Department of Health

Mental Health Policy Implementation Guide

National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments

This hand painted silk scarf was designed and produced by Workwise art and design trainees, as a service of commission pieces for Bury St Edmunds and Norwich Cathedral, capturing the striking colours of stained glass.

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Entry is open to anyone who has experienced mental illness themselves or has been affected by the mental illness of someone they care about.

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Art Works in Mental Health is sponsored by Pfizer Ltd and collaborating organisations involved in the project are Breakthrough, Coventry Healthcare NHS Trust, Depression Alliance, NSF, The Northern Centre for Mental Health, South London and Maudsley NHS Trust, PriMHE (Primary care Mental Health Education) and Priority Healthcare Wearside.

National Standards for PICU and Low Secure Environments

The PICU Policy, Research and Development Group have been specially commissioned by the Department of health to produce these standards

Report Editors: Dr Stephen Pereira, and Colum Clinton
on behalf of the PICU/Low Secure Practice Development Consensus Forum

Strategic and Project Lead:

Dr Stephen Pereira, Head of PICU Policy, Research and Development Group, NELMHT

Colum Clinton, Project Officer, PICU Policy, Research and Development Group, NELMHT

Network Steering Committee:

Malcolm Rae (Nursing Officer, DoH)

Kevin Gournay (Institute of Psychiatry)

Dr Stephen Pereira (NELMHT)

Host organisations:

North East London Mental Health NHS Trust (NELMHT)

Redbridge and Waltham Forest Health Authority (RWFHA)

Department of Health

Contents

Introduction

Background

In May 2001 the PICU Policy Research and Development Group based at NELMHT were specially commissioned by the Department of Health to produce National PICU Standards. The Group initiated a PICU and Low Secure Practice Development Network. This Network, which consisted of a multidisciplinary group of professionals and user representatives from around the UK, met for 9 consensus workshops between May 2001 and January 2002. The aim of the workshops was to develop standards for psychiatric intensive care and low secure environments.

Through the consensus workshops the network was able to create a forum that would bring together professionals from different:

- Disciplines

- Geographic locations

- Types of unit

This was in order to create as representative a group as possible.

The remit of the group was to:

- Identify and agree standards for psychiatric intensive care and low secure services

- Identify general good practice guidance for each of the standards

The objective of developing these standards is to provide users, clinicians, managers, and commissioners with a dynamic framework for delivering high quality services. Through standard setting and evaluation, services can be clear about where they are and what they are aiming for.

PICU Definition

Psychiatric intensive care is for patients compulsorily detained usually in secure conditions, 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 enable their safe, therapeutic management and treatment in a general open acute ward.

Care and treatment offered must be patient-centred, multidisciplinary, intensive, comprehensive, collaborative and have an immediacy of response to critical situations. Length of stay must be appropriate to clinical need and assessment of risk but would ordinarily not exceed eight weeks in duration.

Psychiatric Intensive Care is delivered by qualified staff according to an agreed philosophy of unit operation underpinned by principles of risk assessment and management.

Low Secure definition

Low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security.

This is according to an agreed philosophy of unit operation underpinned by the principles of rehabilitation and risk management. Such units aim to provide a homely secure environment, which has occupational and recreational opportunities and links with community facilities.

Patients will be detained under the mental health act and may be restricted on legal grounds needing rehabilitation usually for up to 2 years.

1. Admission criteria

1.1   Rationale

Detention in a locked environment constitutes a fundamental loss of freedom for an individual. PICU and low secure staff need to work collaboratively with referring services to ensure that admission is appropriate to the individual's needs. There should be no more restrictions on a person's freedom than is warranted by his or her clinical condition.

1.2   Standards

Criteria for admission

1.2.1   Patients admitted to the PICU/Low secure environment will have behavioural difficulties which seriously compromise their physical or psychological well-being, or that of others and which cannot be safely assessed or treated in an open acute inpatient facility.

1.2.2   Patients will only be admitted if they display a significant risk of aggression, absconding with associated serious risk, suicide or vulnerability (e.g. due to sexual disinhibition or overactivity), in the context of a serious mental disorder.

1.2.3   The admission for PICUs is due to a new episode or to an acute exacerbation of the patient's condition. In low secure units patients may be experiencing chronic behavioural disturbance.

1.2.4   It has been demonstrated that multidisciplinary management strategies in the referring acute admission unit have not succeeded in containing the presenting problems.

1.2.5   There must be mutual agreement between referrer and admitting unit on the positive therapeutic benefits expected to be gained from the time limited admission including a clear rationale for assessment and treatment.

1.3   Additional criteria – Inclusion

1.3.1   Patients admitted will be aged 16 or over (18 or over if in full-time education). Patients will not normally be over the age of 65.

1.3.2   Patients will be detained under the appropriate completed assessment/treatment section (not admitted on Sec 4, 5/2, 5/4 or 136) of the mental health act/order.

1.3.3   All PICU's and low secure units will develop standardised, robust risk assessment procedures. These will include objective validated measures as well as comprehensive, multidisciplinary, clinical risk assessment systems.

1.3.4   Assessment by members of the multidisciplinary team will occur prior to admission. The assessment provided could include objective measures and be clinically robust.

1.4 Additional criteria – Exclusion

1.4.1 The patient is assessed as presenting too high a degree of risk for a low secure environment: some may require admission to forensic services. Restricted patients should not be accepted unless there is provision to transfer them to an open ward if warranted by their clinical condition.

1.4.2 The patient has a primary diagnosis of substance misuse.

1.4.3 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.

1.4.4 The patient has a primary diagnosis of dementia.

1.4.5 The patient has a primary diagnosis of learning disability.

1.4.6 The patient's physical condition is too frail to allow their safe management in a PICU.

1.4.7 Admission would mix the sex of the patient population unless separate sleeping areas and day areas (new build) are available.

1.5 Good Practice Guidance

1.5.1 Differences in function between PICU's and Low Secure environments need to be taken into consideration when implementing the above standards.

1.5.2 The PICU/Low secure environment should be the 'least restrictive environment' as clinically possible (National Service Framework for Mental Health).

1.5.3 Assessment

While historical factors will play an important part in assessment, current symptomatology will be the prime consideration in determining if admission is appropriate. However, this emphasis may be different for low secure environments.

1.5.4 Follow up support

If admission is not thought to be appropriate, PICU/low secure staff may offer advice and guidance on the management of the patient. In PICU's follow-up contact should occur within 24 hours to assess whether the situation has changed.

1.5.5 The needs of young people should be identified and met through a comprehensive assessment and the provision of an appropriate environment.

2. Core interventions

2.1 Rationale

The PICU/Low secure service should ensure that patients are provided with an intensive, multidisciplinary, therapeutic program and evidence-based interventions whilst admitted to the unit.

2.2 Standard

2.2.1 All patients will receive an intensive therapeutic programme, appropriate to their needs, and underpinned by:

2.3 Biological Interventions

2.3.1 All patients should receive the necessary physical investigations whilst an inpatient on the unit.

2.3.2 Polypharmacy and high doses of medication should, as far as possible, be avoided. However, when used, Royal College of Psychiatrists guidelines (CR26) and current best practice should be adhered to. A clear rationale should also be outlined to patient and carers.

2.3.3 Patients should be informed of pharmacological treatments and should, whenever possible, be included in the decision making of their medication treatments.

2.3.4 Patients and carers should be provided with both written and verbal information on medications.

2.3.5 Side effects of medication should be closely monitored.

2.3.6 As far as possible, medications with the least side effects for that patient should be preferred, such as atypical neuroleptics and newer antidepressants.

2.3.7 Rapid Tranquillisation can be safely used to control violent behaviour when all other methods of de-escalation have failed.

2.3.8 Electroconvulsive therapy (ECT), if clinically indicated, should be given in line with Royal College of Psychiatrists guidelines (CR39).

2.4 Psychological & Other Interventions

2.4.1 Counselling/therapy (individual and group).

2.4.2 Cognitive and dialectical behavioural approaches. Other approaches may also be found to be useful such as psychodynamic, systemic or integrative.

2.4.3 Psychosocial interventions with patients and their families.

2.4.4   Recreational activities as therapeutic diversional interventions including engaging in creative work, hobbies, special interests.

2.4.5   Life skills training incorporating psycho-education on topics relating to activities of daily living such as interpersonal communication, relationships, coping with stigma and stress management.

2.4.6   Health promotion activities including diet, exercise, substance misuse and smoking cessation.

2.4.7   Boundary setting within the context of physical and psychological containment. This may include: contracting, de-escalation, restraint, time-out, and seclusion ('Management of Imminent Violence', Royal College of Psychiatrists).

