver sustainably consistent care standards across PICUs and to ensure that services remain cost effective within limited financial resources. With this in mind, the ongoing challenge for the PICU community (clinicians, commissioners and providers) is to better understand and objectively measure the value of the PICU model.

NAPICU is delighted to have been working in collaboration with the Mental Health Commissioners Network to develop this commissioners' guidance. This guidance seeks to empower and enable commissioners, managers and clinicians to jointly develop high quality PICUs. NAPICU welcomes this guidance, and we look forward to being able to say with even greater confidence in the future that we are able to respond effectively to the challenge of treating patients presenting with extremes of behaviour.



Dr Stephen Pereira

Chairman NAPICU



Dr Faisal Sethi

Vice-Chairman NAPICU

Foreword

The Mental Health Commissioners Network is delighted to have been involved in the creation of this guidance. As more and more mental health services are provided in community settings, inpatients tend to be more acutely unwell and in turn there is pressure on PICUs. This guidance is intended to assist and support commissioners and providers to ensure that they have adequate and appropriate services for one of the most vulnerable and at risk groups in society – those who have an acute mental health crisis.

We are all only too aware that mental health has been underfunded for many years. Underfunding does not just affect current care – it also affects the ongoing development of services. It is time to rectify this by taking a good look at the evidence and best practice around PICUs, and use that to support those who commission and provide the services. This will help to give the best treatment and best experience to those who are suffering an illness that many in society fear.

In doing so, we hope to continue the process of undoing the stigma that attaches to our relatives, friends and colleagues who are going through probably the worst time of their lives – a mental health crisis. They need our support and understanding, not our disapproval and exclusion. We hope that looking to create the very best in PICU provision will make a real difference, and help to reduce the discrimination that has often occurred.

We commend this guidance for careful consideration. It is intended to support and enable, and not to be an additional burden to those already hard pressed in commissioning or providing services. It is done with the conviction that people in mental health crisis deserve care that follows the best practice, and it is also the most efficient and effective way to deliver care.



Dr Phil Moore

Chair of the NHSCC Mental Health Commissioners Network

Deputy Chair of NHS Kingston CCG

1. INTRODUCTION AND PURPOSE

- 1.1. The Department of Health received 39 responses to its 2012 consultation on draft psychiatric intensive care and low secure commissioning guidance documents (Department of Health, 2012a, b, 2014a).
- 1.2. This document provides summary guidance for commissioners with regard to the commissioning of psychiatric intensive care units (PICUs) to meet the needs of their population whilst achieving the ambition of the *Five Year Forward View* (NHS, 2014): patient safety, clinical effectiveness and patient experience.
- 1.3. The core tasks of mental health services include assessment, treatment and ongoing care of people with a mental disorder, whether in the community, in hospitals or in the criminal justice system. Psychiatric intensive care is a speciality within mental health inpatient services which specifically addresses acute need. It is for patients experiencing an acute mental disorder who require more rapid assessment and stabilisation through active engagement and treatment. (A definition of psychiatric intensive care is provided in Chapter 2 of this commissioning guidance.)
- 1.4. Intensive care and treatment is provided within a specialist environment that has additional measures aimed at managing the clinical acuity and risk presented by patients in PICUs. The degree and nature of these measures will be determined by the overall service setting and the needs of the local patient population.
- 1.5. In 2001, the Department of Health endorsed work being undertaken by the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU; <http://www.napicu.org>) to define national minimum standards for these services, which were published in 2002 (Pereira & Clinton, 2002). Since then there have been changes to other points on the mental health care pathway, including a reduction in open acute care beds and the advent of specialist community teams (e.g. assertive outreach, home treatment and crisis intervention teams). As a result, the acute care pathway has been significantly streamlined and a clearer patient delineation has been created.
- 1.6. In recent years, the care provided in PICUs has changed significantly, with a greater emphasis on the contribution of multidisciplinary teams and quality improvement. The more clinically derived elements of the 2002 national minimum standards were updated by NAPICU (2014) with additional standards for young people published the following year (NAPICU, 2015).
- 1.7. The vast majority of psychiatric intensive care is provided in locally commissioned PICUs, which form part of general adult psychiatric inpatient care pathways. This

commissioning guidance includes good practice examples from some of these PICUs. However, this document and the national minimum standards (NAPICU, 2014, 2015) are equally as important to psychiatric intensive care within secure settings. This commissioning guidance is therefore aimed at those who commission PICUs in either general or secure services, and is applicable to both clinical commissioning groups and NHS England specialist commissioning teams. It will also be of interest to service providers, patients, carers, clinicians and prison health services.

