Psychiatric intensive care units, a design for living

Roland Dix and Kelwyn Williams

The psychiatric intensive care unit (PICU) is now at the cutting edge of acute psychiatric care. Very little guidance has been produced to ensure that the PICU structure and design is able to meet the complex demands put upon it. The creation, development and relocation of a PICU has taken place within the Severn NHS Trust. We describe the experience gained from a recently commissioned unit together with a review of the relevant literature. Recommendations are offered for core features and design.

The demands upon the general adult in-patient facility have become increasingly complex over recent years. With pressure to treat more patients with ever increasing efficiency, patients who demonstrate problematic behaviours have been the subject of considerable attention. The psychiatric intensive care unit (PICU) is now a necessary provision for dealing with patients who demonstrate aggression, suicidal behaviour and a motivation to abscond (Dix, 1995). The re-emergence of the PICU (previously the locked ward) has coincided with the closure of large Victorian institutions in favour of smaller units. In addition, the Reed Committee (1992) have recommended that providers of mental health services include various levels of security in order to improve service provision for mentally disordered offenders.

The Severn NHS Trust has recently commissioned a PICU. The service was first established in a specially converted ward in a Victorian institution. It was relocated to a brand new building on the site of a District General Hospital. The physical environment in which the acutely disturbed patient is treated has had a major impact on the quality and efficacy of clinical intervention that can be provided, however no standard exists for the structure and design of the PICU.

Review of the literature

Little has been published in terms of recommendations for PICU design. The first real guidelines related to secure units and appeared in the DHSS document Regional Secure Units: Design Guide, in 1975. The recommendations produced advised on the level of prison-type security, the discreteness of this and the need for the secure unit to blend in with the surrounding hospital. In a survey of the regional secure unit programme carried out in 1985, Snowden criticised cramped conditions, poor ventilation and limited clinical interview rooms in some RSUs. These guidelines were superseded with the publication in 1993 by NHS Estates of the Design Guide - Medium Secure Psychiatric Units which took on board criticisms made by Snowden and included recommendations from a multidisciplinary team evaluation. Important points were made regarding standards of space, patient numbers (ideally six), window and door security, seclusion rooms, daytime facilities and observation.

However, it was in the early 1980s in the USA that PICUs began to be developed as an adjunct to psychiatric units to cope with problematic behaviour resulting from the acute phase of mental illness. Allan et al (1988) described the planning of a psychiatric intensive care unit. They placed little emphasis in their paper on actual design considerations, except in noting the need for ample space and the facility to observe patients continuously. Musisi et al (1989) described the operation of a psychiatric intensive care unit in a provincial hospital in Toronto. Their unit centred on a large, easily observed open area with six dormitory style beds separated by rectangle privacy drapes. Positioning of the nursing station allowed observation of all patients. There were separate lounge and dining areas, a bathroom, meeting room and emergency buzzer system. The importance of the need for continuous observation was stressed with one-way mirrors and plexiglass in the nursing station. A survey of nurses’ attitudes proposed a strengthening of windows for the observation station and improved sound-proofing of the quiet rooms.

Some studies have addressed area, patient density and over-crowding on intensive care units. Khan et al (1987), of the Harbourview Medical Center in Seattle, describe a ward offering each patient (five in all) 284 square feet of dayroom space and speculated on the anti-psychotic effect of the milieu (1987, 1990).

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Palmstierna et al (1991) reported on the relationship between increased number of patients on the ward and increased likelihood of aggressive behaviour, again highlighting the need for adequate space.

The concept of the specialised PICU, usurping the old style 'locked ward' crossed the Atlantic in the early 1990s with the Reed Report (Reed Committee, 1992), establishing the PICU as part of UK adult mental health provision. These new units tended to be adapted from the pre-existing facilities on acute psychiatric units, but few, if any, guidelines for design existed. Reporting of British PICU experience with reference to design features has been scanty. In looking at the principles and problems of psychiatric intensive care, Hyde & Harrower-Wilson (1994), endorsed the need for a locked ward, special observation and quiet rooms. Zigmond (1995) talked of the need to maintain the fabric and furniture of the ward so as to keep an acceptable environment. Recent attention has focused on personal security. Lillywhite (1995), looking at the risk of violence to junior psychiatrists, made recommendations for the design of interview rooms, namely that they should be close to staff areas; have an alarm system; have a door opening outwards; have a means for unobtrusive observation; and be quiet and private.

Recommendations for PICU design

The Severn NHS Trust PICU became operational in July 1994. The cost of converting the rehabilitation ward for use as a PICU was in the region of £20 000. Five weeks were needed for the work to be completed. The appointed nurse manager for the unit had complete control over the modifications to the ward. After seven months in the converted ward the service was relocated to a brand new building. The new ward was approximately one-third of the size of its predecessor. Before the move to the new unit, and after the relocation, further modifications to the new ward proved necessary.