2.5   Social Interventions

2.5.1   Staff should foster a therapeutic milieu for patients whilst on the closed ward e.g. through use of milieu therapy.

2.5.2   Social skills training, including anger management, should be provided where appropriate.

2.5.3   The MDT should obtain details of the family and social circumstances prior to admission.

2.5.4   Social workers should be actively involved in the provision of social work assessments, CPA meetings and links with the MDT on the closed ward. Social workers also have a role in helping longer-term patients maintain social ties to the wider community by encouraging appropriate visits and activities.

2.6   Environmental Interventions

2.6.1   All patients, including those who are acutely disturbed, should have access to fresh air and secure external space.

2.6.2   Patients should have access to and space for regular exercise with appropriate supervision.

The above categories are used for clarity only as many of the interventions cross 2 or more categories.

2.7   Good Practice Guidance

2.7.1   All of the above should be based on a comprehensive assessment of patient need and may also inform advice on further interventions following transfer from the PICU or Low secure setting.

2.7.2   Interventions should aim to:

- Meet the individuals needs

- Be adapted to the PICU/Low secure environment

- Promote functioning where this has become impaired thereby maximising patients chances of an independent life in the community

2.7.3   Staff have an important role in promoting optimum engagement with the treatment programme through encouragement, negotiation education and user involvement in their own care planning.

It is desirable that the MDT considers the role of complementary therapies on the unit.

See appendix 1 for further guidance.

3. MDT Working

3.1 Rationale

Multidisciplinary working is at the heart of PICU/Low secure practice. Good teamwork enables the provision of effective, comprehensive care. Meeting the patient's needs is the primary task of the multidisciplinary team (MDT). All relevant professionals should be able to contribute to this task while maintaining good inter-professional relationships.

3.2 Standard

The following should be in place to enhance MDT working:

3.2.1 A clear written philosophy providing a shared 'vision' with clarity of MDT roles & responsibilities locally derived, documented, and clearly understood. Users should be involved in the formation of the vision.

3.2.2 Clear guidelines on who should be involved in providing care and treatment.

3.2.3 Full MDT Clinical Review Meetings occurring at least once a week.

3.2.4 Weekly/fortnightly partnership forum that would include the MDT, service user representative, managers, and patient advocacy to discuss how the unit is functioning.

3.2.5 All units should have a monthly team business meeting with Trust service managers.

3.2.6 All units should have a 6 monthly forum for meeting with all stakeholders to consider important topics such as referrals, service developments, and issues of concern and to re-affirm good practice.

3.2.7 A lead clinician with clear accountability for ensuring MDT meetings occur.

3.2.8 Team building activities should occur once every 6 months.

3.2.9 A clear procedure for when members of the MDT disagree.

3.2.10 Shared in-house MDT training, education, and practice development activities should occur on the unit on at least a monthly basis.

3.2.11 There should be shared documentation e.g. MDT case notes.

3.2.12 Patients should receive multidisciplinary care planning.

3.3   Good practice guidance

3.3.1   In order to work intensively there must be a shared vision and cohesion among team members. This could be enhanced by:

-      MDT involvement in selection of colleagues

-      Multidisciplinary working included in job descriptions

-      Joint and specialist training

3.3.2   The qualities identified for a successful team are:

-      Clear goals

-      Clear roles

-      Right skill mix to deliver the results

-      A good process for involving all members

-      Trust between team members

-      It works for the individuals in the team

See appendix 2 for further guidance.

4. Physical environment

4.1 Rationale

The physical environment of a PICU or Low Secure environment is one of its defining aspects. The design of any unit should maximise the primary functions of safety, therapy and security.

4.2 Standard

4.3 PICU/Low Secure Position and Lay out

4.3.1 Gender specific areas such as bedrooms, corridors, bathrooms and toilets are needed as outlined in 'Safety, Privacy and Dignity in Mental Health settings' DoH.

4.3.2 The PICU/low secure unit should preferably be on the ground floor.

4.3.3 For PICU/low secure unit's that are part of hospitals, an entrance to the unit that does not necessitate travelling through the rest of the hospital should be provided.

4.3.4 Multiple corridors should be avoided in order to promote unobtrusive observation.

4.3.5 Bed numbers should preferably be 12 but no more than 15.

4.3.6 There should be access to an enclosed secure garden.

4.3.7 Effective designs should be based on a risk assessment of the environment e.g. pipes, wires, heating are hidden and inaccessible to patients.

4.3.8 Wherever possible there should be clear lines of sight. This should also be possible around corners, by means of aligned windows or convex mirrors.

4.3.9 Corridors should be wide enough to allow 3 abreast comfortably.

4.3.10 Ceiling height should be 3 meters minimum to give the feeling of space.

4.3.11 The ceiling should be fitted with skylights that allow increased day light into the main corridor (if stand-alone, single storey building).

4.3.12 There should be a designated smoking area on the unit.

4.3.13 An area should be designated for use when children are visiting

4.4   Security Levels

4.4.1   All security measures, for example window restrictors, should be as discreet as possible.

4.5   Main Entrance

4.5.1   An air lock design is recommended for the main entrance, comprising 2 doors set opposite to each other.

4.5.2   The main entrance should be located away from the main clinical area.

4.6   Fire exits

4.6.1   The local fire officer must be involved at an early stage of planning.

4.7   Windows

4.7.1   Any unit design should aim for as much natural daylight as possible into the main clinical areas.

4.7.2   Polycarbonate, toughened glass and laminated glasses are recommended.

4.7.3   Ventilation is important and windows should have a restricted opening of no more than 125 mm.

4.7.4   An assessment of the necessity of any fitting that could be used for suicide by hanging should be undertaken. Where this is unavoidable, fixings should not be able to load bear more than 20 kilos.

4.8   Doors

4.8.1   All doors should be of solid core construction of at least 50 mm thickness.

4.8.2   There should be as many doors as possible opening outward.

4.8.3   Double doors should be installed in rooms such as the day room, dining room, activities room and other areas in which more than 2 patients gather.

4.9   Locks

4.9.1   As many of the rooms as possible should be lockable.

4.9.2   Rooms such as the day and dining area will, for the majority of the time, remain open for free access by patients. There may be times however, when it will be necessary for these rooms to be temporarily restricted.

4.9.3   The kitchen area presents particular problems and should always be considered a potentially dangerous place.

4.9.4   Bathrooms and toilets will need to be lockable from the inside; staff must be able to override these locks from the outside, with keys held by staff only.

4.9.5   Bedrooms and other rooms may also be locked from the inside with the same precautions as above i.e. with override system.

4.10   Observation

4.10.1   As many clear lines of sight as possible should be available, avoiding numerous corners and corridors.

4.10.2   All doors (with the exception of the bathrooms and toilets) should be fitted with a polycarbonate observation panel. This will enhance safety when moving around the unit by ensuring that the staff and patients can see the other side of doors.

4.10.3   Bathrooms and toilets may be fitted with a "fish eye" observation lens. A lockable panel should cover this.

4.10.4   Bedrooms should be fitted with a louvre type window controlled from the outside.

4.10.5   Switches with a dimmer, one located inside and the other outside the room should control bedroom lights. This will allow for nighttime observation.

4.10.6   Where corridors meet, and in other areas without clear lines of sight, convex mirrors can be fitted at ceiling level to allow views around corners.

4.11   Recreation, Occupational therapy and other fittings

4.11.1   An effective PICU design will have given the provision of therapeutic activity an equal status to safety and security.

4.12   Recreation/activity facilities

4.12.1   Access should be available to a games room.

4.12.2   An activities room in which board games, art equipment and stereo equipment is placed.

4.12.3   Day room and sitting room equipped with television and video.

4.12.4   Access to enclosed garden area.

4.13   Furniture and fittings

4.13.1   The unit environment should be made as comfortable as possible.

4.13.2   The unit should be fitted with a pay telephone to which the patients have free access (Mental Health Act Code of Practice 1993). This could be on a portable trolley in case of persistent inappropriate use.

4.14   Staff and Patient Safety

4.14.1   Personal alarm systems should be carried by staff that when activated alert others to an emergency and its location.

4.14.2   Wall mounted emergency buttons with audio-visual output are also a necessary fitting. These should be installed in addition to the hand held systems as they also offer protection for patients.

4.14.3   A call button should be placed in all rooms and at regular intervals in corridors.

4.14.4   The system should be clearly understood by all staff (regular & non-regular, PICU and external).

4.14.5   There should be a clear policy/procedure.

4.14.6   Testing of the system should occur regularly.

4.15   Communication systems

4.15.1   There should be an established means of communication during escorted leave etc. such as two-way radios.

4.17 Good practice guidance

4.17.1   The PICU/Low secure environment should provide:

- Increased safety against aggressive, impulsive and unpredictable behaviour towards self and others.

