BRITISH PSYCHOLOGICAL SOCIETY (1986) *Responsibility Issues in Clinical Psychology and Multidisciplinary Teamwork*. Leicester: BPS.
DEPARTMENT OF HEALTH & SOCIAL SECURITY (1980) *Organisational and Management Problems of Mental Illness Hospitals*. London: HMSO.
DEPARTMENT OF HEALTH (1990) *Community Care in the Next Decade and Beyond*. London: HMSO.
DEPARTMENT OF HEALTH/SOCIAL SERVICES INSPECTORATE (1991) *Care Management and Assessment: managers guide*. London: HMSO.
GALVIN, S. W. & MCCARTHY, S. (1994) Multi-disciplinary community teams: clinging to the wreakage. *Journal of Mental Health*, **3**, 167–174.
MENTAL HEALTH NURSING REVIEW TEAM (1994) *Working in Partnership*. London: HMSO.
MENTAL HEALTH ACT COMMISSION (1993) *Fifth Biennial Report 1991–1993*. London: HMSO.
MERSON, S., TYRER, P., ONYETT, S., LACK, S. *et al.* (1992) Early intervention in psychiatric emergencies: a controlled clinical trial. *Lancet*, **339**, 1311–1314.
MORRIS, D. & DAVIDSON, L. (1992) Community mental health centres in a changing environment. *Journal of Mental Health*, **1**, 295–299.
NHS MANAGEMENT EXECUTIVE (1994a) *Introduction of Supervision Registers for Mentally Ill People from 1 April 1994*. HSG(94)5. HMSO.
— (1994b) *Guidance on the Discharge of Mentally Disordered People and Their Continuing Care in the Community*. HSG(94)27. HMSO.
NORTH, C. & RITCHIE, J. (1993) *Factors Influencing the Implementation of the Care Programme Approach*. London: HMSO.
ONYETT, S. (1992) *Case Management in Mental Health*. London: Chapman & Hall.
— & DAVENPORT, S. (1994) Care programming and care management in Rochester. *Community Care Management and Planning*, **1**, 116–123.
—, TYRER, P., CONNOLLY, J., MALONE, S. *et al.* (1990) The Early Intervention Service: the first 18 months of an inner London demonstration project. *Psychiatric Bulletin*, **14**, 267–269.
—, HEPPLESTON, T. & BUSHNELL, D. (1994) A national survey of community mental health teams. *Journal of Mental Health*, **3**, 175–194.
OVRETVEIT, J. (1993) *Coordinating Community Care: multidisciplinary teams and care management*. Buckingham: Open University Press.
RITCHIE, J., DICK, D. & LINGHAM, R. (1994) *Report of the Christopher Clunis Enquiry*. London: HMSO.
STEIN, L. I. (1992) On the abolishment of the case manager. *Health Affairs*, **Fall**, 172–177.

Steve Onyett, *Senior Research Fellow, Centre for Mental Health Services Development, Kings College London, Campden Hill Road, London W8 7AH*

A nurse-led psychiatric intensive care unit

Roland Dix

Severn NHS Trust has recently commissioned a psychiatric intensive care unit (PICU) which became operational on 18 July 1994. Although the number of PICUs is increasing and their services are greatly valued, they are often fraught with problems. A model for the development of PICU services is described. It includes admission criteria, overall clinical organisation of the PICU, discharge criteria and a discussion. The model described is based on the hypothesis that the primary role of the PICU is to deal with clinical nursing problems rather than medical problems. The discussion points out some of the instrumental components necessary for the successful development of PICU services.

Since the demise of locked acute wards in the early '70s, many general adult in-patient services have identified a need for a ward which can provide a higher level of nursing intervention (Glancy, 1975). Such a unit should also be able to deal effectively with problematic behaviours that often result from the acute phase of mental illness (Tarbuck, 1994). The Reed report (1992) recommends 40 psychiatric intensive care unit (PICU) beds per million population. The PICU is now a well established part of many adult mental health provisions.

https://doi.org/10.1192/pb.19.5.285 Published online by Cambridge University Press

Although the number of PICUs is increasing and their services are greatly valued (Khan *et al*, 1987), they are often fraught with problems, including the following:

(a) bed blocking by patients who demonstrate long-term behavioural problems requiring rehabilitation and not intensive care
(b) de-skilling of nursing staff working on acute wards reducing their tolerance to problematic behaviours and resulting in ever increasing demands on the PICU
(c) unrealistic expectations of the PICU to offer care to patients with a potential for serious dangerousness who need a regional secure unit
(d) unnecessary delays in admitting patients to the PICU.

Setting up a PICU

The Severn NHS Trust has recently commissioned a PICU which became operational on 18 July 1994. The unit has six beds serving four wards with a collective total of 66 beds. The unit is staffed with an overall number of 20 nurses, providing an average of four nurses per day shift and three at night. Seventy-five per cent of the nurses are qualified. All nursing staff working on the unit undertook an intensive three week training programme before the unit became operational. Thirty per cent of the nursing team hold a post registration course in the assessment and management of acutely disturbed patients (ENB, 1994).

The main entrance to the unit is not permanently locked, but can be locked if needed. Patients who demonstrate extremely disturbed behaviour are nursed in an extra care area (a closely supervised living space, away from the main clinical area). The unit has no seclusion facility.

For six months up to the opening a multidisciplinary project group met every two weeks to devise an operational policy for the unit. The project group recognised that the main function of the PICU was to overcome clinical nurse management problems rather than medical management problems. Mindful of the operational management difficulties faced by other PICUs the project group produced the following model for the development of PICU services.

