Advancing Practice in Mental Health: Editorial Group

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If you would like to discuss or submit an article to be considered for publication in Advancing Practice in Mental Health, then please send an e-mail to one of the editorial group-members.

Articles for submission should be forwarded in MS Word format, to: John.Butler@sept.nhs.uk

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Editorial: Enhancing the Patient Experience

John Butler
Consultant Nurse (PSI)
Chair of Editorial Group

It gives me great pleasure to introduce the first edition of the re-titled Journal, *Advancing Practice in Mental Health*, formerly known as ‘Advancing Practice in Bedfordshire’, reflecting the move into the new Trust: SEPT Providing Partnership Services in Bedfordshire, Essex and Luton.

The important theme of direct patient care forms the focus for this edition, our eighteenth regular issue. In particular, much of this edition is the product of a time-limited working group (*Enhancing the Patient Experience of Direct Care*) which met on a number of occasions during the latter half of 2009.

The purpose of this themed edition, consonant with the aims of the journal editorial group, may be described as: focusing upon service-user orientated practice standards; sharing positive practices in promoting the patient experience of direct care; inspiring and challenging other teams and services to respond by developing and/or sharing similar positive practices; and, providing contacts for further information.

This issue includes a number of papers which demonstrate the realisation of positive practice standards in enhancing the service-user’s experience of direct care, which focus upon three key themes:

1. engaging and informing the service-user;
2. enabling the care team – considering the core characteristics of the well-organised and functioning Unit / Team;
3. providing meaningful intervention.

In setting the scene, I thought that it would be interesting to share the outcome of discussions by the working group on service-user orientated practice standards. Intending to convey and focus upon the key messages for direct care, in user-friendly language, describing such in no more than one page, a set of practice standards were proposed by the group, as summarised in Fig. 1. These have been influenced through discussion at Impact (Mental Health)-facilitated service-user meetings within the Bedfordshire & Luton adult acute in-patient units.
Our Service will:

[insert vision statement for Unit / Service]

<table>
<thead>
<tr>
<th>As a user of our service, you can expect...</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>to be spoken to in a friendly, courteous and helpful manner</td>
<td>team-members to give you time, listen to your concerns, and act promptly in responding to your concerns</td>
</tr>
<tr>
<td>to be shown around and welcomed to the Unit</td>
<td>to have access to an interpreter if you need one</td>
</tr>
<tr>
<td>to be asked your preferences for either a male or female named nurse</td>
<td>to be informed about who will be your named nurse in the first 24-hours</td>
</tr>
<tr>
<td>to meet with your named / associate nurse within the first 48-hours and at least twice each week</td>
<td>to meet with your doctor at least once every week, at arranged appointment times</td>
</tr>
<tr>
<td>to have privacy when receiving visitors, your medication &amp; physical health care, and when discussing personal issues</td>
<td>to be asked about your dietary preferences and be offered a choice of meals</td>
</tr>
<tr>
<td>a range of activities to be available</td>
<td>to receive your meals without interruptions</td>
</tr>
<tr>
<td>to be involved in planning your own care</td>
<td>to be involved in regularly reviewing your care</td>
</tr>
<tr>
<td>to receive information about your treatment and care</td>
<td>to be involved in planning for your discharge</td>
</tr>
<tr>
<td>to be able to practice your faith in a private and quiet place</td>
<td>for your family / named carer to be given information about you, if you consent to this, though we'll always provide general information to family members / carers</td>
</tr>
</tbody>
</table>

Please have a think about the other things that would be important and helpful to you, and write these in the space below. Your named nurse or doctor will then discuss these with you.
Of course, it is ultimately for the particular team/service to decide, in discussion with their service-user group, whether or not these would form a good description of the definitive standards for guiding practice, perhaps agreeing a modified local version for implementation. Certainly, the version shown in Fig. 1 will require further discussion within service-user meetings and related Service Forums.

Implementation of an agreed set of practice standards will require special consideration, in realising such within direct care provision. Implementation could be facilitated through the service-user and stakeholder forums of the Trust and local Service Induction Programme for new staff-members, through discussion within managerial supervision, and by monitoring as an aspect of the local service-user survey of direct care experiences.