- Difficulty in absconding

- Space for a range of therapeutic activities.

- Adequate space and facilities for a homely environment in which a patient can spend the majority of their day.

4.17.2   It is not possible to describe every detail of the ideal PICU or low secure physical environment. The design guidance offered is not overly prescriptive but is intended to provide the principles on which PICU/Low secure design can be based. The design of PICU or low secure physical environments may also vary due to their differing functions.

The above standard should be read in conjunction with 'Safety, Privacy & Dignity in Mental Health Units' DoH.

For further detail see chapter 15. R.Dix in 'Psychiatric Intensive Care' 2001 (Beer, Pereira, Paton, Eds.). GMM Ltd.

See appendix 3 for further details including extra care areas.

5. Service structure: personnel

5.1   Rationale

The multidisciplinary team, its make-up and functioning, is a crucial factor in the provision of an effective, quality service.

5.2   Standard

5.2.1   Multidisciplinary Team

All PICU/low secure units, should be staffed by the following core services:

- Medical

- Nursing

- Psychology

- Occupational therapy

- Social work

- Pharmacy

- Dedicated social worker especially for long stay low secure environments

Leadership

5.2.2   There are some PICU/Low secure units with multiple Consultant Psychiatrists involved without any of them having specific responsibilities for how PICU/Low secure services as a whole operate. This is an unsatisfactory model that may compromise quality of care provided to patients, and support to staff.

- All PICU/low secure units should at a minimum have a designated lead clinician (Medical or Nursing) with authority to make decisions regarding all aspects of unit operation.

- Each PICU/Low secure unit should have their own dedicated lead Consultant who will provide expert input into key matters of PICU/Low secure service delivery, staff support and supervision, and overall service coordination.

- Specific sessions should be set aside in Consultant job plans to ensure sufficient time available for their consistent and regular input to PICU/Low secure team and related forums.

These recommendations are in line with Department of Health guidance (Adult Acute Inpatient Care Provision, 2002).

Level of Experience

5.2.3   A multidisciplinary team should staff the PICU/Low secure environment. The majority of whose members are experienced in this area. Ideally this would consist of:

- Designated lead PICU Consultant with an interest or experience in psychiatric intensive care and low secure care and expected to devote a significant amount of his/her time to the PICU/Low secure service.

- Medical: junior doctor with more than 3 house jobs in psychiatry

- Nursing: Newly qualified staff generally after a period of preceptorship on an acute ward

- Occupational therapy: senior 2 but desirable to have senior 1

- Psychology: clinical psychologist with experience in adult acute care.

- Social worker with experience in mental health act work.

5.3   Good practice guidance

5.3.1   All PICU/low secure units should be a dynamic clinical and learning environment through commitment to in-house and within Trust training as well as external continuing professional development.

5.3.2   Student placements also play an important role as students of all disciplines make a positive contribution to the care and treatment of patients.

5.3.3   It is desirable that other therapists provide input e.g., art therapy, recreational therapies.

6. User involvement

6.1 Rationale

In order to create a genuinely patient-centred service several processes should be created to enable users to contribute to the design and delivery of care. The aim is to promote a non-judgemental, non-patronising, collaborative approach to care.

6.2 Standard

Service users should be involved at managerial and monitoring levels of service provision.

6.3 Good practice guidance

Possible approaches could include:

6.3.1 User feedback processes via:

- A user group to provide feedback on therapeutic activities.
- A user group with multi-disciplinary team membership
- Involvement with user induction/orientation programmes
- Involvement in promotion of an awareness of users' psychological and social needs.
- Involvement in the promotion of full range of psychological therapies.
- Involvement in the design of relevant therapeutic activities programme.

6.3.2 Managerial

- User Representation on PICU/low secure operational forum, so as to promote users' views on -
- Therapeutic and recreational facilities
- Ward environment, e.g. bedrooms, ward furniture, décor, etc.
- Planning of new facilities.
- Operational policies and procedures.
- Complaints.
- Staff recruitment and training.

6.3.3   Monitoring

- Advice/involvement in the auditing of issues arising from clinical care e.g. adverse incidents, near misses as a learning process.

- Any reporting should enable users to take unresolved issues to the appropriate person in the Trust.

All the above to be guided by an agreed model of confidentiality.

See appendix 4 for further guidance.

7. Carer involvement

7.1 Rationale

Carers should be involved in every appropriate aspect of the patient's care and treatment in order to maximise positive experiences and reduce stigma. All PICUs/Low secure environments should respond to carers concerns regarding treatment in a secure environment.

7.2 Standard

7.2.1 Carers should be involved at the beginning of care through the Care Programme Approach (CPA) process.

7.2.2 Every PICU/low secure unit should provide written information about all aspects of the local PICU/Low secure environment. This should be given to relevant carers within 24 hours of admission when possible.

7.2.3 All identified carers or relatives should be informed within 24 hours of admitting or discharging patient to/from PICU/low secure unit.

7.2.4 If any restriction to carer involvement applies then there should be a clear unit policy and carers should be notified accordingly.

7.2.5 With the consent of the patient, carers should be entitled to have their views expressed at weekly multidisciplinary reviews.

7.2.6 A crisis plan especially for absconding should include carers and any specific persons who may be at risk.

7.2.7 Where requested, carer views on the care and treatment process (including transfer to and from PICU/low secure unit) will be expressed in a face to face meeting with any one member of the unit team.

7.2.8 Sufficient basic demographic information should be checked and agreed with carers.

7.2.9 All PICU/low secure units should have processes and an environment that provides safety, privacy and dignity during visits.

7.2.10 All PICU/low secure units should provide training for staff on meeting the needs of carers.

7.2.11 A carer support network or group should exist and be available to carers of patients admitted to PICU/Low secure unit.

7.2.12 A list of voluntary organisations that provide information and support for carers should be available.

7.2.13 Protocols for carers' assessment should be agreed with local CMHTs.

7.2.14   All carers providing substantial care should have their needs assessed and a written care plan in line with the National Service Framework.

7.2.15   All information leaflets about the PICU/Low secure unit for users and carers should be reviewed every six months by a team including representatives of the local carers support group.

7.2.16   Risk management plans should include risk to and incorporate views of carers(usually with users consent).

7.3   Good practice guidance

Clinicians should be aware of the emotional impact on carers, the value of active carer involvement and any potential difficulties that may result as part of this process.

All the above to be guided by an agreed model of confidentiality.

8. Documentation

8.1 Rationale

It is important that all PICU's and Low Secure environments have an information system that is adequate and effective. Inadequate systems and processes can compound the difficulties around communication. Some of the main tools of communication are the documentation that is used to assess, plan, and evaluate care as well as inform others.

8.2 Standard

Listed below are some of the processes of care that need specific documentation and the types of documents that should be in place in addition to the usual statutory and other legal documents e.g. the Mental Health Act.

8.3 General documents

8.3.1 Description of the unit

8.3.2 Introduction/Induction to the unit for patients & staff

8.3.3 Security Check

8.3.4 Visitors Book

8.4 Pre-Admission documents

8.4.1 Referral form

8.4.2 Pre-admission assessment form (where appropriate)

8.5 Admission documents

8.5.1 Front sheet (Demographics)

8.5.2 Initial assessment (Individual/MDT)

8.5.3 Doctor's assessment

8.5.4 Nurse's assessment

8.5.5 3 day assessment

8.5.6 Care Plan

8.5.7   Risk assessment

8.5.8   Care Programme Approach (CPA)

8.5.9   Property check

8.5.10   Property disclaimer

8.6   During Admission documents

8.6.1   Incident forms

8.6.2   Level of access assessment form

8.6.3   Level of supervision/observation

8.6.4   Section 17 form

8.6.5   Primary nurse weekly summary

8.6.6   Weekly multidisciplinary reviews summary

8.6.7   Mental Health act Rights Form

8.6.8   Management of aggression Form (RESTRAINT, SCIP etc)

8.6.9   Seclusion

8.6.10   Complaints

8.7   Pre-Discharge documents

8.7.1   Care Programme Approach (CPA)

8.7.2   Part 1 discharge summary

8.8   Post Discharge documents

8.8.1   Discharge summary from all disciplines within the multidisciplinary team outlining problems, needs, progress and recommendations specific to each of the disciplines.

8.8.2   Transfer sheet outlining current management plans and treatment details to facilitate smooth handover of care to receiving unit or team.

9. Ethnicity, culture and gender

9.1   Rationale

All PICU/low secure units have the responsibility to ensure that all patients receive equality of treatment without prejudice to gender, sexuality, disability, religious beliefs, or ethnicity.

