NICE Guidelines: Feedback on Safe staffing for nursing in inpatient mental health settings.

Hello Nigel,

I am sure at least some of this would be in your response, but I wanted to put in a narrative to assist the response.

Safe levels of nursing is not just about the ration of staff to inpatients, although minimum standards regarding the knowledge, skill and experience mix would be useful. The Francis and Berwick Reports highlight that whilst most staff working within inpatient settings are excellent, organisational structures, processes and dynamics can help or hinder the delivery of compassionate and effective care. Challenging dynamics inevitably arise in healthcare organisations where staff literally work with life and death. Effective multidisciplinary team work is essential. Nursing staff in particular are expected to perform a number of tasks and roles that include attending to both the physical and mental health of the patient, everything from self-care, counselling, organising practical help and support to everything in between. Nurses are actively encouraged to spend as much time as possible in direct contact with patients and are on call from every moment of their shift.

These guidelines include healthcare assistants and assistant practitioners working in inpatient mental health settings. A significant number of healthcare assistants and assistant practitioners are psychology graduates seeking relevant experience before starting training as psychologists or psychotherapists. This means that there would be a range of psychological theory available to a mental health ward and if supervised this theory can be put into practice. This also means that turnover of staff in these roles is likely to be high as these roles are likely to be a stepping stone onto different work.

Quality of staff-service user relationships key determinant of outcomes (Berry et al., 2011).

Team formulation specifically recommended as an effective means of achieving cultural change within teams and promoting a more psychological perspective (DCP, 2011).

Preliminary evidence from case studies and simple pre-post measure designed studies of change in staff beliefs about service users and/reductions in ‘challenging’ behaviours. (Janes & Shirley, 2008; Berry et al., 2008; Ingham, 2011; Meaden & Hacker, 2011; Newman Taylor & Sambrook, 2012).

Berry, 2008
Key findings post treatment: - Staff were less likely to attribute responsibility to service users for problems - Staff were less likely to perceive problems would endure - Staff reported more understanding of problems - Staff reported less negative feelings towards service users - Staff reported more confidence in and control over their work

There are a number of roles for psychologists and psychotherapists in working alongside nursing staff within inpatient settings.

**Schwartz rounds**

Schwartz Rounds are meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Research into the effectiveness of Schwartz Rounds shows the positive impact that they have on individuals, teams, patient outcomes and organisational culture. Schwartz Rounds were originally developed by the Schwartz Centre for Compassionate Healthcare in Boston USA. In the UK 100 trusts and hospices are contracted to run Rounds. The Point of Care Foundation is the sole licensed provider of training and support for Schwartz Rounds in the UK.

The implementation of Schwartz Rounds has been recommended in the Department of Health’s response to the Francis Inquiry.

A NIHR funded project evaluating Schwartz Rounds has recently begun at Kings College London led by Professor Jill Maben.

References:


**Effective multidisciplinary working**

PIE

Support service user recovery, emotional resilience and satisfaction. Develop staff’s psychological skills, improve staff satisfaction, reduce staff burnout.

1. Developing a psychological framework of understanding and working with residents.
2. Physical environment and social spaces – designing environments that promote communication and feeling safe and cared for.
3. Staff training and support.
4. Managing relationships – between staff and between staff and residents.
5. Evaluation of outcomes.


**Tree of Life**


**Positive behaviour support**
As part of the Department of Health review into Winterbourne View and how children, young people and adults with learning disability or autism who also have mental health conditions or behave in ways that are often described as challenging are supported across England, stakeholders reported that although there were many examples of good practice which illustrates the good work that can and is being done in local areas, there is some difficulty in disseminating the good practice. Positive Behavioral Support (PBS) is an empirically validated, function-based approach to eliminate challenging behaviors and replace them with prosocial skills. Use of PBS decreases the need for more intrusive or aversive interventions (i.e., punishment or suspension) and can lead to both systemic as well as individualized change. This approach has been used within intellectual disability services and schools and is now expected to be used within all residential care settings. **Looking for reference**

**Is indirect work helpful?**

Psychologists argue that training and supervising MDT staff to carry out interventions such as behavioural activation, graded exposure and relapse prevention, can enhance client wellbeing and functioning. Promoting the psychological mindedness of teams through formulation and reflective practice can increase their empathy and understanding for their clients’ difficulties, allowing them to provide more compassionate and effective treatment. Furthermore, providing such reflective space can improve morale and reduce staff burnout, thereby enhancing team functioning. Moreover, all three of these benefits have potential cost savings via reduced client contact with services, staff sickness and turnover. Whilst these benefits make sense in theory, do we have any evidence?