1.8. This commissioning guidance sets out overarching policy principles on the nature of psychiatric intensive care. It is not a service specification and does not contain specific advice on ward size, staff numbers or length of stay, for example. It does not provide detailed information about building design. The guidance is intended to support effective commissioning and service delivery by:

- Supporting commissioners with quality, innovation, productivity and prevention (QIPP) priorities and signposting to case studies
- Supporting commissioning decisions on potential service reconfiguration for PICUs
- Providing a definition of psychiatric intensive care for commissioners
- Setting out a model of care
- Identifying the patient groups likely to benefit from PICU
- Identifying the position of PICUs within the mental health system
- Establishing service principles governing the overall approach to the provision of a safe environment in PICU
- Advocating key performance indicators for operation and quality of care delivery
- Supporting the commissioning of high quality, evidence-based care for patients and their families
- Assisting with the preparation of business cases and highlighting relevant national priorities.

1.9. This commissioning guidance should be read in conjunction with the NAPICU (2014, 2015) national minimum standards.

- 1.10. This commissioning guidance may be useful for various groups of commissioners, including:
- Health commissioners including those based within clinical commissioning groups
 - Integrated health and social care commissioning teams
 - Lead providers who sub-contract on behalf of clinical commissioning groups.
- 1.11. Lead commissioning arrangements may be appropriate for PICUs as the commissioning population for intensive care is small, and most organisations provide PICU services to more than one commissioner. These commissioning agreements need robust governance arrangements, and if they exist, they should link with existing networks.
- 1.12. Commissioners should ensure that the services they commission contribute to the delivery of the following domains in the NHS outcomes framework 2015/16:
- Domain 1: Preventing people from dying prematurely
 - Domain 2: Enhancing quality of life for people with long-term conditions
 - Domain 4: Ensuring that people have a positive experience of care
 - Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

2. PICU PATHWAYS

Definition

- 2.1. Psychiatric intensive care is for patients who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not allow their safe, therapeutic management and treatment in a less acute or less secure mental health ward. Care and treatment must be patient-centred, multidisciplinary, intensive and have an immediacy of response to critical clinical and risk situations. Patients should be detained compulsorily under the appropriate mental health legislative framework, and the clinical and risk profile of the patient usually requires an associated level of security. Psychiatric intensive care is delivered by qualified and suitably trained multidisciplinary clinicians according to an agreed philosophy of unit operational policy underpinned by the principles of therapeutic intervention and dynamic clinically focused risk management. (NAPICU, 2014, p. 5)
- 2.2. PICUs are small, highly staffed units which provide short periods of rapid assessment, intensive treatment and stabilisation for patients before or during a longer period of inpatient care. Admission will be based on an individual needs assessment and in some cases, patients may be admitted directly to a PICU. Following their time in PICU, patients are highly likely to continue to receive treatment in other inpatient ward settings.
- 2.3. The emphasis is on intensive psychological, psychosocial and pharmacological treatment delivered by a multidisciplinary team, combined with a range of physical, procedural and relational security measures that will help to minimise risk, disturbance and vulnerability.
- 2.4. PICUs need to be able to provide services for those who have co-morbid conditions derived of disorders of both physical and mental health.
- 2.5. The majority of patients enter the PICU from, and return to, other inpatient mental health services. However, some referrals come direct from the community and a number from courts, prisons and police custody.

