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EDITORIAL

A nurse-led psychiatric intensive care unit: 25 years on

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In 1995, psychiatric intensive care units (PICUs) remained a relatively new concept in mental health care. Although many acute mental health trusts had PICU provision, their operating models remained poorly defined with a lack of evidence to support their function, patient outcomes and experiences. Dix (1995) appeared to be the first paper to describe a new operating model for PICUs: that of the nurse-led PICU.

In this editorial, we reflect on the model described by Dix (1995) in the context of preliminary findings from a small-scale evaluation study of a nurse led PICU in the West Midlands (UK). We also consider the advances in the concept of 'nurse-led' PICUs and the longevity and impact of Dix's model in the 25 years since it was originally described.

What is a nurse-led psychiatric intensive care unit?

In an article describing the commissioning and operational planning of a new PICU within The Severn NHS Trust, a new model of working was presented by Dix (1995): 'a nurse-led PICU'. Prior to this, the Reed Report recommended 40 PICU beds per million population, an increase which was greatly welcomed (Reed 1992). However, the increase highlighted potential problems with the operational model of PICUs, including clinical issues such as unrealistic demands of PICUs, delayed discharges and the de-skilling of nursing staff working on acute wards.

In the 1990s, medically led services were the norm and this also applied to historical PICU practices and operational procedures (Gouldney et al. 1985). For the first time, Dix (1995) presented what seemed to be a new way of working and provided a clear rationale to support the model. The paper (published in a medical journal) suggested that the primary role of the PICU was to manage clinical nursing problems rather than medical problems. These 'nursing problems' were placed into four categories which included internally and externally directed aggression, absconding and unpredictability. These, it was argued, were primarily 'clinical nursing problems' forming the basis of assessment and admission criteria to PICU. As the model considered the unit's function to primarily provide interventions for nursing problems, it was nurses who completed admission assessments and decided when both admission discharge from the PICU should occur.

By defining the primary purpose of the PICU, the clinical presentations warranting admission to PICU and the nature of PICU interventions, it can be argued that the nurse-led PICU model described 25 years ago continues to inform the modern day PICU practice we see today.

Contemporary context of the PICU

The model espoused by Dix (1995) has become the presiding basis for the majority of PICUs in the UK. The clinical nursing problems set out in the paper were later enshrined into national minimum standards (NAPICU 2014) and the Royal College of Psychiatrists provides PICU accreditation standards that reflect aspects of Dix's model (Townsend & Georgiou 2020). Despite the model underpinning PICU clinical practice, there has been very little critical review or reflection on the model in the literature. This begs the question that if no challenge of critical examination of the model has been undertaken then how do we know it is the most effective and appropriate?

The Midlands PICU operates in a similar way to the Severn Trust (now Gloucestershire Health & Care Trust) PICU where Dix's model was developed and first implemented. Nurses accept, screen and assess referrals and decide upon admission. They remain involved in the ongoing treatment and review of patients and their opinion on suitability for discharge is key to the overall multidisciplinary (MDT) decision. Anecdotally, it appears that this is the case for the majority of PICUs nationally.

The change to nurse-led PICUs has been maintained for over 25 years. During this time there have been important changes to nursing practice and mental health legislation, offering opportunities to advance the role of nurses and the model further.

Advances in nursing practice

One such development in nursing practice has been the emergence of Nurse Prescribers. Prescribing any medication is a significant responsibility and up until 1992 the role was reserved for the medical profession. In 1992, changes in legislation meant that community nurses could legally prescribe from the Extended Formulary for Nurse Prescribers (UK Parliament 1992). Further national advances between 1997 and 2000 concluded that Nurse Prescribers could expand the list of medications they could prescribe under a supervisory framework (a partnership between a doctor and nurse), known as supplementary prescribing. As the landscape of the NHS and access to healthcare changed, so too did prescribing policies. In 2006, the Department of Health announced that Independent Nurse Prescribers would be able to prescribe any licensed medicine for any medical condition. Since the emergence of Independent Nurse Prescribers, there has been significant evidence to support the role. Wide scale studies suggest higher patient satisfaction, better adherence to prescribed medications and a reduction in over prescribing of medications (Latter & Courtenay 2003).

