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REPORT

COVID-19 and acute inpatient psychiatry: the shape of things to come

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ABSTRACT

Psychiatric services that provide acute inpatient care have to respond to the challenges brought about by the COVID-19 pandemic to consistently deliver high standards of treatment to patients and ensure the safety of staff. This can only be achieved by fostering a culture that rewards initiative and empowers inpatient teams to implement and comply with changes which everyone understands and benefits from. The experience of an inner London acute psychiatric unit has shown the value of combining proactive leadership, multidisciplinary decision making and good communication in adapting services to an ever-changing environment. Practical solutions have emerged that have improved service delivery and patient care, and which will likely outlast the COVID-19 pandemic. These include changes to team work and routine, streamlining patient care with a focus on goal directed admissions, developing a healthier work environment and adopting novel technology in patient care and multidisciplinary collaboration.

KEY POINTS

- Psychiatric inpatient units have to manage the COVID-19 crisis alongside the risk of acutely disturbed behaviour, while ensuring high standards of care and patient throughput.
- To respond to the COVID-19 crisis, inpatient units have to foster a culture that rewards initiative and empowers teams to implement and comply with changes that everyone understands and benefits from.
- Adaptive strategies should include good communication, a healthy work environment, flexible rules, dynamic infection control and adopting novel technology for clinical care and multidisciplinary work.
- Proactive leadership, multidisciplinary teamwork, transparency and a shared ethos of responsibility are the main tools to build effective inpatient teams.

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Guidance to contain the spread of COVID-19 (Royal College of Nursing 2020; World Health Organisation 2020; Public Health England 2020a, 2020b) has focussed mainly on staff redistribution, protective equipment, social distancing, early identification of COVID-19 and psychological support. Inpatient psychiatry teams face the unique challenge of managing the risks associated with COVID-19 alongside the risk of acutely disturbed behaviour (Luming 2020). Not only is social distancing harder to implement in inpatient units (National Association of Psychiatric Intensive Care and Low Secure Units 2020), but poor awareness of risk and non-compliance with personal protection in acutely disturbed patients may increase their susceptibility to infection (National Association of Psychiatric Intensive Care and Low Secure Units 2020; Yao et al. 2020). Moreover, high prevalence of medical comorbidity, smoking and obesity in severe mental illness (SMI) is associated with risk of COVID-19 complications (Liu et al. 2017; Vincent and Taccone 2020).

Adapting to the COVID-19 pandemic

Our 20-bedded acute all-male unit is located in a deprived inner-London area, across a general hospital with a large emergency department. It has a throughput of around 200 admissions a year, and patients typically present with psychotic disorders and medical comorbidity. Most are compulsorily admitted and have a forensic history (Tai et al. 2019). As other psychiatric units were converted for medical care of COVID-19 emergencies, keeping our patient throughput was crucial. Of the over 50 patients admitted over a 3-month period from the start of the outbreak in London, only five contracted COVID-19. All were treated on the ward and fully recovered. One staff member who developed COVID-19 safely returned to work after 14 days of isolation at home.

To operate effectively during the pandemic, we introduced practical steps in response to the evolving needs of our service. These are low-cost and easy to implement interventions which could be of interest to other inpatient teams.

Regular team briefings

As the epidemic gathered pace, our multidisciplinary team was exposed to a tsunami of information on COVID-19, often in the form of overdetailed emails which felt disorienting. Led by the medical team, and duly observing social distancing and use of personal protective equipment (PPE), we organised briefing sessions regularly for updates on COVID-19. Morning huddles were used to disseminate information 'face-to-face' and raise awareness of key changes to our routine. Discussing practical examples across disciplines – medical, nursing, occupational therapy, pharmacy, ancillary – proved the best approach to effecting behaviour change. Posters were displayed in communal areas with information about testing, social distancing and use of PPE. Additional meetings could be arranged to bring medical, nursing and

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ancillary staff together and brainstorm about infection control. These meetings generated practical insights and boosted morale.

Air ventilation

Provision of adequate natural ventilation, one of WHO four key recommendations for infection control in healthcare settings (Atkinson et al. 2009), is often neglected. Dietz et al. recommend maintaining windows open in healthcare facilities to allow entry of outside air as means of diluting and removing contaminated air (Dietz et al. 2020). To facilitate unobstructed passage of air through the ward, we endeavoured, whenever safe to do so, to keep windows open in all clinical and non-clinical rooms. Physical space was rearranged to functionally separate clinical and non-clinical areas.

Patient flow

A policy of goal directed admissions and promptly implementing care plans helped to keep patient throughput and reduce the risk of contagion. Barriers to discharge were addressed early in all admissions. Patients who tested positive for COVID-19 and who had responded satisfactorily to psychiatric treatment were prioritised for discharge once medically well. Older patients and those with medical comorbidities, hence more vulnerable to COVID-19 complications (Vincent and Taccone 2020), were also given priority. As the need for admissions remained unabated, the pandemic instigated a new impetus in community services to facilitate patients' discharge.