Patients in need of intensive therapy would generally present clinical nursing problems of four types.

Externally directed aggression
Significant risk of harm to others or extreme aggression towards property.
Internally directed aggression

(a) Significant risk of suicide and lack of co-operation with preventive measures available.
(b) Self-harming bevaviour with a serious risk to health or life that is likely to respond to intensive therapy.

Absconding
Patients who are detained under the Mental Health Act where the consequences of persistent absconding are serious enough to warrant treatment on the PICU.
Unpredictability
Describes a patient's presentation in which there is difficulty in making an accurate assessment of his/her mental and behavioural state.

Furthermore, there is a significant possibility that the patient has the potential to demonstrate one or more of the previous behavioural problems described and further assessment in a safe environment is required.

The admission criteria provided a sound foundation from which a comprehensive clinical assessment tool could be assembled.

Admission process

Referrals are accepted from qualified nurses, responsible medical officers (RMO), on-call consultants or nominated deputies. All referrals to the unit are first assessed by members of the PICU nursing team – senior staff nurse or above. Nurses designated to assess referrals to the PICU were all specially trained to implement the clinical assessment tool. Most assessments are performed on the appropriate catchment acute wards. The needs of the patient are evaluated in collaboration with staff from the acute ward. If admission to the PICU is indicated a qualified nurse, key-worker from the acute ward, is nominated to act as a consistent liaison point to monitor the progress of the patient in the PICU. In the event that admission to the PICU is not indicated then alternative clinical interventions can be offered by the PICU staff; for example, input into care planning, PICU staff assistance for a specified period of time and a further assessment if the patient's behaviour deteriorates.

https://doi.org/10.1192/pb.19.5.285 Published online by Cambridge University Press

Medical and nursing clinical management

Medical responsibility for patients admitted to the PICU is retained by the RMO. Sessions from a clinical medical officer provide day to day medical cover. For the duration of the patient's stay on the PICU, the key-worker from the catchment ward to which the patient belongs is required to participate in the patient's nursing care plan. When the nursing assessment indicates that the patient has achieved the PICUs discharge criteria (see below), a review meeting is called with the catchment ward's nursing staff and the patient is transferred. In addition to the nursing management of the PICU in-patient group, the nursing team have a primary role in providing clinical advice and support to all other wards within the hospital.

Discharge criteria

Discharge is indicated when at least one of the following criteria is fulfilled.

(a) The patient has demonstrated increased control over problematic behaviours that would allow him/her to function within a less intensive provision.
(b) The patient is demonstrating a potential for serious offending that would require a regional secure unit.
(c) The patient has experienced a significant decrease in psychiatric symptomatology and any residual problematic behaviour is assessed not to be resulting from a serious mental disorder.
(d) The patient has achieved the maximum benefit from the available treatment and is unlikely to respond further to a prolonged stay.

First five weeks

In the first five weeks 19 referrals were made, 15 by nurses and four by medical staff. The mean age of the referrals was 30 years. Of the total referrals 11 were admitted to the PICU, eight males and three females. Of the total admissions two were informal. The mean length of stay was 14 days.

Comment

Michalon & Richman (1990) pointed out the importance of the PICU creating a clear identity and role in order to prevent bed blocking. Indeed the establishment of appropriate admission criteria can be instrumental in providing quality PICU services (Hyde & Harrower-Wilson, 1994). Interestingly, the creation and implementation of clear discharge criteria may prove to be almost as essential. The importance of staff training in the activities performed by the PICU cannot be over-emphasised (Allan *et al*, 1988). Severn NHS Trust have developed their PICU on the hypothesis that the primary function of the unit is to deal with clinical nursing problems that have already occurred, or are likely to occur if a patient is treated on a standard acute ward. The PICU multidisciplinary project group attempted to effectively address the seemingly innate operational problems common in such units. The unit has not been operational for the length of time necessary to accurately evaluate its performance. However, the first five weeks of delivering intensive care services has suggested a degree of optimism for the chosen model.

Acknowledgement

I would like to thank Dr James Laidlaw for his helpful comments.

References

ALLAN, E., BROWN, R. & LAURY, G. (1988) Planning a psychiatric intensive care unit. *Hospital and Community Psychiatry*. **39**, 81–83.

ENGLISH NATIONAL BOARD (1994) Avon & Gloucestershire College of Health, Department of Nursing Studies. Clinical course No. 956. Coping with Violence and Aggression.

GLANCY REPORT (1975) *Revised Report of the Working Party on Security within NHS Psychiatric Hospitals*. London: HMSO.

HYDE, C. & HARROWER-WILSON, C. (1994) Psychiatric intensive care: principles and problems. *Hospital Update*, **295**, 287–288.

KHAN, A., COHEN, S., CHILES, J., STOWELL, M. *et al* (1987) Therapeutic role of the psychiatric intensive care unit and acute psychosis. *Comprehensive Psychiatry*, **28**, 264–269.

MICHALON, M. & RICHMAN, A. (1990) Factors affecting length of stay in a psychiatric intensive care unit. *General Hospital Psychiatry*, **12**, 303–308.

REED COMMITTEE (1992) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services*. London: Department of Health/Home Office Consultation Documents.

TARBUCK, P. (1994) The therapeutic use of security: a model for forensic nursing. In: *Lyttle's Mental Health and Disorder*, 2nd ed, 552–562. London: Baillière Tindall.

Roland Dix, *Nurse Manager, Psychiatric Intensive Care Unit, Wotton Lawn, Horton Road, Gloucester GL1 3PX*