**Current evidence**

Most of the literature on indirect work consists of books or chapters on various approaches (e.g. Clarke & Wilson, 2009; Johnstone & Dallos, 2013; Meaden & Hacker, 2010) or articles in DCP publications describing innovative practice (e.g. Dexter-Smith, 2007, 2010; Jackman, 2013; Lake, 2008; Leaning, 2011). However we are starting to see published studies exploring the impact of training others (Waller et al., 2013) and team formulation. Team formulation has been found to have been positively received and improve staff views of clients in mental health rehabilitation services (Berry, Barrowclough and Wearden, 2009; Summers, 2008), learning disability services (Ingham, Selman, & Clarke, 2011) and older adult services (Craven-Staines, Dexter-Smith, & Li, 2010).
Although improved staff confidence has been evidenced, none of these studies investigated the actual impact on staff-client relationships, working practice or client outcomes, nor did they use a control group. Newman-Taylor and Sambrook (2012) did explore changes in client behaviour and staff attitudes and found reductions in challenging behaviour and staff burn-out following a consultation intervention within an inpatient psychiatric setting. However, again, the study was not controlled.

**Developing the evidence-base**
Concerned about the lack of hard evidence for indirect work, the PCMH’s CMHT Network decided to hold its 2013 CPD event on this issue. We sourced three psychologists within complex mental health who have recently evaluated an innovative indirect psychological intervention.

Katherine Berry described preliminary results of an NIHR-funded study, following up the Berry et al (2008) findings. The study used a cluster randomised design across several psychiatric rehabilitation services, evaluating a weekly staff formulation group against no treatment. Clients in the treatment arm reported significantly better relationships with staff post-treatment and there was a positive effect on client symptoms. As potentially the first controlled research study of team formulation, it is hoped the results will inform a larger RCT.

Nic Bunker described his role in developing ‘Psychologically Informed Practitioner’ (PIP) training and supervision for MDT staff. Importantly, it was supported by local managers as he linked it with his Trust’s ‘Talking Therapies’ CQUIN (Commissioning for Quality and Innovation) target. Each PIP provided a psychologically-informed intervention to six clients. Pre-post evaluations revealed improvements in clients’ symptoms, distress and functioning. As a result of these benefits, the PIP training and supervision has been rolled out to all Trust localities.

Finally, Kathy Taylor has been developing and evaluating a ‘Psychologically Informed Environment’ (PIE) with a homeless resettlement hostel. The project includes training, reflective practice and informal support for hostel staff. Evaluations one year on revealed improvements in residents’ wellbeing and engagement with other services, potential cost savings (reduced A&E and police call-outs) and improved satisfaction of both residents and staff. The initiation and implementation of the project required strategic and assertive skills in leadership and influencing, including gaining ‘buy-in’ from the Trust’s management structures, sourcing a supportive steering group and allying with local housing organisations.

**References**


Intensive Support Programme – Isabel Clarke

Making Sense of Crisis: A whole systems approach to get Acute Mental Health services operating psychologically.

Intensive Support Programme (ISP) is designed to meet challenges faced by Acute adult mental health services:

• The pace of the highly desirable move from inpatient to community provision is being forced by shrinking resources.
• Service user demands for holistic, more psychologically oriented treatment.
• Need to skill staff in a psychological approach – culture change
• The public's unrealistic expectations of elimination of risk.

Aims of the ISP:

To give the service user in crisis the following hopeful Recovery message:

Their distress is understandable and taken seriously – Their central role in making things change is demonstrated.
• To teach new ways of coping and support the use of these skills.
• To Introduce a radically new way to view mental health difficulties (beyond diagnosis!)
• To enable all staff to work with the psychological model, through training, supervision and support from the therapy service.
• To include carers, family, partners and important others as supporters of the individual’s recovery.
• To prevent admission to hospital/enable early discharge.

Comments
Safe staffing- it is crucial that the scoping and review looks to audit in detail a snapshot national view of the relationship between levels of nursing staff and skill mix with:
- increased risk of harm to service users
- increased risk of harm from service user to service user
- increased risk of harm from service user to staff
- actual harm – from the above
- escalation and use of restrictive practices – including use of seclusion – medication and use of PICU
- Unplanned discharge- often due to disruptive behaviour including – use of alcohol on the wards- non prescribed medication – illicit substance misuse.

Working in acute mental health care with potentially challenging scenarios and service users in states of high distress can increase levels of sickness, absence and turnover among staff as well as incidents and complaints. By using in-house clinical psychologists to contribute to practice development and staff training initiatives, staff moral will be maintained at higher levels and the ward milieu improved. This can help reduce instances of sickness, absence and turnover.

Numbers of Service Users per ward: Some comments from the scoping on the numbers of service users/beds per ward for Acute wards and rehab wards. Specifically commenting on standards and quality of care that can be offered – know that this varies nationally 18-24 beds and is a different question to staffing per ward.

Reflective Practice/Staff support: very important (re Francis and Winterbourne) to include within the scoping time for staff to attend weekly reflective practice meetings led by psychology staff. All too often staff are unable to attend due to the pressures on the ward- need for protected time for reflection.

Evidence for reflective practice can be found in: Berry, K et al. 2009 A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. Behavioural Psychotherapy, 37, 39-48.

Staff reported positive experiences:
- Greater psychological understanding
- Improved recovery focused care
- Compassionate therapeutic alliance
- Increased staff confidence
- Improved ability to provide a consistent approach
- Positive management of complex problems.