9.2   Standard

As a minimum all PICU/low secure units should have the following:

9.2.1   A clear policy statement on equal opportunities and racial harassment which all staff and patients are aware of. The policy should cover staff/patient and patient/patient harassment. The Trust Board should sign up to the policy. There should be a system for monitoring adherence to the policy with a clear method of investigation.

9.2.2   Any assessment tools used should be sensitive to the ethnic and gender needs of the patient.

9.2.3   Access to interpreters, sign language and other communication medium.

9.2.4   A commitment to ensuring that the ethnicity of staff members reflects that of their patients.

9.2.5   Availability of resources to meet ethnic specific needs e.g. Afro-combs, hairdressers, dietary choices, ethnic minority newspapers, radio, and video.

9.2.6   Access to relevant faith specific support preferably through someone with an understanding of mental health issues.

9.2.7   Forums (internal or external) to encourage and facilitate cultural, religious and spiritual practices e.g. prayer room, covered copies of the Koran.

9.2.8   Gender specific areas for activities e.g. bathroom, toilet, bedroom and lounge.

9.2.9   Patients should have the opportunity if possible to choose the gender of the practitioner carrying out any intimate physical investigations or interventions (emergencies exempt).

9.2.10   Induction pack for patients informing them of the resources available to meet their ethnic and gender needs.

9.2.11   Information for carers and relatives relating to the resources and commitment to meeting the ethnic and gender needs of patients.

9.2.12   Recording systems should be in place to collect data on issues such as legal status, ethnicity of staff and patients, and adverse incidents with a view toward enhancing good practice.

9.2.13   All PICUs and Low Secure units must comply with the Race Relations (Amendment) Act 2000.

9.3   Good practice guidance

Members of staff should be aware of the issues, needs and resources available to be able to carry out assessments and meet patient needs under this standard. Staff should receive training in inequality issues to enhance cultural competence.

For further detailed guidance on issues relevant to ethnicity, culture and gender see 'Safety, Privacy and Dignity in Mental Health Units' DoH.

10. Supervision

10.1 Rationale

In line with clinical governance, it is essential that there is a well-defined and robust system of clinical supervision within PICUs/Low secure environments. Team clinical discussions/reflective group learning as well as individual responsibility for Continuing Professional Development (CPD) should support this.

10.2 Standard

10.2.1 Clinical supervision should occur at a minimum of once every 2 weeks or more frequent as per professional body guidance.

10.2.2 All PICU/low secure units should have a clear system of monitoring and auditing supervision. This should be reviewed every 6 months.

10.2.3 All PICU/low secure units should have clear clinical supervision guidelines which incorporate supervision contracts between supervisor and supervisee to cover:

- Learning/training objectives

- Resolution of conflict (arbitrator identified)

- Roles and responsibilities

- Practicalities e.g. location

- Boundaries e.g. time and agreed agenda

- Documentation to be used

- Confidentiality (adherence to professional code of conduct and Trust policy)

- Actions in event of non-attendance or cancellation

- Frequency & duration

10.2.4 All PICUs/Low secure environments should have a list of appropriate supervisors.

10.2.5 At the start of employment the supervision process should be made clear to the new staff member.

10.2.6 Supervision should be included in the PICU/Low secure job description.

10.2.7 Emergency adhoc supervision should be available in times of crisis.

10.3 Good practice guidance

10.3.1   A Comfortable and private room should be identified for supervision.

10.3.2   A relevant evidence-based model for supervision should be identified and implemented within the unit.

10.3.3   Supervision should adhere to a specific structure (relevant to the appropriate professional body) and also address both clinical and managerial factors including:

- Monitoring: including patient concerns

- Development: core skills & training for staff

- Support: self-development, support in stressful situations

- Action Plans: shared agreement of actions

10.3.4   Supervisors should receive appropriate training.

11. Liaison with other agencies

11.1 Rationale

Consistent with the current NHS Plan for interagency working and the agenda for social inclusion, the PICU/Low secure service should ensure that mechanisms are in place for rapid access to agencies or services.

11.2 Standard

11.2.1 Each PICU/low secure unit should have a clearly identified and documented contact/link person in each agency involved with the patient.

11.2.2 PICU/low secure units should disseminate information about the unit to all relevant agencies.

11.2.3 PICU/low secure units in liaison with the relevant agencies should develop clear protocols about shared level of involvement.

11.2.4 In accordance with individual care plans all possible links to other agencies identified should be passed on to the relevant mental health team to ensure continuity of care.

11.2.5 Patients should have information on the other agencies involved in their care and the care plan should reflect this.

11.3 Good practice guidance

11.3.1 It is the responsibility of all PICUs/Low secure services to develop effective networks with other agencies:

- To maximise the quality of the care package available to individuals
- To maximise engagement and therefore improve quality of life and future well being for individuals
- To maximise the available resources and empower the patient to choose what is best suited to their needs.
- To reduce stigma attached to treatment in a secure environment.

11.3.2 Links should be made with agencies under 5 broad categories:

- Social Support
- User Agencies
- Legal/Judicial
- Community & In-patient Mental Health
- Medical services – primary and secondary

12. Policies and procedures

12.1 Rationale

A Policy can be defined as a statement of the Trust's position and philosophy on key issues, setting out a framework and rules of practice within which managers and staff must operate.

12.2 Standard

Policies specific to the PICU/Low secure environment should be developed to include:

12.2.1 Access & Discharge

12.2.2 Treatment & Interventions

12.2.3 The physical environment

12.2.4 Human Resources & Staff Development

12.2.5 Legal & Other Issues

12.2.6 Equality & Anti-Discriminatory practices

12.3 Good practice guidance

12.3.1 A number of policies may be very specific to a particular department or unit. In the absence of a Trust policy in regard to a specific area of PICU/Low secure practice, policy development should include those who implement them and those that they impact upon.

12.3.2 When developing specific policies for the PICU/Low secure environment consideration must be given to:

- The policy statement
- The rationale
- The evidence
- The competencies required
- The instruction
- The implementation, monitoring, evaluation and review methods

12.3.3   The following should also inform policy development:

- Gender and culture issues

- Codes of practice

- Equality legislation

- Human rights legislation

- User/Carer involvement

See appendix 5 for further guidance.

13. Clinical audit & monitoring

13.1 Rationale

Clinical audit is at the heart of clinical governance (NICE 2002) and is an essential tool in raising the quality of care through:

- Assessing the quality of practice against agreed standards.

- Highlighting areas of concern regarding the quality and cost-effectiveness of patient care.

- Improving practice through informed feedback.

Clinical audit should be an integral part of service culture in order to monitor service responsiveness to the various aspects of patient care.

13.2 Standard

13.2.1 All of the standards outlined in this document should be audited.

13.2.2 High risk activities, which are essential to practice, should be accurately documented, audited and reviewed to ensure good clinical practice and positive learning. These activities could include:

- Restraint

- Seclusion and other restrictive practices

- Rapid tranquillisation and high dose medication

- Adverse incidents and 'near misses'

A central reporting mechanism should support this process.

13.2.3 At least one individual should be identified as lead, to ensure that clinical audit and monitoring is carried out.

13.2.4 Users and carers should be involved in the process of clinical audit as far as possible.

13.2.5 The MDT member responsible for clinical audit should have a good understanding of the function, methods and application of clinical audit.

13.2.6 Results of clinical audit should be disseminated to all stakeholders for recommendations to be made regarding future practice.

13.2.7 The MDT members responsible for audit and monitoring should adhere to regulations of the Data Protection Act (1998) and supplementary documents.

13.2.8 Service responses to the ethnic, cultural and gender needs of patients should be audited regularly.

13.3 Good practice guidance

13.3.1 As a key tool in delivering clinical governance, clinical audit should be part of routine practice within a PICU/Low secure environment. Higher levels of risk, loss of liberty and legal status of patients suggest a greater need for clinical audit and monitoring than usual with particular attention paid to areas such as: observation, seclusion, restraint and rapid tranquillisation.

13.3.2 For clinical audit to be successful the MDT needs to give full co-operation to the implementation of the audit process including incident reporting, review of incidents and 'near misses' and generation of good practice principles. This process should be based on a reflective learning approach to practice so that positive learning can occur from mistakes.

See appendix 6 for further guidance regarding priority areas for clinical audit within PICU/Low secure environments.

14. Staff training

14.1 Rationale

In a highly demanding and stressful work environment it is essential that staff be well trained. In the current climate of evidence-based practice, it is also important that clinicians keep up to date in the knowledge, skills and attitudes needed to provide high quality care.

14.2 Standard

14.2.1 All staff in a PICU/low secure unit should attend a minimum compulsory 2 days of relevant professional training every 6 months, to keep updated with current best practice.