Inclusion criteria

- 2.6. Patients admitted to a PICU will have behavioural difficulties which seriously compromise the physical or psychological well-being of themselves or others, and cannot be safely assessed or treated in an open acute inpatient facility (usually a general adult inpatient mental health ward).
- 2.7. Patients will only be admitted to a PICU if they display a significant risk of aggression, absconding with associated risk, suicide or vulnerability (e.g. due to sexual disinhibition or over-activity) in the context of a serious mental disorder.
- 2.8. It is envisaged that all PICU patients would be detained under the Mental Health Act (MHA) 1983, as admission and detention in a locked PICU environment constitutes a fundamental loss of freedom for an individual. If a patient has been discharged from their MHA detention at short notice, there may be a short period of time during which they remain on the PICU informally until an onward care plan and pathway is arranged.
- 2.9. The inclusion criteria for PICU admission include:
- Externally directed aggression **or**
 - Internally directed aggression including significant risk of suicide and suicidal behaviour **or**
 - Unpredictability in the context of other risks including increased potential for absconding with assessed concern for other associated risks **and**
 - There is a requirement for a goal-orientated period of more intensive treatment that could not be achieved in a less intensive environment within the context of other associated risks **and**
 - Patients should be cared for in an age-appropriate PICU service, and hence there will be PICU service-specific age criteria.
- 2.10. In addition, patients should not be admitted to PICU unless:
- It has been demonstrated that multidisciplinary management strategies in the referring service have not succeeded in containing the presenting problems **and**
 - There is an agreement between referrer and admitting PICU on the positive therapeutic benefits expected to be gained from the time limited admission including a clear rationale for assessment and treatment.

Exclusion criteria

2.11. The exclusion criteria for PICU include:

- The patient has a primary diagnosis of substance misuse, intoxication or dependence
- The patient's behaviour is as a direct result of substance misuse and they are not suffering from an exacerbation of their mental disorder at the time of referral
- The patient has a primary diagnosis of dementia
- The patient has a primary diagnosis of learning disability
- The patient has a primary diagnosis of a significant brain injury
- The patient has a primary diagnosis of borderline personality disorder with no presentation of psychotic or severe mood disorder
- The patient's physical condition is too frail to allow their safe management in a PICU, in which case an assessment will be made by the PICU unit locally.

2.12. In exceptional circumstances, there are scenarios in which a patient is admitted to a PICU with a primary diagnosis of dementia, or a primary diagnosis of learning disability, or a primary diagnosis of a brain injury, or is suffering from a significant physical condition leading to frailty. In such circumstances, the PICU admission should proceed for the shortest duration possible with senior medical, nursing and managerial support for seeking an appropriate placement for the patient as soon as possible. It is important to ensure that the relevant specialist expertise is made available to support the PICU and provide the appropriate medical and nursing care for the patient. Examples include the provision of temporary nursing and medical staff with a higher level of expertise in learning disability care, brain injuries and organic psychiatric syndromes, and general medical and general nursing (i.e. non-psychiatric). For patients who require forensic services (including Learning Disability) commissioners should refer to the service specifications for medium and low secure services (<https://www.england.nhs.uk>).

3. PSYCHIATRIC INTENSIVE CARE MODEL

- 3.1. Commissioners must work jointly with clinicians when using the CQUIN (Commissioning for Quality and Innovation) payment framework as a lever for service change in psychiatric intensive care.
- 3.2. The primary function of a PICU is the rapid assessment and intensive management of acute mental disorder and behavioural disturbance within an integrated care pathway.
- 3.3. Patients will present with increased vulnerability, posing a level of risk to themselves or to others which means they are unable to be safely managed in a non-PICU ward setting. The treatment provided in a PICU will have a direct impact on reducing short and medium-term clinical risk.
- 3.4. PICUs should be available for newly admitted patients and patients already being treated within inpatient services who require rapid assessment, intensive treatment and stabilisation.
- 3.5. The nature of PICU services means that processes for referral, assessment, admission and discharge should be dynamic. Referrals should be accepted 24 hours a day, 7 days a week, and assessments should be completed as a matter of urgency. The PICU is an inpatient psychiatric emergency service, and the processes should reflect this philosophy.
- 3.6. The multidisciplinary team will take an active, treatment-focused approach aimed at rapid stabilisation, crisis resolution, risk-reduction, prevention of relapse and promotion of recovery. Goals for recovery, including an estimated date of discharge from the PICU, should be set as part of the admission process. The emphasis is on short term intensive treatment with regular reviews of progress. There is an expectation from referrers, PICU staff, commissioners, patients and their carers that the length of stay will be kept to a minimum; not normally exceeding 6–8 weeks. Effective links should be maintained with the referring service to support on-going treatment and transfer back. PICU staff should work collaboratively with health (both mental and physical), criminal justice and social care agencies to support effective pathways.

Case study

Patient A was 25 years old and was admitted to the general psychiatric ward informally with elevated mood. In the first 48 hours he became acutely unwell with disinhibition, attempts at self-harm and frequent altercations with staff and other patients. He tried to leave the ward and was assessed under the MHA 1983, leading to detention under Section 2. The multidisciplinary team attempted to therapeutically engage him using: regular engagement with a primary nurse; enhanced nursing observations (one-to-one); and oral medication (which he took erratically). He was only partially engaging with the treatment plan and the risk to himself and other patients was increasing. By day 4, he was transferred to a PICU.