A second significant change occurred with the revision of the English and Welsh Mental Health Act (MHA 1983) in 2007. Amendments to the act created the role of the Approved Clinician (AC) and the Responsible Clinician (RC). The Responsible Medical Officer (RMO) role was removed and the responsibility of holding the overall responsibility for the care of those detained under the MHA was opened to other professionals including nurses, occupational therapists, psychologists and social workers. For wider mental health services, this presented a significant change and opportunity for the development of professions, care and services. Within PICUs, considering the model presented by Dix (1995) and subsequently established in practice, this change and opportunity appeared particularly pertinent. If the prevailing view is that admission to PICU is predominantly for management of nursing problems, and nurses lead assessment and discharge decisions, then how could the service be further enhanced or developed with a nurse acting as AC or RC? Or, would this be a step too far? Would this grant too much influence and power to one profession? Certainly, combining the Severn Trust model with a Nurse RC would add greater justification to the description of a truly 'nurse led' PICU.

Advancing Dix's model

The Midlands PICU follows a similar operational model to that described by Dix. Referrals are predominantly received from acute admission wards; they are screened and assessed by nursing staff who decide whether admission is indicated. This is based on the four categories described above and if admission is not assessed as required, then advice and support is offered to the referrer. The care and treatment of patients is the responsibility of the MDT as a whole; medical review, a strong focus on occupational therapy assessment and intervention, psychosocial interventions and assessments are all key components. The largest contribution to care is provided by the nursing staff (both registered and unregistered). Others have attempted to describe and quantify the nature of the care provided (Salzmann-Erikson 2015; McAllister & McCrae 2017) and it is evident that the closest contact, and the greater proportion of interaction and involvement in the patient's journey, is held by the nursing team. As such, the nursing staff are key stakeholders in discharge planning and their assessment is a prime determining factor in the vast majority of discharges.

The Midlands PICU advances Dix's nurse-led model around the issue of who holds the overall responsibility for the care of patients. In the Severn Trust (pre-2007 MHA revision) this remained with the RMO. In the Midlands PICU the amendments to the MHA 1983 have enabled a change in this practice. The ward currently has

provision for a dedicated Consultant Psychiatrist (whole time equivalent (WTE) 0.6) and also a Consultant Nurse who is an AC (WTE 1.0). On admission to the unit, the Consultant Nurse (who is also an Independent Prescriber) is allocated as RC for all patients admitted. Increased availability and accessibility make this the preference in the first instance. During the first MDT review, allocation of the most appropriate RC (as described in the Mental Health Act Code of Practice; DH 2015) is discussed with the patient and the team, and will subsequently be reviewed and changed if necessary. Following this review, the Consultant Nurse holds the ongoing RC role for at least 50% of the PICU caseload.

In 2019, two years after the establishment and embedding of this model within the Midlands PICU, a service evaluation was completed to identify any benefits the role may have introduced and any further opportunities for research and development.

Qualitative evaluation

To capture views about the Midlands nurse-led PICU, staff working in the PICU were asked to complete a bespoke questionnaire as part of a service evaluation. The questionnaire was distributed to 45 members of staff, including: psychiatrists, registered nurses, occupational therapists, assistant practitioners and healthcare support workers. The questionnaire, which was anonymised and asked respondents to identify only their profession, included the following questions, designed to elicit open, qualitative data from respondents:

- Do you feel the Responsible Clinician role held by a Nurse has changed patient care? Can you explain why it has or hasn't?
- Has the Nurse-held role changed the MDT nature of the care we provide? Can you explain why it has or hasn't?
- Has the introduction of the Nurse-held role changed the access patients have to their Responsible Clinician? Can you explain why it has or hasn't?
- Has the role changed how responsive the service is to patients' needs? Can you explain why it has or hasn't?

Data were analysed in NVivo using a thematic approach to identify key themes from open text responses (Braun & Clarke 2006).