Converting a ward in the Victorian institution for use as a PICU and its subsequent relocation to the brand new building has proved insightful. With a review of the relevant literature, we are able to make a number of suggestions that may be useful in designing an effective PICU environment. The following points are intended to show the design considerations that differ from a standard acute ward and a medium secure unit.

Ward positioning and layout

The PICU should be sited on the ground floor with access to an enclosed garden. An entrance to the ward, which does not require travelling through the rest of the building, should be available for acutely disturbed admissions. This should preferably be near the extra care area (see below). Four abreast should be comfortably accommodated by all corridors. Each patient should have their own bedroom. Six to eight beds is a good number.

Security

The main entrance to the PICU should be sited away from the main clinical area of the ward. This will help prevent absconding at times when the entrance is in use. A lockable door is desirable, but the electronic key pad should be avoided as patients soon become familiar with the combination. Windows should have a limited opening and be of durable design. Within the garden area standard garden fencing or hedges should be sufficient as it is intended to provide a recreational area with obstacles to absconding rather than the more elaborate security of a medium secure unit. Fire exits can be secured on magnetic locks that open if the fire alarm is activated.

Special clinical facilities

Seclusion rooms have lost favour in recent times. The PICU should include a facility away from the main clinical area in which a single acutely disturbed patient can be nursed, commonly referred to as an extra care area (EGA). Unless staff numbers will allow two nurses to be dedicated to the EGA it should not be separated from the rest of the ward by means of a physical barrier (i.e. wall or partition). The ECA should be able to provide for the daily living needs of a single patient and include the following, all in close proximity to each other: a room in which up to five people being a three person control and restraint team, the patient and one other could fit into comfortably, and the physical composition of which meets the Mental Health Act Commission standards for a seclusion room; a showering and washing facility with a toilet; a quiet room with simple furnishings.

Recreation

A general activities room in which items such as a pool table and table tennis can be comfortably accommodated should be provided, as well as a good size quiet room with a television and music centre away from the main day room.

Observation and safety

Numerous corners and corridors should be avoided. Where corridors meet convex mirrors
can be fitted at ceiling level to promote non-
obtrusive observation. Disturbance buttons (with
audiovisual output) should be placed in all
rooms. This system should have the provision to
be deactivated centrally in the event of persistent,
 inappropriate use by patients. In-built transmis-
ter receiver type ultrasonic personal alarm
systems are useful for indicating an emergency.
All doors should open both ways. Bedroom doors
should be fitted with a louvre type observation
panel, operated from the outside. All other doors
should be fitted with a plexiglass window (with
the exception of bathroom and toilet). Each
bedroom should have a vandal-proof light fitting,
which can be dimmed and operated from the
outside of the room for night time observation.
Some bedrooms should be without electrical
sockets in the event that additional safety is
required.

Fixtures and fittings
The ward environment should be as homely as
possible. Wall mounted pictures, pot plants and
non-moulded furniture may be used with discre-
tion as items of this type promote a relaxed
environment and do not present a significant risk
to safety. Plastic mirrors should be used in all
the appropriate areas. A public telephone should be
fitted within the ward.

Comment
The role of the PICU in the provision of acute
mental health care is becoming increasingly
important. Its place in the in-patient spectrum
is fixed between the acute ward and the RSU,
although the RSU may be the closer cousin. The
recent policy of making PICU beds available to
mentally disordered offenders with its implication
for security has emphasised the need for PICUs to
be designed carefully. Mixing patients who have
offended and have a legal requirement to remain
in a PICU with patients who are acutely disturbed
is a complex equation. We would hypothesise that
much dissatisfaction exists among clinicians with
the design of PICUs in many new hospital
developments. It is often wrongly assumed that
the length of stay of patients in the PICU will be
much shorter and consequently that comprehensive
internal facilities are unnecessary. However, the
opposite may be the case (Citrome et al. 1994).
The clinical focus of the PICU often requires that
on a day to day basis, the patient spends more
time on the ward and escort is often necessary
when patients do leave the ward. In view of this, it
can be argued that the PICU should contain a
more comprehensive range of internal facilities
than that of general acute wards.

The PICU is the reality of modern mental health
care for the acutely disturbed patient. Crucial to
that care is the environment in which it is
provided. To date the design aspects of these
units has been neglected. We have outlined what
we consider to be core features of structure and
design. We recommend that a comprehensive
document, similar to that available for the design
of medium secure units, is urgently needed.

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