The PICU accepted the transfer with the initial goal of a short term admission (3–5 days). The cornerstone of the PICU plan included clinical re-assessment, rationalising his medication plan, and engagement in structured therapy (occupational therapy and psychological therapy) in an intensive but containing clinical environment. In the early stages of his PICU admission he required rapid tranquillisation in the context of acutely disturbed behaviour and non-response to de-escalation strategies.

Over the next five days, the medication was changed and as his compliance improved, this had positive effects in his mental state and behaviour. By day 5, his condition allowed short periods of escorted leave. His engagement with the staff improved as his concentration and self-awareness improved. He was transferred back to the general psychiatric ward on day 7, by which time he had also engaged in a basic functional skills assessment by the PICU occupational therapist.

- 3.7. The service should operate within the principles of ‘nothing about me without me’ placing the patient at the centre of their care and supporting informed patient choice within the unit where this is clinically appropriate. The service should actively encourage patients and their carers to engage with and participate in the formulation, and ongoing review of a multidisciplinary therapeutic evidence-based programme appropriate to the patient’s individual needs.
- 3.8. All therapeutic interventions and treatments should comply with the relevant NICE and professional association guidance. All patients should be offered information about their medication options, including potential benefits and side-effects.

Case study

Patient B was a 40 year old male who was serving a prison sentence for burglary. In the first two months of his sentence he started to display evidence of psychosis. The prison psychiatrist's assessment was that he required rapid stabilisation of acute psychosis. He was not fully complying with psychiatric medication in prison healthcare.

An application was made to the Ministry of Justice for hospital transfer. He was transferred to a PICU under Section 47 of the Mental Health Act (MHA) 1983. The PICU was required due to the acuity of the clinical need and challenges in therapeutic engagement. Patient B was assessed as being suitable for management in a general adult psychiatric intensive care unit.

Patient B was treated with a combination of medication, talking therapy and therapeutic containment strategies. Over the course of a two month PICU admission, he was stabilised on medication, leading to an improvement in his mental state (including insight) and behaviour.

An application was made to the Ministry of Justice to transfer him back to prison healthcare, en route to ordinary location in prison. Clinical and risk management recommendations followed the patient to the prison, and the PICU team followed up his care over the next week to ensure smooth and effective transfer of care.

De-escalation, PICU extra care areas and seclusion

- 3.9. In line with other hospital units, PICUs should have a policy on de-escalation, the use of the PICU extra care area and seclusion, based on the Mental Health Act Code of Practice (Department of Health, 2015).
- 3.10. Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving (Department of Health, 2015). Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others. Seclusion should be used as a last resort, for the shortest clinically appropriate period and be monitored according to the Mental Health Act Code of Practice (Department of Health, 2015).
- 3.11. Rapid tranquillisation, where required, should comply with NICE (2015) guidance.
- 3.12. All restrictive interventions (including physical restraint, 'pharmacological' restraint and seclusion) in the PICU, should be used in line with the Department of Health's Positive and Safe Initiative (Department of Health, 2014b, c). If a restrictive intervention has to be used, it must represent the least restrictive option. All stakeholder agencies (including commissioners, health and social care providers) are seeking to minimise restrictive practices in health and social care settings.

Case study

Patient C was a 40 year old male with a diagnosis of paranoid schizophrenia. He was being managed in the community by the Assertive Outreach Team. He was well known to have a relapse signature whereby he would rapidly become paranoid, psychotic and violent; often in the context of disengagement from the treatment plan.

In recent weeks, he had stopped taking his medication and his mental state was showing signs of deterioration, over the last week in particular. An MHA 1983 assessment was organised with the help of the police and he was placed under Section 3 of the MHA 1983. As this decision was communicated to him, he attempted to seriously assault the approved mental health professional. With the assistance of police he was conveyed directly to the local PICU for hospital admission.

On admission he was taken to the PICU extra care area for de-escalation and searching. His level of aggression escalated further when the police removed the handcuffs. He was restrained by the PICU team using appropriate clinical restraint methods and the rapid tranquillisation protocol was followed in conjunction with medical input. This led to the administration of intramuscular medication.