Summary of evaluation findings

A total of 25 (56% response rate) completed surveys were returned over a two-week period (May 2019). Thematic analysis identified five themes that described views on the changes to the service and clinical practice. The themes include:

- Accessibility
- Relationship with patients
- A different perspective
- Communication
- Responsiveness

An overview of the findings are detailed in Table 1.

Discussion

Dix (1995) pioneered nurse-led intensive care units, which have since been embedded in clinical design and practice. Dix described a model for operational procedures but perhaps more importantly it defined the invaluable role of nurses in the clinical landscape of psychiatric intensive care. Over the subsequent 25 years, the model has become well established in PICUs nationally and has significantly influenced both national minimum standards and accreditation standards.

As such it is difficult to deny both its impact and longevity. Over time, as legislation and context has evolved, further opportunities to build on the model have become available. Independent prescribing and the provision of Nurse RCs have further enhanced the model.

The service evaluation carried out in 2019 suggested multiple benefits from the role and the themes identified contain data which supports a nurse led service.

The themes of *Accessibility* and *Responsiveness* contribute to the picture of the nursing role being at the forefront of patient care, both in delivery and in leading care within PICU. Respondents also reported that patients reacted positively to the role and appeared to benefit from a more accessible RC with whom they were more easily able to engage with and build a therapeutic relationship.

The evaluation did not include patient responses, however, if the findings were replicated in this group, then a strong argument could be made the Nurse RC may often be the most suitable and appropriate RC within PICU. This remains an area for future research.

The theme of communication provided positive responses regarding the role, particularly related to improvements within the communication of the MDT and with patients. These factors relate directly to the statutory competencies required to become an AC, namely the ability to:

- Communicate clearly the aims of the treatment to patients, carers and the team
- Assimilate the (potentially diverse) views and opinions of other professionals, patients and carers, whilst maintaining an independent view.

Table 1. Summary of survey responses by theme.

Theme heading	Definition	What participants described
Accessibility	The introduction of the role of the Nurse AC/RC has increased access between patients, carers and the PICU team.	The role had improved how regularly the patient gets to meet with their RC which results in more regular reviews and timely care.
Relationship with patients	The role has improved care by changing the relationship between patient and RC. Respondents felt that this was a result of two main factors. Firstly, that the increased accessibility and visibility improved relationships.	Patients often felt able to more easily build a therapeutic relationship with the Nurse RC and the increased availability and closer understanding of the patients day to day experiences were a significant factor in this.
A different perspective	The nature of the care has moved away from a medical model following the introduction of the role. This has led to the development of an approach which provides an increased focus on social and psychological aspects of care.	The role provided a more bio-psycho-social approach which led to a greater understanding of issues that may impact on the delivery of care by the nursing team.
Communication	Improved communication with patients following the introduction of the role. This appeared to be linked to the themes of 'accessibility' and 'relationships with patients' as replies focused on the increase in opportunity to meet with the RC and improved engagement as demonstrating improved communication.	The Nurse RC role created a 'bridge' between the nursing and medical teams which increased collaborative working.
Responsiveness	Improvement in the responsiveness of the service linked to increased accessibility.	Responses highlighted the ability of the Nurse RC role to quickly respond to changes in presentations and emergencies. This was felt to make care more dynamic and allow for a more rapid evaluation of treatment.

AC, Approved Clinician; RC, Responsible Clinician

This small-scale service evaluation has clear limitations, which include potential researcher and responder bias and an absence of patient feedback. Further research that involves patients, is multi-site and contains qualitative data related to outcome measures would aid further development of clinical, professional and service model guidelines related to PICUs.

It is apparent that the view, posited originally by Dix, that the primary purpose of a PICU is one related to clinical nursing problems has not been challenged. It is embraced nationally by individual units, national bodies and in fact accepted as the norm. Ultimately, it is the patients who find themselves in need of a PICU who, for the time being, experience the greatest problems which require assistance to resolve so that there can be a return to more independence. The question is, how well can the nursing ideology and skill set can help with those problems? Given the rapid development in nursing practice over the last 25 years, this question now requires robust evaluation.

We can also see that legislation and nursing practice has evolved enabling further development of the model. We may now need to ask: is this progress positive? And if so, how do we share the advances to ensure that they achieve the longevity of Dix's original model?

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