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Commentary

The need for clear leadership on the psychiatric intensive care unit

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Abstract

This commentary aims to explore the benefits of having a designated, specialised clinical lead on the psychiatric intensive care unit (PICU). It discusses the problems, disadvantages and risks of not having such leadership, especially where a multiple consultant psychiatrist model is employed. The impact of clinical leadership on specific aspects of work on the PICU is examined including multidisciplinary team working, patients' clinical time and safety, decision making, resource expertise, delayed discharges, and staff stress levels. Reference is made to standards in the literature which show that departure from designated leadership on the PICU is unsatisfactory.

Keywords

Psychiatric intensive care unit; PICU; IPCU; clinical leadership; medical leadership; lead clinician; multidisciplinary team; ward management

INTRODUCTION

The Argyll and Bute Hospital, Lochgilphead, Scotland is currently undergoing service redesign and the designated Psychiatric Intensive Care Unit (PICU) consultant psychiatrist is having to look for evidence to retain the designated PICU consultant role. A designated or dedicated PICU consultant is one with overall responsibility for the ward (Smith, 1997). He or she is expected to devote a significant amount of time to the PICU and is able to provide expertise specific to the ward and the service it provides (Department of Health, 2002b). Such a consultant will not have onerous duties outside the PICU and they will be full time or near full time.

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An unpopular alternative to having a designated PICU consultant is having multiple sector consultants with major duties elsewhere, extending their responsibility to their sector patients on the PICU.

In 2006 the Argyll and Bute designated consultant was away for six weeks and five sector consultants replaced her role on the PICU. We took the opportunity to compare the two systems using questionnaires and identified many problems with the sector consultant system (Ingle & Meechan, 2006). All five consultants and all six nursing staff wanted to return to the designated consultant system. Discussion with other services reinforced the validity of our experience and highlighted failings elsewhere of not having a designated PICU lead.

The Department of Health clearly specifies that the involvement of multiple consultant psychiatrists on the PICU, without any of them having specific responsibility for the PICU is

unsatisfactory. All PICUs should have a designated lead clinician, whether it be medical or nursing, in order to provide necessary input of time, leadership and expertise (Department of Health, 2002b). Loss of the designated PICU consultant would be a departure from this standard which was upheld throughout Scotland in 1997 (Smith, 1997), by 74% of units in England in the same year (Beer et al., 1997) and by 15 of 17 London PICUs in 2005 (Pereira et al., 2005).

RELEVANT ISSUES WHEN COMPARING PICU LEADERSHIP MODELS

Multidisciplinary working is paramount to successful PICU practice (Department of Health, 2002b; Musisi et al., 1989). Organising and operating the multidisciplinary team (MDT) is problematic without a dedicated lead. Full MDT clinical review meetings should occur at least once a week (Department of Health, 2002b). Assembly of the team for multiple rounds per week to suit the availability of several consultants can impact on clinical time, ability of MDT members to attend and on nursing stress levels (since they typically arrange the meetings). Multiple smaller rounds consume more clinical time than fewer but longer rounds: more telephone calls, increased travelling time, and increased waiting until all of the necessary MDT members have arrived are some of the reasons why. The loss of clinical time from organising multiple rounds increases risk to patients in an area defined by risk and intensive clinical need. It also represents a departure from the Department of Health recommendation that time spent therapeutically with patients should be maximised and activities which detract from this should be reviewed (Department of Health, 2002a). Multiple rounds increase the probability of absence of key members of the MDT from a meeting. At this extreme, the MDT ceases to exist.

Clarity of clinical leadership is important to efficient and appropriate use of the PICU facility (Beer et al., 2001) and in managing multidisciplinary teams in the NHS (Gorman, 1998). Consistency in leadership, decision making and boundary construction are threatened by a multiple consultant system. When our consultant was away, we found a shift of decision making towards nursing, away from the MDT. Having several consultants on the PICU rather than one can result in inconsistent clinical treatment, inconsistent application of admission criteria and inconsistent management of issues such as how breaches of ward rules are dealt with.

Implementation of appropriate admission and discharge criteria are needed to provide quality PICU services (Dix, 1995). Loss of the expertise of the dedicated lead opens a PICU to acceptance of inappropriate referrals which blocks beds and may increase unnecessary detentions. Conversely, specialised PICU leadership is often needed to negotiate appropriate transfers from PICU to other wards which can be resistive. Loss of a specialised PICU lead runs the risk of delayed discharges which blocks beds for other service users and is inconsistent with the Department of Health principles of timely patient access to appropriate beds and using the least restrictive option (Department of Health, 1999; 2002a). Such problems at entry and exit to the ward have been described as 'stagnation in the efficiency of PICUs' (Michalon & Richman, 1990).

Lack of physician familiarity with the unit can lead to feelings of inadequacy and doubt which can culminate in dictatorial directives which are not commensurate with the realities of the situation (Hay & Oken, 1972). A dedicated lead (medical or nursing) will obviously build familiarity with their unit from repetition of practices and through increased time on the unit.

It is common for patients admitted to the PICU to be in conflict with their usual consultant: indeed this may be the reason for PICU admission. The patient can appreciate encountering a different consultant on the PICU, and the consultant can obtain a second opinion from a colleague.

PICU nurses at Lochgilphead found the period of designated consultant absence stressful and related their stress to organisational and administrative pressures, most notably the multiple ward rounds and loss of control of admissions. In a study by Dawkins et al. (1985), psychiatric nurses generated lists of professional stressful events

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which were then ranked by a sample of the nurses. Administrative and organisational issues were found to be the most stressful (in contrast to negative patient characteristics and the clinical nursing role); a result also found in their study of psychiatrists. Staff stress can cause poor mental health, alcoholism, absenteeism, burnout, high turnover and poor quality work. Work anxiety can impair decision making capacity leading to clinical mistakes, which in turn increases anxiety-establishing a vicious cycle (Hay & Oken, 1972). It is not difficult to imagine how such a self perpetuating problem could cause total loss of control on the PICU with disastrous clinical consequences. The ability to provide high quality care is compromised by all of the above consequences of stress (Dawkins et al., 1985). It is acknowledged that given a long enough time, staff can adapt to changes, but where the system is inherently inferior, stress and inefficiency are likely to be perpetuated despite the efforts of staff to adapt.

The PICU is a ward where the staff take pride in the specialised and challenging nature of their work. Morale is all important (Rachlin, 1973). Argyll and Bute nurses perceived devaluation and loss of identity of the ward as a consequence of the change to the sector consultant model and morale was reduced by the change. Fortunately for the Argyll and Bute in 2006, the designated consultant model was reinstated, but what would have happened if it was not, and what will be the consequences if the sector consultant model is permanently instated following service redesign?

It would be an oversimplification to restrict discussion of PICU management models to a comparison of a designated consultant psychiatrist lead versus the sector consultant system. PICUs with designated consultants vary in their additional involvement of sector consultants and some PICUs with designated consultants retain the sector consultant as the registered medical officer during admission to the PICU. Dix has described a successful consultant nurse led unit (Dix, 1995) and proposed that some of the PICU interventions and expertise might even be deliverable in the patient's own home (Dix, 2007). What is clear is that the multiple consultant model does not work on the PICU and specialised and specified clinical leadership is essential for this specialised ward.

Research by Ingle and Meechan discussed in commentary was approved by the local Audit Committee.

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