He presented as calmer after a period of 60 minutes in the extra care area, and the decision to move to his room (in the PICU) was made in conjunction with the patient. A few hours later he became agitated over a difficult interaction with another patient, and the de-escalation attempts led to another serious attempted assault on a staff member. Patient C was restrained and taken back to the PICU extra care area.

To alleviate the need for, and risks associated with, a lengthy restraint and ongoing distress for the patient, the clinical decision was made to seclude patient C in the PICU seclusion facility. This cycle of behaviour proceeded over the next 36 hours, with attempts at termination of seclusion and multiple intramuscular medication administrations. During this time, the therapeutic engagement with staff was improving to the extent that he began partially complying with oral medications. By day 7 he was fully complying with his oral medications, and although still residually psychotic he had been supported to record his account of the events. By day 21 on the PICU, in discussion with the multidisciplinary team, patient C was able to make an advance statement about medicines that may be used for rapid tranquillisation, and agreed to consider switching to a depot antipsychotic. By day 30, patient C was stepped down to the acute general psychiatric ward, with recommendations for consideration of a Section 17A Community Treatment Order further down the line.

Physical healthcare

- 3.13. The links between mental illness and poor physical health (e.g. cardiovascular disease and cancer) are well established and services should ensure that patients are routinely offered a full assessment of both physical and mental health needs.
- 3.14. All staff at all grades should be trained in physical health care.
- 3.15. Care and treatment plans should reflect both mental health and physical healthcare needs and all patients should:
- Be actively supported to adopt healthier lifestyles, and if they smoke to stop smoking
 - Have access to a comprehensive range of primary healthcare services
 - Undergo regular and comprehensive physical health checks during their inpatient stay starting with an initial assessment at the point of admission
 - Undergo follow-up investigations and treatment for physical conditions identified in their assessment during their admission
 - Have regular monitoring of the effects of medication including those used for physical health issues
 - Have a regular review of any medication prescribed on an 'as-required' basis.
- 3.16. The service should:
- Meet screening targets expected of primary care services
 - Provide general physical and dental health promotion activities including dietary advice and the opportunity to exercise (with appropriate supervision)
 - Aim to be a smoke-free environment and provide targeted programmes to support both patients and staff to stop smoking.

Service environment

- 3.17. The impact that PICU ward size, ward design, patient numbers and population mix will have on the therapeutic environment should be taken into account when managing risk.
- 3.18. PICU wards are locked.
- 3.19. PICUs should be on the ground floor and require dedicated entrances. Access to PICU via other wards should be avoided.
- 3.20. Entrances should have a double door, airlock system.
- 3.21. Staff should be easily identifiable, and the wearing of a full uniform should be considered.
- 3.22. The PICU should have a dedicated outdoor space for patients which is directly accessible from the ward.
- 3.23. The service should be homely with consideration given to providing a low stimulus environment with high levels of natural lighting. The service should be furnished in a way that minimises the potential for fixtures and fittings being used as weapons, barriers or ligature points. The balance between homely and secure is important, as an overly oppressive or restrictive environment has a negative effect on behaviour.
- 3.24. Building design should ensure that extremes of temperature in both clinical and non-clinical areas are avoided.
- 3.25. Patient areas should have wide corridors (that allow staff to escort or move patients who are being restrained) with unrestricted lines of sight, and with no concealed and unsecured areas.
- 3.26. It is important to maintain a balance between privacy and observation; however, the primary concern is to provide a safe environment for both patients and staff. For example, doors in rooms used by patients should have observation panels, consideration should be given to using integrated louvre blinds operated by patients with an override feature for staff. The nature of the overall service setting will determine what is appropriate.

- 3.27. Staff should be able to override any locks that are lockable from the inside (e.g. patient bedrooms and bathrooms). Doors should be designed to prevent holding, barring or blocking.
- 3.28. Services should comply with national guidance regarding the provision of single sex accommodation (ideally this would constitute single-gender PICUs) (Department of Health, 2010a).

Access to external spaces

- 3.29. Access for patients to outside areas including secure gardens should be determined by an individual risk assessment and take account of all factors including the weather.
- 3.30. Garden furniture, fencing and fittings should be fixed and able to withstand attempts to dismantle, be used as a weapon or to exit the service.
- 3.31. To facilitate safe access to outside areas for patients including those on Section 17 leave, a number of safeguards are needed:
- Consideration of appropriate staff supervision, engagement and other observation (including use of CCTV) given the mix and number of patients outside or on leave at any one time
 - Retaining appropriate staffing levels and skill mix on the unit whilst patients are outside or on leave
 - Provision of appropriate escorts given the nature, purpose and location of leave.