Patient education

We set as a priority to explain clearly and transparently all changes to our patients. As most group sessions were suspended, occupational therapy activities were offered on a one to one basis, including educational sessions on COVID-19, and group activities where social distancing rules could be implemented, such as gardening groups and music therapy, were expanded. Despite concerns around little awareness of risk of COVID-19 transmission in SMI patients (Yao et al. 2020), our patients – most of whom are detained under the England and Wales Mental Health Act 2003—were receptive to the changes. Social distancing remained a challenge throughout as patients were allowed in the communal areas, but most understood the need for reductions in their leaves from hospital and in our therapeutic programme.

'No visit policy' for family visits and non-team members

We decided to stop all family visits, save for a few exceptions (Luming 2020; Royal College of Nursing 2020). The response was largely positive from relatives and patients, who maintained contact between themselves and with our team via telephone or online video, including during ward rounds. With the aim to reduce the risk of contagion, we also decided to limit access of non-ward staff. Non-clinical meetings were all suspended. All relevant personnel were given a clear explanation for this and fully cooperated.

Use of PPE

All staff who were in contact with patients as part of their normal duties started to wear scrubs (National Association of Psychiatric Intensive Care and Low Secure Units 2020). Surgical face masks, gloves and plastic aprons were worn for all direct patient contact and disposed of prior to entry onto non-clinical areas. Surgical face masks were worn by staff in non-clinical areas as well when it was not possible to maintain safe distancing (>2 m). Protective eyewear was made available. N95 masks and long sleeve gowns were reserved for use in the event of a cardiopulmonary resuscitation.

Use of isolation and SARS-CoV-2 – testing

Patients suspected of COVID-19 were placed in isolation in single rooms and barrier nursed. We used a non-test-based strategy to decide when to end isolation. Patients in isolation with confirmed COVID-19 (on nasopharyngeal SARS-CoV-2 testing) were allowed out of isolation 7 days after initial symptoms (or positive test) so long as they had been apyrexial for at least 48 h and were improving clinically. We balanced recommendations from guidelines (Centre for Evidence Based Practice 2020) with patients' clinical needs and the 7-day period for isolation ultimately proved appropriate. The decision to forgo a test-based approach, which would require two negative tests before cessation of isolation, was partly determined by limited testing capacity at the time. Guidelines recommend both approaches (Centre for Evidence Based Practice 2020; Public Health England 2020b).

Innovative technology for clinical care

We introduced point-of-care testing to measure antipsychotic blood levels in our patients, initially for clozapine (Kalaria and Kelly 2019). As results could be obtained in minutes rather than days, this informed dose titration and expedited treatment. We also are in the initial stages of piloting e-prescribing for our Trust, which will fully replace prescription charts and make drug prescribing safer and more efficient across services.

Virtual links with community services and outside agencies

As online video conferencing replaced face-to-face meetings with community teams, we were able to engage community services in patient care, rationalise aftercare planning and facilitate early discharge. Management meetings were also held virtually along with external patient assessments by social services. Mental Health Tribunals, for patients who appeal against their detention in hospital, were also conducted via videoconferencing.

The new face of acute psychiatry

We have learned that information is key. Uncertainties around COVID-19 are the greatest source of anxiety for most. Briefing our team on COVID-19 clearly and concisely, in safe meetings open to all, has proved instrumental to inform changes and instil motivation. Consulting with all staff across disciplines for suggestions on adapting the ward for the pandemic untapped a wealth of expertise. Ideas on patient safety and optimising the use of physical space were promptly implemented. The format of these briefings will become a permanent feature of our service.

With new restrictions in place and in the absence of many group activities, we adopted innovative ways of interacting with our patients and their families while providing a therapeutic milieu. Good communication and candour proved essential. Even the most acutely disturbed patients responded well and were able to adapt. We also streamlined treatment plans. All involved seemed to benefit from a focus on goal directed admissions.

The ward has gained from a healthier environment. Enhanced ventilation, frequent handwashing and use of disinfectants and renewed awareness of infection control, along with flexible use of physical space, are here to stay. Training for medical needs has been revamped, including SARS-CoV-2 testing as part of routine clerking. Wearing of scrubs with the Trust logo by all promoted group cohesion and an invigorating sense of professionalism. It may also reduce risk of violence on the ward and has now become permanent.

The COVID-19 experience has been a catalyst for the transition of our unit from a traditionally low-tech inpatient psychiatry service into a vibrant medical specialty operating with modern technological resources, ranging from novel communication tools through to innovations in clinical care, like point-of-care testing and e-prescribing.

Conclusion

The COVID-19 pandemic is unlikely to end anytime soon, yet these steps have already reshaped our service. Coping with pandemic has brought about opportunities for innovation and most will become part of our new routine. We have also learned the importance of a culture that rewards motivation and empowers the team to implement and comply with changes that everyone understands and sees the benefits of. In any branch of medicine, inpatient care is an organised, multidisciplinary and interpersonal service where, to secure consistent care for patients, strategic priority should be given to staff stability and education in order to build teams with a shared ethos of responsibility (Dratcu 2017). More than any guideline, fostering this spirit is the surest way to raise to the challenge, and to the others to come.

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Disclosure statement

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