14.2.2 New staff members should be able to gain a basic understanding of the core skills.

14.2.3 Staff should be able to demonstrate those competencies appropriate to their job/role within 6 months of joining the team.

14.2.4 The appropriate clinical lead should be accountable for providing opportunities for new staff to acquire and/or demonstrate the appropriate competencies.

14.2.5 Continuing training/re-fresher courses e.g. interpersonal skills should be available for all staff.

14.2.6 Managerial supervision is the vehicle to ensure that these core skills can be demonstrated.

14.2.7 Regular training for all staff in addressing inequality issues and developing cultural competence. This should lead to understanding and sensitivity in meeting patients ethnic, cultural and gender needs.

14.3 Good practice guidance

14.3.1 As part of continuing professional development (CPD) every PICU/low secure unit staff member needs a Personal Development Plan, which is regularly reviewed (refer to individual Trust guidelines). Core competencies detailed below should form the basis of an individuals training and development plan. Any staff training should be underpinned by a clear philosophy of patient care.

Training should cover:

- Management & Administration
- Assessment
- Treatment & Care Management
- Interpersonal Skills
- Collaborative Working

14.3.3   Within the context of a PICU/low secure unit, interpersonal skills are as important as technical skills. Opportunities should therefore be available for staff to acquire or update the necessary skills, attitudes and knowledge to provide intensive, high quality care.

See appendix 7 for further details.

15. PICU and low secure support services

15.1 Rationale

Many staff external to the unit are essential for good care and treatment but may not be aware of safety and/or security issues on the PICU/Low secure unit. A system needs to be in place that informs non-regular staff and others of procedures that they need to adhere to while in the PICU/low secure unit.

15.2 Standard

The following are recommended in order to maintain a high level of safety and security.

15.2.1   PICU/low secure unit staff should provide information and input into Trust induction training programme.

15.2.2   All support staff should receive full induction and training regarding the PICU/low secure environment.

15.2.3   All support staff should receive a general information pack regarding PICU/low secure unit.

15.2.4   All patients should receive consistent input from support services across PICU/low secure and adult acute mental health services. In addition, low secure staff require input from rehabilitation and forensic support services.

15.2.5   When entering the PICU/low secure unit all support staff should report to the Nurse in charge to receive a handover, appropriate to their presence and purpose for visiting the unit, and in accordance with local policies.

15.2.6   All support staff should be oriented to the PICU environment and informed of safety issues (e.g. security systems).

15.3 Good practice guidance

Support services in a PICU/low secure environment may include:

- Phlebotomist

- Housekeepers

- Maintenance

- Catering

- Porters

- Identified officials

- Administrative staff

- User representatives

- Patient advocacy

- Pastoral services

- Library staff

- Voluntary agencies

- Hairdresser

- Legal representatives

- User employees

- Leisure/creative therapists

Implementation

Rationale

Using these standards

The standards should not be seen as immutable or as definitive but should over time and with use develop in relevance and effectiveness. In this way standard setting becomes a dynamic process, which contributes to good quality care as well as clarity in the field of psychiatric intensive care and low secure services.

Conclusion: adopting these standards

Implementation of these standards will:

- Provide the basis of effective and responsive services

- Enable the development and maintenance of high quality services

- Encourage an equitable and consistent approach to service delivery nationally

- Improve service user and carer experience of psychiatric intensive care and low secure services

The standards may also provide guidance to those involved in the planning of psychiatric intensive care and low secure services.

Next Steps

An appropriate and useful way forward would be for local units throughout the country to achieve these standards through the guidance and support of a PICU/Low secure Practice Development Network.

This may also involve various multidisciplinary clinicians and managers keeping up to date with current best practice via specialty associations e.g. NAPICU (National Association of Psychiatric Intensive Care Units) as well as the relevant specialty groups in their own professions.

Contributors

Anne Jackson (Senior Practice Development Officer, RCN)

Bob Gillies (Nurse Manager,IPCU Gartnavel Royal Hospital, Scotland)

Carole Baker (Ward Manager, Pathways PICU)

Christine Bullivant (RUN-UP User group)

Colum Clinton (Coordinator, PICU Policy, Research & Development Group, NELMHT)

Dr Dominic Beer (Consultant Psychiatrist, Bracton Centre, Oxleas NHS Trust)

Dr Gerry Lynch (Consultant Psychiatrist, Holywell PICU Northern Ireland)

Dr Stephen Pereira (Consultant Psychiatrist, Pathways PICU, NELMHT)

Dr Zerrin Atakan (Consultant Psychiatrist, Eden Ward,SLAM)

Dr Henok Getachew (Researcher,PICU Policy, Research & Development Group, NELMHT)

Francis Adzinku (Ward Manager Oxleas Hse London)

Gary Davies-Ebsworth (Ward Manager Centurion PICU West Sussex

Jason Hole (Charge Nurse, Centurion PICU West Sussex)

Jaz Leat (Senior Charge Nurse, Greyfriars PITU, Gloucester)

Jean Haldane (Breakthrough, National User Group)

Joseph Nkonde (Ward Manager Oxleas NHS London)

June Clutterbuck (Unit Manager, Hull & East Riding Community Health)

Karen Rogers (Senior OT, Rosewood Hse, Swindon)

Kath Dempsey (Project Manager, Nottinghamshire Healthcare NHS Trust)

Keir Harding (Occupational Therapist, Pathways PICU)

Kevin Connor (Service Manager, Graylingwell Hospital Chichester, West Sussex)

Luciano Gentilini (User Representative, RUNUP)

Lucy Dimery (Researcher, PICU Policy, Research & Development Group, NELMHT)

Marc Goldstein (Specialist Clinical Psychologist Pathways PICU, NELMHT).

Maria Quinn (Acting Head of Occupational Therapy in Northumberland)

Marissa Morroco (Unit Manager, Graylingwell Hospital Chichester, West Sussex)

Marjory Irons (Ward Manager Holywell PICU Northern Ireland)

May Sarsam (Researcher, PICU Policy, Research & Development Group, NELMHT)

Nigel Short (Lecturer, Institute of Psychiatry)

Paul Dawson (Researcher, PICU Policy, Research & Development Group, NELMHT)

Pauline Gill (Social Work representative NAPICU)

Roland Dix (Nurse Consultant, Greyfriars PITU, Gloucester)

Sandra Crawford (Acting Clinical Services Manager, Millbrook MHU, Notts)

Sarah Merrin (Occupational Therapist, Basildon Mental Health Unit)

Invitees:

Dr James Anderson, Consultant Forensic Psychiatrist, Bracton Centre Oxleas NHS Trust.

Caroline Reid, Commissioner, Redbridge & Waltham Forest Health Authority.

Rick Tucker, Professional Nurse Advisor, UKCC.

Additionally the standards were sent to the following individuals for comment and input:

Malcolm Rae, Nursing Officer, Mental Health, DoH.

Antony Sheehan, Joint Head of Mental Health, DoH.

John Mahoney, Joint Head of Mental Health, DoH.

Professor Kevin Gournay, Institute of Psychiatry.

Paul Rooney, South Birmingham Mental Health Trust.

Professor Louis Appleby, National Director of Mental Health, DoH.

Professor John Cox, President, Royal College of Psychiatrists.

Professor Pamela Taylor, Consultant Forensic Psychiatrist, Broadmoor Hospital.

Dr Anthony Zigmond, Consultant Psychiatrist, High Royds Hospital.

Professor Tony Maden, Consultant Forensic Psychiatrist, Imperial College London.

Professor Jeremy Coid, Academic Section of Forensic Psychiatry, St. Bartholomew's and the Royal London School of Medicine and Dentistry.

Dr Harvey Gordon, Consultant Forensic Psychiatrist, Bethlem Royal Hospital.

Dr Matt Muijen, Director, Sainsbury Centre for Mental Health.

Eddie Kane, North West Regional Director Of Mental Health, DoH.

Rick Tucker, Professional Nurse Advisor, UKCC.

Ann Jackson, Senior Practice Development Manager, RCN Institute.

Len Bowers, Professor of Psychiatric Nursing, City University.

College of Occupational Therapy.

British Psychological Society.

Cliff Prior, Chief Executive, NSF.

Tony and Angie Russell, Breakthrough.

Marjorie Wallace, SANE.

Jim Haliwell, NHS Estates.

Dr. Leonard Fagin, Consultant Psychiatrist, NELMHT.

Professor Stefan Preibe, Community Psychiatry, Newham.

Professor John Gunn, Chairman Forensic Faculty, Royal College of Psychiatrists.

Paul Gocke, Chief Executive, NELMHT.

Dr. Annie Lau, Medical Director, NELMHT.