Facilities for visitors

- 3.32. The service should provide facilities for visitors. Separate, appropriately furnished facilities for children's visits should be provided. Visiting rooms should have measures in place to ensure that an appropriate level of observation can be maintained.
- 3.33. Lockers should be provided for visitors away from patient areas so they may store prohibited or large items whilst they are on the unit.
- 3.34. Providing a safe environment for patients, staff and visitors is integral to the provision of clinical care. This involves consideration of risk, safety and security.

Risk management

- 3.35. Risk is dynamic and requires a multidisciplinary approach to its identification, assessment and management. It is integral to good care planning and should be adjusted to take account of, for example adverse incidents and observed behaviour. The aim within a PICU is not to eliminate the risk but to reduce it to a level that enables treatment at a lower level of security. This requirement, and how it will be measured, should be agreed as part of the admission process.
- 3.36. The PICU should have an agreed approach to risk assessment including which planning tools are to be used. In 2007, the Department of Health published guidance on managing risk that set out an evidence-based best practice framework for mental health services and practitioners (Department of Health, 2007).
- 3.37. All staff working directly with patients should be trained to incorporate risk identification and management into individual care, treatment and support plans. Staff should be skilled at:
- Identifying and assessing potential risk factors/situations
 - Planning how to manage identified risks
 - Managing identified risks
 - Therapeutic positive risk identification and management.
- 3.38. Risk reduction should be evidenced through assessment, and the setting and monitoring of treatment outcomes. The implementation of the Safewards interventions (<http://www.safewards.net>) provide an evidence-based framework for the reduction of incidents of conflict and containment that can result in safer wards.

Safety

3.39. Safety will be enhanced through:

- Clear rules on and identification of prohibited and restricted items, and on patient possessions
- Clear policies governing access to and appropriate use of the internet by staff and patients
- Provision of staff lockers away from the patient area for the storage of any items not allowed on the unit
- Systems governing the issuing of and accounting for keys and swipe cards
- Designation of a security nurse on the daily rota with responsibility for hourly environmental checks, as well as monitoring of keys, swipe cards and alarms
- Monitoring access to and use of edged implements e.g. kitchen knives and utensils, equipment or tools
- Adequate facilities for the secure storage of patients' possessions
- Adhering to established policies around searching patients and preventing the use of illicit drugs and alcohol by patients and their visitors
- Staff training in breakaway techniques and management of violence and aggression.

4. PICU SECURITY

- 4.1. All PICU services should consider the three interdependent domains of security and manage them jointly. They are:
- **Physical:** The security mechanisms (e.g. locking systems, CCTV) and other physical barriers
 - **Relational:** The understanding and use of knowledge about individual patients, the service environment and the overall population dynamic
 - **Procedural:** The timely, correct and consistent application of effective operational procedures and policies.
- 4.2. Security is defined around the needs of the patient and PICUs work on the philosophy that the dynamic and responsive treatment of the patient is part of the overall security matrix. In this respect, the treatment model of the PICU (acute and dynamic clinical and risk management) can be considered to be a fourth security domain, which acts in conjunction with the physical, relational and procedural security domains.
- 4.3. The balance in emphasis between each domain will change given the operational needs of the unit as a whole, or the needs of a particular patient and/or group of patients, and the setting in which the service is provided. An extensive guide to relational security is available on the Department of Health website (Department of Health, 2010b)

5. WORKFORCE

Capacity and capability

- 5.1. Psychiatric intensive care services require a comprehensive, cohesive multidisciplinary team with a shared vision and with the capacity and capability required to meet the complex needs of patients.
- 5.2. The service should have an identified lead consultant for the psychiatric intensive care unit (NAPICU, 2014, 2015). In addition the multidisciplinary team should include appropriate medical, nursing, social work, clinical pharmacy, psychology and occupational therapy staff as standard.
- 5.3. The PICU staffing should be sufficient to safely deliver optimal treatment and care, manage demand, and be responsive to critical care, 24 hours a day, 7 days a week.
- 5.4. PICUs require a multidisciplinary team with the capacity and capability to engage effectively with highly disturbed patients and provide a range of therapeutic interventions and clinical treatments within the agreed model of care. Staffing capacity should be sufficient to deliver the care and treatment model and maintain a safe environment at all times. Staff mix and ratios should be flexible enough to meet changing levels of risk.
- 5.5. Organisations should have the capacity to respond to patient need and gender specific issues.