**Challenges**
- The ward is too busy
- It is too difficult (painful) to look back at incidents
- Not sure what to say
  - Don’t want to say something contradicting others
- Mistrust of process
  - What will happen to this information

**Benefits**
- Improved team cohesion
- managing complex users
- supporting the team
- Gives confidence to staff
- Being on the same page

**Nursing Activities**: looking to develop more psychologically informed environment – working with Nursing staff to develop basic level 1 psychological skills to develop alternatives and complimentary psychological interventions to deescalate stressful situations – includes Mindfulness-distress tolerance- anxiety management that nursing staff could offer service users on the wards under the supervision of a skilled senior practitioner and psychology staff.


**Crisis management**: look to develop nursing teams to offer alternatives to admissions using emotion focused formulation to develop shared understandings of crisis with the service users.

**Use of skills-based approaches in developing the therapeutic Milieu on the wards with Nursing staff teams**
Recent developments in therapy for personality disorders (such as Metallisation Based Therapy (MBT; Fonagy et al., 2004) and dialectical behaviour therapy (DBT; Linehan, 1993) rely on skills teaching and skills generalisation coaching as a core mode of therapy delivery. For example, DBT skills target management of troublesome emotions and interpersonal problems. As emotion management and personal relationships lie at the heart of most mental health symptoms, the application of DBT skills transdiagnostically is being developed and evaluated in the in-patient setting. (Dimeff & Koerner, 2007; Durrant et al., 2007; Clarke & Wilson, 2008, Chapters 6, 7, 8, 13 and 14.). This approach makes a division of labour in the delivery of psychological therapy particularly easy because: the skills to be taught are manualised; this is so that the psychoeducational aspects of the programme can be delegated to staff who are trained in the approach, but do not necessarily have a wider psychotherapy qualification; and the coaching of skills in the natural environment plays a crucial part. This is well-suited to facilitation by either ward or team staff, with some level of induction in the model, whose role it is to support the individual. This frees the expert clinical psychologist to: provide training and supervision for the wider staff group to enable them to deliver the skills training and coaching; formulate complex cases for the benefit of the individual and of the team; and offer treatment in the case of individuals deemed to be in need of that level of intervention.

Direct interventions

Basic level
Progressive nursing programmes stress the importance of one-to-one sessions between the allocated nurse and each person on the ward, ideally occurring each shift for each patient. Such sessions require the following skills of staff to be effective and therapeutic:
Engagement skills.
Listening skills (e.g. using the Talk Well document, Bright 2009).
Motivation enhancing skills.
Enhancing the knowledge base of non-mental health trained staff: support workers, non-clinical workforce (domestics, canteen staff, maintenance staff, administration staff) e.g. through basic mental health awareness training – a forum to give information, air queries, amend preconceptions. Service users should be involved in the development and delivery of such training. An understanding of the impact of cultural values on a service user’s understanding of their condition.

Low intensity interventions
Some staff will have the interest and ability to develop more advanced psychological ways of working provided the necessary support is available. Psychological skills that could be developed include:
arousal management;
emotion regulation;
psychotic symptom management;
problem solving;
assertiveness and self esteem building;
activity scheduling;
graded exposure;
confidence building; and working with any spiritual aspect of their condition via the Chaplaincy. Such interventions can be delivered in a group or individual format. Manuals, either published or site/team specific, facilitate the consistent delivery of such programmes. The clinical psychologist can introduce these and provide teaching for their use.

**High intensity interventions**
Direct intervention by clinical psychology or other staff with a qualification in psychological therapy in cases of:
- n complexity and risk combined;
- n severe motivational deficit; and
- n psychological formulation of complexity to facilitate effective team working (e.g. diagnostic uncertainty; cases of team splitting, etc.).

*Training for acute care pathway staff in applied psychological approaches*
The National Audit Office document *Helping People Through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services*, advocates ‘integrating training for CRHT and acute in-patient service to equip staff to operate in both settings’ (National Audit Office, 2010, Section 1.vi, p.8). Joint psychological training of the two staff groups, delivered by clinical psychologists, would affect this and promote joined up working across the pathway.

A number of initiatives point to the need for in-patient staff to receive training in evidence based nursing care (NIMHE, 2004; CQC, 2007; Clarke, 2004; RCPsych, 2009; *Chief Nursing Officers Review*, 2009; *Ten Shared Capabilities* (Department of Health, 2004a); Star Wards, Bright, 2006). Whilst a number of courses have developed nationally to address this need (see Clarke, 2004), some advantages of making use of an in-house clinical psychologist to support training initiatives include the following: training can be tailor made to the needs of the ward team and designed to be relevant to everyday practice, thus increasing the likelihood that the training will lead to an improvement in practice; training can be supplemented by follow-on support, thus transferring skills into clinical work and sustaining psychological practice; and it is cost effective. These, together with support from management, can serve to increase staff interest and motivation to stay in the post and improve the quality of patient care.

Commissioning and Delivering Clinical Psychology in Acute Mental Health Care : Guidance for Commissioners, Service Managers, Psychology Managers and Practitioners BPS 2012

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