Dr. K. Aswani, PCT Lead, Redbridge & Waltham Forest Health Authority.

Caroline Reid, Commissioner, Redbridge & Waltham Forest Health Authority.

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Jane Bakewell, General manager, Bushey Fields Hospital, Dudley.

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If you wish to provide feedback on the standards please contact:

Editors:

Dr Stephen Pereira (Consultant Psychiatrist, Pathways PICU, NELMHT, Head of PICU Policy, Research and Development Group, NELMHT) Out-Patient Department, Goodmayes Hospital, Barley Lane, Goodmayes, Essex, IG3 8XJ. 020 8970 5833. email:Stephen.Pereira@nelmht.nhs.uk

Colum Clinton (Coordinator, PICU Policy, Research & Development Group, NELMHT)

Pathways PICU on Tagore, Chapters House, Goodmayes Hospital, Barley Lane, Goodmayes, Essex, IG3 8XJ. Tel: 020 8215 6637. email:Colum.Clinton@nelmht.nhs.uk

Further copies of this document can be downloaded from www.pathwayspicu.org.uk and www.napicu.org.uk

Appendix 1
Standard 2: Core interventions

The following provides some further guidance on the interventions outlined in the standard and the aims of the interventions.

1.   Biological Interventions

Physical investigations:

a)   People with mental health difficulties should be entitled to a thorough physical examination and access to other appropriate medical services.

b)   All patients should be entitled to the necessary physical investigations whilst an inpatient on the unit.

c)   These investigations include full blood and urine tests, EEG and ECG. Scanning should be an option available for those patients of which neurological investigations are required.

Pharmacological interventions:

d)   Polypharmacy and high doses of medication should as far as possible be avoided.

e)   Patients should be informed of pharmacological treatments and should, whenever possible, be included in the decision making of their medication treatments.

f)   Patients and carers should be provided with both written and verbal information on their medications.

g)   Side effects of medication should be closely monitored.

h)   As far as possible, medications with the least side effects should be preferred, such as atypical neuroleptics, and newer anti-depressants.

Rapid Tranquillisation (RT):

i)   Rapid tranquillization can be safely used to control violent behaviour when all other methods of de-escalation have failed.

ECT

j)   Electroconvulsive therapy (ECT) may be included in some cases of physical treatment of mental illness.

2.   Psychological & Other Interventions

a)   Patients being admitted should be entitled to an assessment of their therapeutic needs.

b)   Psychological interventions offered should be adapted to the PICU/low secure unit or low secure environment.

c)   Due to the varied duration of stay, psychological interventions should be adapted to individual patient needs.

d)   Psychological interventions can be provided on an individual, group and/or family level.

Psychological interventions offered in a PICU/Low secure environment should aim to:

e)   Explore emotional stressors/reasons leading to admission on to the closed ward.

f)   Improve patients understanding and responses to anger and aggression whether directed toward self or others.

g)   Attempt to help strengthen patient's coping mechanisms with regard to external stress and crises.

h)   Prepare patients and their carers for the psychological impact of admission and stay on a closed ward.

i)   Address levels of insight into mental health difficulties and the effect of such difficulties on self and others.

j)   Combat suicidal ideation and intent and help patients to cope with feelings of despair and hopelessness.

k)   Address patient's interpersonal styles and means of communication with others.

l)   Engage patients who are generally more difficult to reach emotionally.

m)   Involve non-verbal therapeutic processes such as music, art and movement to engage patients.

n)   Offer psycho-education as a core therapeutic intervention. This should include providing information regarding mental illness, relapse signs and risk factors to patients and carers.

o)   Prepare patients for the transition back to an open ward or other forms of rehabilitation.

p)   Identify core psychological dynamics and longer-term needs that should be addressed within the acute, community or rehabilitation setting.

3.   Social Interventions:

a)   Staff should foster a therapeutic social milieu for patients whilst on the closed ward perhaps incorporating principles of milieu therapy (Gunderson, Will, Mosher 1983).

b)   The MDT to collect data on the social circumstances prior to admission.

Processes to address the social needs of individual patients should include:

c)   An assessment of patient's social support and links to the broader community.

d)   Providing links to outside agencies specialising in welfare and housing issues, and user-friendly employment agencies.

e)   Social Workers should be actively involved in the provision of social work assessments, CPA meetings and links with the MDT on the closed ward.

f)   For the MDT to aid with rehabilitation and practical interventions related to social issues.

g)   Group settings in which patients are helped to gain an awareness of the impact of their social functioning on others and the need for boundaries.

h)   To help longer-term patients to maintain social ties to the wider community by encouraging appropriate visits to the community.

4.   Environmental Interventions:

a)   All patients, including those who are acutely disturbed, should have access to fresh air and secure external space.

b)   Patients should have access to regular exercise with appropriate supervision.

c)   The environment is seen by users, carers and staff as playing an important role in the care and treatment process (RCPsych. OP41) and therefore needs to be managed accordingly.

It is desirable for the MDT to consider the role of complimentary therapies on the unit e.g. yoga, massage or aromatherapy.

Appendix 2
Standard 3: Multidisciplinary Team (MDT) Working

Multidisciplinary teams are the linchpin of effective modern healthcare (Gorman 1998).

1.   The following are recommended based on the principal that good communication is a fundamental of MDT working:

   a)   A clear written philosophy to provide a shared 'vision' for the team that both established and new staff can sign up to. This would provide each team member with an understanding of the overall MDT aims and objectives.

   b)   Clear guidelines on who should be involved with an individual's care and in what capacity based on patient need.

   c)   Full MDT Clinical Review Meetings – once a week to ensure that every patient is reviewed regularly. (Other meetings involving certain members of the MDT occur as required) This meeting should involve all professionals involved with an individual's care as appropriate.

   d)   Weekly/fortnightly partnership forum that would include the MDT, service user representative, managers, and patient advocacy to discuss how the unit is functioning.

   e)   All units should have a monthly team business meeting with Trust service managers.

   f)   All units should have a 6 monthly forum for meeting with all stakeholders to consider important topics such as referrals, service developments, and issues of concern and to re-affirm good practice.

   g)   Clear accountability for ensuring MDT meetings occur. The responsible person could be a nominated lead clinician e.g. ward manager, clinical service manager, consultant.

   h)   Clarity of MDT roles & responsibilities locally derived, documented, and clearly understood. This should be outlined in the unit operational policy or through the development of an integrated care pathway.

   i)   Team building activities ranging from in-house strategic review to 'away day' type events which enable the review of team functioning and enhance team cohesion. This should occur once every 6 months.

   j)   A clear procedure for when members of the MDT disagree possibly involving an external facilitator.

   k)   Practice development activities involving the MDT should occur once every 2 weeks. This could take the form of 'reflective practice' meetings which enable the team to review current events or difficulties, learn important lessons, and capture good practice.

   l)   To enable sharing of expertise and increased understanding of each others role within the team, shared in-house MDT training/education sessions should occur weekly or fortnightly on the unit.

   m)   There should be shared documentation

   n)   Patients should receive multidisciplinary care planning.

2.   Some of the benefits of multidisciplinary teams are (West & Slater,1996):

    a)   Better quality decisions. Diagnostic and treatment issues can be highly complex and serious. By using all the information from all the team there is less danger of decisions being taken in ignorance of vital data.

    b)   Clear roles and responsibilities. The allocation of roles and responsibilities is transparent and understood where all team members are together in a team meeting.

    c)   Greater commitment to the care plan. Ownership of decisions is better when people have participated in the choice of treatment.

    d)   One team, one voice. The whole team is working to a single treatment plan and is speaking with one voice to the patient and their family. There are few things more disturbing to patients and their families than team members disagreeing over treatment.

    e)   Mutual support and encouragement. Team members can be a source of support and encouragement to each other in environments that are often stressful and pressurised.

The last point is particularly relevant for a PICU/low secure unit.

Appendix 3
Standard 4: Physical environment

The design of any unit should maximise the primary functions of safety, therapy and security. However, it is acknowledged that this may be easier in a new building. Where physical changes are not possible i.e. old buildings, considerable thought needs to be given to the processes and practices that are necessary to minimise any shortcomings.