Training and continuing professional development

- 5.6. In addition to the range of mandatory and non-mandatory training provided by their employing organisation, staff should:
- Meet the training and education requirements of their professional association; staff training needs should be identified and reviewed on an annual basis and be monitored as part of the staff appraisal system
 - Be trained in safeguarding children and vulnerable adults, and have awareness training in equality and diversity
 - Receive comprehensive training in all aspects (clinical, security and procedural) of the operation of the service initially as part of their induction to the service and prior to having access to keys, swipe cards or other means of operating physical security mechanisms
 - Have a solid grounding in relevant specialist knowledge (e.g. mental health legislation and medications)
 - Receive regular clinical supervision.
- 5.7. Staff who deliver clinical supervision should receive appropriate training in how to do so.
- 5.8. Mandatory training should include clinical techniques associated with the assessment and management of aggression and violence. This should incorporate de-escalation techniques, and the techniques commonly known as the 'therapeutic management of violence and aggression' (TMVA), or other approved 'control and restraint' procedures. A TMVA instructor should be available to provide advice if the team are experiencing particular difficulties.
- 5.9. Mandatory training for clinicians working in PICU should include an adequate level of life support training, to reflect the clinical acuity and physical health risks encountered by patients in psychiatric intensive care (Resuscitation Council (UK), 2014).
- 5.10. All staff should receive training in how to search patients.

6. GOVERNANCE

PICU standards and outcome measures

- 6.1. We recommend that all PICUs should engage with the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) and their accredited quality initiatives (e.g. the AIMS-PICU scheme, which is collaboration between the Royal College of Psychiatrists Centre for Quality Improvement and NAPICU).
- 6.2. PICUs should participate in other national benchmarking activities such as the Prescribing Observatory for Mental Health (POMH) national prescribing audits.
- 6.3. PICUs should be actively involved in auditing specific areas of care delivery, including physical health monitoring, Mental Health Act 1983 legislation compliance and care planning.
- 6.4. PICUs should develop key performance indicators (KPIs) or outcome measures to determine the quality of care provided to patients. Example areas include:
 - Generic patient related outcome measures (PROMs): this may include patient satisfaction measures, carer satisfaction measures and complaints
 - Generic clinician related outcome measures (CROMs): this may include measures such as the Health of the Nation Outcome Scale (HoNOS)
 - Patient safety measures (adverse events, measure related to the occurrence or management of violent incidents)
 - Measures associated with the use of restrictive interventions in the PICU: this may include the rates of use of rapid tranquillisation, high-intensity psychiatric observation, physical restraint, extra care area use and seclusion
 - Performance or 'Fidelity to PICU Model' measures (response times to referrals, transfer times to the PICU, average PICU length of stay, transfer delays out of PICU including those to NHS England commissioned services, PICU re-admission rates)
 - PICU multidisciplinary team measures (staffing levels and skill mix, sickness and industrial injury rates, training compliance, referrer satisfaction measures).

(NAPICU, 2014, 2015; Joint Commissioning Panel for Mental Health, 2013, p. 19)

Monitoring and evaluation

- 6.5. Monitoring and evaluation of PICU commissioned services is essential to ensure the achievement of clinical outcomes and actions within this guidance.
- 6.6. Quality assurance mechanisms and data sources already exist to evaluate several aspects of psychiatric intensive care described within this guidance and commissioners may choose to develop further local indicators for their services.
- 6.7. Commissioners should ensure they have quality schedules in place. The quality schedule will provide a clear primary focus for NHS clinical commissioning groups to monitor and receive assurance from providers about the delivery of high quality care in PICUs. Data can be triangulated across the quality schedule to create an early warning system.
- 6.8. Commissioners should monitor their commissioned service via the contract specification process including the KPIs that relate to physical health and performance (see 6.4 above).
- 6.9. Commissioners should monitor patient-reported data sources, and compare them with operational performance. Examples include:
 - Patient-led assessments of the care environment (PLACE)
 - Care Quality Commission (CQC) inpatient surveys
 - Patient experience surveys
 - Complaints intelligence
 - Safeguarding (number of issues relating to malnutrition and dehydration; data on patient safety incidents).