1.   PICU/low secure unit Position and Lay out

a)   Gender specific areas such as bedrooms, corridors, bathrooms and toilets are needed as outlined in 'Safety, Privacy and Dignity in Mental Health Settings', DoH.

b)   The PICU/low secure unit should preferably be on the ground floor.

c)   This will assist in the admission of acutely disturbed patients, and facilitate access to the fresh air.

d)   For PICU/low secure unit's that are part of hospitals, an entrance to the unit that does not necessitate travelling through the rest of the hospital should be provided.

e)   Multiple corridors should be avoided in order to promote unobtrusive observation.

f)   The amount of space to which patients have access has been an important factor as overcrowding can increase risk of aggression.

g)   When assessing the available space for patients in a PICU/low secure unit, the mistake of including staff areas in the square metreage should be avoided.

h)   Bed numbers should preferably be 12 but no more than 15.

i)   There should also be access to an enclosed garden.

j)   Effective designs share a number of general characteristics e.g. pipes, wires, heating are hidden and inaccessible to patients.

k)   Wherever possible there should be clear lines of sight. This should also be possible around corners, by means of aligned windows or convex mirrors.

l)   Corridors should be wide enough to allow 3 abreast comfortably.

m)   Ceiling height should be 3 meters minimum giving the feeling of space.

n)   The ceiling should be fitted with skylights that allow increased day light into the main corridor (if standalone, single storey building).

o)   There should be a designated smoking area on the unit.

p)   An area should be designated for use when children are visiting

2.   Security Levels

a)   The level of interior and perimeter security may be influenced by whether the PICU/low secure unit is serving the general adult population or the forensic population.

b)   It is easy to either over or under estimate levels of security for the general adult PICU/low secure unit.

c)   Consider the likely methods that may be used by a patient to abscond.

d)   All security measures, for example window restrictors, should be as discreet as possible.

3.   Secure Garden

a)   The level to which the garden is secure will largely be a matter for the PICU/low secure unit planning group.

b)   Standard operational procedure will generally require a staff presence when the garden is in use.

c)   A sensible balance should be drawn between the construction and height of the fence against the oppressive image created by fencing.

4.   Main Entrance

a)   An air lock design is recommended for the main entrance, comprising 2 doors set opposite to each other.

b)   Once a person has entered through the first door, the second will not open until the first has closed.

c)   This may be achieved by means of magnetic lock systems or by synchronised key operated locks.

d)   The main entrance should be located away from the main clinical area.

5.   Fire exits

a)   Fire safety and security are frequently in conflict.

b)   The local fire officer must be involved at an early stage of planning

c)   It is possible for fire exits to be secured on magnetic locks that become inactive when the fire alarm is activated. However, there are problems with this system e.g. patients may soon become familiar with this arrangement or the locks will need to be disconnected from the test procedure.

6.   Windows

While windows offer an obvious target for absconding, they also help the unit to feel less claustrophobic.

a)   Any unit design should aim for as much natural daylight as possible into the main clinical areas.

b)   Ample outside windows in all rooms, and where appropriate interior windows across rooms, if possible.

c)   Polycarbonate, toughened glass and laminated glasses are recommended.

d)   It is also important for the frame to withstand determined attempts at dismantling.

e)   Ventilation is also very important and windows should have a restricted opening of no more than 125 mm.

f)   In addition to the windows standard restrictors the inclusion of a camouflaged durable steel bar, fixed to the out side wall may also be useful.

g)   In some sitting areas some windows should be placed 700 to 800mm above the floor to allow seated outside views.

h)   In the **extra care area** (see below), and possibly other areas of the unit, curtain poles should be avoided. Integral window blinds may be used instead.

i)   An assessment of the necessity of any fitting that could be used for suicide by hanging should be undertaken. Where this is unavoidable, fixings should not be able to load bear more than 20 kilos.

7.   Doors

a)   All doors should be of solid core construction of at least 50 mm thickness.

b)   Doors will be durable against abuse and also offer good soundproofing.

c)   There are benefits to as many doors as possible opening outward. These benefits include:

–   prevention of patient barricading themselves in

–   promoting easy exit.

Aggression and access through doors:

Areas of high patient concentration are often the location of aggressive incidents.

d)   Double doors should provide access to areas from which a patient may require relocation involving restraint.

e)   This will provide enough width to allow access for a 3-person restraint team.

f)   As a general principle double doors should be installed in rooms such as the day room, dining room, activities room and other areas in which more than 2 patients gather.

g)   For bedrooms a half leaf arrangement is useful for allowing access to a restraint team.

8.   Locks

Where should locks be fitted?

a)   It is desirable to be able to lock off as many of the rooms as possible.

b)   Rooms such as the day and dining area will, for the majority of the time, remain open for free access by patients. There may be times however, when it will be necessary for these rooms to be temporarily restricted.

c)   The kitchen area presents particular problems and should always be considered a potentially dangerous place.

d)   A clear operational policy should describe the use of the kitchen, including the circumstances in which access may be restricted.

e)   bathrooms and toilets will need to be lockable from the inside, staff must be able to override these locks from the outside, with keys held by staff only.

f)   Bedrooms may also be locked from the inside with the same precautions as above.

In any room that can be locked from the inside, care should be taken to ensure that the override system would work, even if the interior side of the lock were held.

A variety of locks are now available for the modern psychiatric hospital (each has it's pro's & cons). These include:

*   electronic numbered key pad

*   swipe and touch card locks

*   traditional key arrangement.

9.   Observation

a)   As many clear lines of sight as possible should be available, avoiding numerous corners and corridors.

b)   Interior windows can be aligned where possible to allow observation across a number of rooms.

c)   All doors (with the exception of the bathrooms and toilets) should be fitted with a polycarbonate observation panel. This will enhance safety when moving around the unit by ensuring that the staff and patients can see the other side of doors.

d)   Bathrooms and toilets may be fitted with a "fish eye" observation lens. This should be covered by a lockable panel.

e)   Bedrooms should be fitted with a louvre type window controlled from the outside.

f)   Bedroom lights should be controlled by switches with a dimmer, one located inside and the other outside the room. This will allow for nighttime observation.

g)   Where corridors meet, and in other areas without clear lines of sight, convex mirrors can be fitted at ceiling level to allow views around corners.

10.   Facilities for managing the most acutely disturbed patient

An Extra Care Area (ECA) can be an alternative to seclusion. This is defined as:

*   a closely supervised living space,

*   away from the main clinical area

*   in which a single patient may be nursed away from rest of the patients.

An ECA, could also include a seclusion room, or, if preferred, a de-escalation room in which staff remain with the patient, rather than the patient being locked in.

Extra Care Area composition:

The ECA should be able to provide for the daily living needs of a single patient. This will require the following all in close proximity to each other:

*   A seclusion/de-escalation room.

*   A toilet and shower facility.

*   A sitting room with simple furnishings.

- An entrance to the ECA directly from outside the unit, for the admission of acutely disturbed patients.

- Access to the garden.

- An intercom system to the main office.

Design of Seclusion/De-escalation room:

- This room should be located in the extra care area of the unit.

- Furnished with a single moulded vinyl safety bed.

- The size should allow for at least 7 square meters and a ceiling clearance that cannot be reached by jumping or standing on the safety bed.

- The room must be able to withstand determined attack and damage.

- Walls and floors lined with a welded seam vinyl surface.

- The door should be of solid core design of a least 55 mm thickness, with an observation panel, double glassed with high grade 5 mm polycarbonate.

- It should be possible to see into the whole room from the observation panel, without any hidden corners.

- Ventilation/heating is provided through air vents placed at ceiling level out of reach. Noise levels generated by this equipment must also be minimised

11. Recreation and Occupational therapy

An effective PICU/low secure unit design will have given the provision of therapeutic activity an equal status to safety and security.

Recreation/activity facilities

a) A games room in which a pool table, table tennis table, exercise equipment may be placed.

b) An activities room in which board games, art equipment and stereo equipment is placed.

c) Day room and sitting room equipped with television and video.

d) Access to enclosed garden area.

e) Agreed policies and procedure for local escorted and unescorted leave.

12. Furniture and fittings

a) The unit environment should be made as homely as possible.

b) Wall mounted pictures; pot plants and non moulded furniture promote a relaxed environment without presenting a major risk to safety.

c) Poster type pictures may be fixed to the wall on a back board covered with polycarbonate.

d) Some units may wish to surround the television and video with a polycarbonate fronted protective case.

e)   The unit should be fitted with a pay telephone to which the patients have easy access.

f)   This could be on a portable trolley in case of persistent inappropriate use.

13.   Staff and Patient Safety

Personal alarm systems carried by staff that when activated alert others to an emergency are useful. The following common problems should be avoided:

a)   Systems that are too directionally sensitive resulting in the need to point the hand set directly at the receiver.

b)   Systems where the hand set is over powered resulting in the activation of several receivers confusing the exact location of the emergency.

c)   Systems that are under sensitive resulting in the need to press the hand unit several times before the alarm is sounded.

d)   Wall mounted emergency buttons with audio visual out put are also a necessary fitting. These should be installed in addition to the hand held systems as they also offer protection for the patients.

e)   A call button should be placed in all rooms and at regular intervals in corridors.

f)   There should be the provision for the system to be de-activated centrally in the event of persistent inappropriate use by patients.

14.   Communication systems

a)   Two way radios are recommended. These are useful for communication around the hospital and on short escorted leave. They are also of particular value in other situations, for example searching for a patient who has absconded.

b)   For extended range it is necessary for a booster transmitter to be installed on top of the building.

c)   For longer distance escorted leave, a mobile phone is recommended, pre-programmed with the numbers of the ward, the hospital reception and the police.

For further detail on some of the points outlined, see chapter 15. R.Dix in 'Psychiatric Intensive Care' 2001 (Beer, Pereira, Paton, Eds.) pub: Greenwich Medical Media Ltd.

Appendix 4
Standard 6: User involvement

1. Membership of a User Group

Membership should reflect the social, cultural and gender mix of the local area.

2. Resources: Appropriate resources need to be made available at Trust level.

These may include:

a)   office space

b)   photocopying facilities

c)   telephones

d)   stationery

e)   expenses and payment

3. Training

- User representatives should undergo appropriate training.

4. Functions of PICU/low secure unit User Group may include:

- Peer support for other users

- Feedback into service development

- Helping run services.

Appendix 5
Standard 12: Policies and procedures

The following are recommended areas for policy and procedure development.

1. **Access & Discharge**

   a) Referral process – response times

   b) Admission policy

   c) Transfer/discharge policy, to include interface issues

   d) Risk assessment & Risk management

   e) Forensic admissions

   f) Interface with others – acute, courts, forensic and criminal justice system

2. **Treatment & Interventions**

   a) Patient induction and orientation

   b) Restriction of movement – Seclusion, Timeout, Special/Extra care areas

   c) Missing patient/A.W.O.L.

   d) Search policy – patient, rooms, visitors

   e) Observation/supervision

   f) Escorted/unescorted leave/incidents during

   g) Substance misuse/taking, supplying

   h) Risk assessment and management of untoward incidents – suicide/self harm/violence and aggression

   i) Medication management – high dose/rapid tranquillisation

   j) Medical emergencies – resuscitation

   k) Management of acute disturbance – De-escalation/de-stimulation/use of restraint & type

   l) Behavioural approaches – behaviour modification- &- reinforcement

   m) Therapeutic activities programme – MDT roles

   n) MDT reviews & CPA'S

   o) Reports – Medical/Nursing/Psychology/OT

   p) Information giving

3. **Environment**

   a) Security and safety

   b) Building – security checks

c)   Access to building- deliveries/ancillary staff/emergency access

d)   Keys/swipe cards

e)   Contraband items to unit

f)   Use of secure garden

g)   Use of facilities on/off site

h)   Equipment storage

i)   Locking of toilets, bathrooms, bedrooms

j)   Alarm systems/staff and patients

k)   Reception/airlock protocol

l)   Security doors

m)   Use of cctv/recording time/lapse

n)   Video recording images

o)   Visiting/children visiting

p)   Single gender areas

4.   Legal & Other Issues

a)   Mental Health Legislation

b)   Confidentiality Issues/Data protection

c)   Informed consent

d)   Police interviews/sharing information

e)   Taking body fluids

f)   Patients property/money

g)   Harassment, intimidation, abuse or violence of patients, staff or visitors

5.   Human Resources & Staff Development

a)   Bank/Agency staff

b)   Induction – Mentoring, preceptorship

c)   Mandatory training – restraint/de-escalation/skills update

d)   Staff support systems – post incident

e)   Personal Development Plans

f)   Clinical Supervision

g)   Managerial supervision

6.   Equality & Anti-Discriminatory

a)   Equal opportunity policy for both staff and patients

Appendix 6
Standard 13: Clinical Audit

The guidance given below refers to priority areas for clinical audit within PICU/low secure units. Although many areas are specified, units may need to prioritise which areas of their service require most urgent attention. This should occur through discussions between the MDT, Trust managers, users and carers.

1.   Prioritisation of audit topics may depend on:

a)   High risk

b)   High cost

c)   Frequency

d)   Rarity

e)   Local concern

f)   Political expediency

g)   Requests from commissioners

(Firth-Cozens 1993)

2.   Possible areas for audit within Psychiatric Intensive Care:

a)   Information provision (rights under MH Act, info on observations)

b)   Advocacy

c)   Legal representation

d)   Clinical Governance/Clinical Effectiveness

e)   Patient Satisfaction

f)   Length of stay

g)   Staff training

h)   Referral response time

i)   Procedures that involve heightened risk for patients or staff e.g. restraint, rapid tranquillisation

j)   Keyworking sessions

k)   Human rights issues – access to culture specific practices, access to garden area, walks etc.

l)   Meeting patient's ethnic, cultural, and gender needs

3.   Definition of Clinical Audit:

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery. (NICE 2002).

4.   Definition of Monitoring:

Monitoring is the process of collecting data for the purpose of audit. Monitoring tools (e.g. databases, forms) should be designed with reference to the specific area for audit.

5.   Legal Requirements:

Routine record keeping and clinical audit are subject to requirements of the Data Protection Act (1998). The document "Use and Disclosure of Medical Data" (Information Commissioner DPA, 2001) provides essential guidance concerning: consent, confidentiality, and justification for record keeping/audit.

Appendix 7
Standard 14: Staff training

The following areas are suggested as important to PICU and Low secure practice and may form the basis of formal or in-house training.

1.   Management & Administration

a)   Legal aspects – Mental Health Act Code of Practice

b)   Report writing/record keeping

c)   Ward design and organisation

d)   PICU/low secure unit Research & development work – EBP – research into practice

2.   Assessment

a)   Use of assessment scales e.g.HoNOS, BPRS

b)   Clinical & environmental audit

c)   Risk Assessments & Safety Issues

d)   Assessing psychopathology

3.   Treatment & Care Management

a)   Responding to ethnic/cultural/gender needs

b)   Cognitive-behavioural strategies

c)   Maintaining security & therapeutic use of security

d)   Treatment of personality disorders

e)   Use of medication/side-effects

f)   Prevention and therapeutic management of violence (including seclusion)

g)   Restraint (training in approved methods)

h)   Rapid tranquillisation

i)   Resuscitation techniques

j)   Observational skills

k)   Milieu therapy

l)   Care of the complex needs patient e.g. suicidal patient and substance misuse

4.   Interpersonal Skills

    a)   Counselling skills

    b)   Communication skills

    c)   De-escalation/talking down

    d)   Debriefing following adverse incident

    e)   Group skills

    5.   Collaborative Working

    a)   User & carer's involvement – 'active partnership'

    b)   Teamworking inc. negotiation & conflict resolution skills

    c)   Training skills – users/carers, students, junior staff

    d)   Psycho-educational approaches

    e)   Working with families/Family therapy

6.   Other issues to consider:

    a)   The psychological and social impact on patient of being in a secure environment (stigma & loss of liberty)

    b)   Working with difficult to engage patients

    c)   Maintaining close and prolonged interpersonal contact with often demanding and challenging individuals (avoiding burnout)

    d)   Impact of maintaining strict boundaries (limit-setting) within an interpersonal space which is often uncertain, unstable, and unpredictable.

References

Beer D., Pereira S., Paton C. (Eds.) (2001) Psychiatric Intensive Care. Greenwich Medical Media Ltd., 137, Euston Road, London NW1 2AA.

Data Protection Act, 1998. HMSO.

Department of Health (1999). National Service Framework for Mental Health.

Department of Health (2000). Safety, Privacy & Dignity in Mental Health Units.

Department of Health (2002). Mental Health Policy Implementation Guide. Adult Acute Inpatient Care Provision.

Firth-Cozens J. (1993). Audit In Mental Health Services. LEA

Gorman P. (1998). Managing Multi-disciplinary Teams in the NHS. OUP.

Gunderson J., Will O., Mosher L. (Eds.) (1983). Principles and practice of milieu therapy. Aronson.

Information Commissioner, Draft Guidance: Use and Disclosure of Medical Data, 2001. www.dataprotection.gov.uk

National Institute for Clinical Excellence (2002). Principles for Best Practice in Clinical Audit. Radcliffe Medical Press.

Race Relations (Amendment) Act 2000. HMSO.

Royal College of Psychiatrists (1993). Consensus statement on the use of high dose antipsychotic medication. Council Report CR36.

Royal College of Psychiatrists (1995). ECT Handbook: The 2nd report of the Royal College of Psychiatrists Special Committee on ECT. Council Report CR39.

Royal College of Psychiatrists (1998). Management of Imminent Violence. Occasional Paper OP41. March.

West, M and Slater J (1996). Teamworking in Primary Health Care, HEA, London.

DH *Department of Health*