Improving patient experience

- 6.10. Commissioners should ensure that the public, patients and carers are involved in commissioning for PICUs. The participation of these groups within the commissioning process can also provide greater insight into the quality of the services that have been commissioned, and can include:
- Strategic planning: involving patients and carers fully to identify and understand their needs and the gaps in the current services from the patients' perspective.
 - Specifying outcomes and procuring services: discussions with patients and carers about how the objectives might be delivered and what the required outcomes in PICUs are (e.g. seeing a dietitian; good information on admission and discharge)
 - Managing demand and performance: discussions with patients and their carers about the way in which outcomes can be measured in PICUs.

Service specification

- 6.11. Commissioners should collaborate with clinicians, local stakeholders, patients and carers when determining what is needed from PICU services for patients with psychiatric intensive care needs.
- 6.12. The PICU care pathway should be person-centred and integrated with other elements of acute mental health care.
- 6.13. Commissioners may wish to take action to stimulate the local market if shortages of PICU providers are identified at any point in the pathway and should note that any qualified provider may include NHS and independent mental health care providers.
- 6.14. Commissioners should ensure that providers are taking steps to achieve the standards set out in the national minimum standards for psychiatric intensive care units (NAPICU, 2014, 2015).
- 6.15. Commissioners should ensure that the PICU services they commission represent value for money and offer the best possible clinical outcomes for their patients.
- 6.16. Commissioners should use quality standards to ensure that high-quality care is being commissioned through the contracting process, to establish KPIs as part of a tendering process and/or to add incentives to provider performance by using the indicators in association with incentive payments such as CQUIN (Commissioning for Quality and Innovation).

- 6.17. Commissioners should ensure that they consider both the clinical and cost effectiveness of PICU services, and any related mental health services, and take into account clinicians', patients' and carers' views, as well as those of other stakeholders when making commissioning decisions.

Reporting and management of adverse incidents

- 6.18. There should be a robust structure and approach to the reporting, management and investigation of serious incidents including an established process for liaising with external agencies such as local authorities and the police. Accountability for serious untoward incident (SUI) processes, including investigations, should be held at senior management level. The lessons learned from incidents should be always be shared widely. Use of the National Learning and Reporting System (NRLS; <http://www.nrls.npsa.nhs.uk/>) will help to ensure that the sharing and learning processes are used to prevent similar incidents occurring in the future. The definition of an adverse incident is an event or circumstance that could have, or did, lead to unintended, unexpected harm, loss or damage (Pereira & Clinton, 2002).
- 6.19. Investigations should be in line with guidance on the discharge of mentally disordered people and their continuing care in the community (Department of Health, 2005).
- 6.20. PICUs should have a robust approach to preventing the use of alcohol and illicit drugs by patients and their visitors. Policies should cover the role of relational security and intelligence, and the management of incidents where drugs and alcohol are brought in by patients or their visitors.
- 6.21. Staff should understand their role regarding risk management.
- 6.22. There should be a procedure for debrief and post-incident review, with the dissemination of lessons learned. The opportunity to report and learn from 'near miss' or 'no harm' incidents should not be overlooked.

Business continuity

6.23. The provider organisation should have a comprehensive business continuity plan setting out the arrangements for maintaining service integrity, and patient and staff safety in the event of operational, security or systems failure. The business continuity plan should address:

- Chain of operational control
- Communications
- Patient and staff safety and security
- Maintaining continuity in treatment
- Patient and staff accommodation.

6.24. The business continuity plan should incorporate any plans agreed with the police and other emergency services.

7. EQUALITY AND DIVERSITY

- 7.1. PICUs should comply with equalities, mental health and human rights legislation. All operational and clinical procedures, processes and policies should reflect their requirements.
- 7.2. The PICU should provide patients with a range of information in appropriate formats regarding their rights under equalities, human rights and mental health legislation. Patients should have access to an appropriate range of advocacy services. This should be clearly displayed in an information area on the wall, stating that further information is available from ward staff. It should also be included in the patient's admission information pack.
- 7.3. The PICU should provide a range of information about what patients can expect from the service, its policies (particularly on searching) and treatment options including information about medication and its potential benefits and side-effects.
- 7.4. Staff should be trained in and have a current understanding of equalities issues and how this may affect patient care.

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