As will be hopefully be evident as you look through and read about the work shared within this edition of the journal, many of these standards are clearly being demonstrated through a range of positive practice initiatives. The challenge is to ensure that such positive practices become more wide-spread and form the expected standards for the service.

Acknowledgements – Enhancing the Experience of Direct Care Working Group (Bedfordshire & Luton: June–Dec 2009):

Debbie Buck, John Butler, Claire Day, Sylvie Downe, Nicole Eaton, Anna Green, Bernie Harrison, Ann Knapper, Phil O’Leary, Clinton Rowling, John Saggers, Harry Sookraj, Kay Sookun.

Editorial Group: Invitation for New Members

Expressions of interest are invited from those of you who would like to join the Editorial Group for the re-titled Journal, and in particular from the Essex area.

If you are interested, then please e-mail:

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Promoting Dignity in Care

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SEPT Providing Partnership Services in Bedfordshire, Essex & Luton

Introduction

Research studies and media reports have highlighted Dignity deficits in care resulting in embarrassment, distress and harm to patients and their families (Baillie 2008). Nurses and all healthcare professionals should ensure that their own professional behaviour is admirable, that it is seen to be of worth and to command respect, because if this is the case, then it will be seen to possess dignity (Gallagher 2008). Dignity applies to everyone equally, whether they have or lack capacity. Everyone has equal worth as human beings and must be treated as if they are able to feel, think and behave in relation to their own worth or value. Even though individual nurses are responsible for dignity in care, dignity clearly needs to be viewed as the business of all staff (RCN 2008).

The Essence of Care programme (DH 2001a) and the National Service Framework (DH 2001b) both emphasised dignity in care. In addition, the Standards for Better Health framework (DH 2004) included core standards which specified that patients and relatives should be treated with respect and dignity.

The Dignity in Care Campaign (SCIE 2006) was launched to stimulate a national debate around dignity in care, setting out a ten-point ‘Dignity Challenge’ to be applied across the health and social care sector. This campaign, which initially focused on Dignity for older people, was extended in August 2007 to Mental Health Services, focusing upon tackling stigma, and to inpatient services and older people’s mental health services.

More recent work undertaken by the Royal College of Nursing (RCN) has helped to clarify the meaning of dignity in a practical way, and an RCN survey (RCN 2008) demonstrated how seriously most nurses take the issue and the measures they are prepared to take to ensure patients are treated in a dignified way.

Dignity in Care Initiative: a local event for Dignity Champions

A Dignity in Care workshop was organised for all Dignity Champions or nominated persons within Bedfordshire and Luton on 29th May 2009.
This offered an opportunity to further focus upon some of the key recommendations that had been made following a pilot of an educational programme within the Trust’s acute in-patient settings, which included:

- identifying a Dignity Champion for each Ward / Unit;
- developing a briefing for the role of Dignity Champion role;
- further supporting the role of the nominated Dignity Champions.

Following a pilot educational programme, it was agreed that Sue Anthony and Komala Vencatasawmy (Practice Development Nurses) would work together in further progressing the Trust’s Dignity & Respect Initiative. This was the beginning of a professional commitment to share expertise, dedication, vision and engaging ideas. ‘It also enabled us to reflect on our values, beliefs and respect for human kind, and particularly for our service users who deserve to be treated with respect and dignity at all times. We were able to set the preparation stages which involved meetings and email communications, and we had the privilege of having the contribution of Carolyn Giles, a former service-user, which added an important perspective and dimension to developing this initiative.’

**DIGNITY Day (or ‘D’ Day): May 29th**

Friday, 29th May 2009, was the date chosen for the first Dignity in Care workshop. Invitations to join the workshop had been circulated via the Trust’s Communications Team and the session attracted twelve participants. Most importantly, the group involved representatives from working age and older people’s mental health services, and from learning disability services, including both in-patient and community staff-members, both registered and unregistered, and administration and occupational therapy team-members. From the outset of the meeting there was a sense that dignity had been high on these participants’ agendas, and not just for patients but for everyone.

Much preparation had taken place before the meeting so as to embed the theme that ‘Dignity will be at the heart of everything we do.’ Flip-charts were cut into heart shapes with the slogan being centred on them, heart shaped post-its were obtained to allow the attendees to make explicit Dignity pledges, and even the refreshments included heart shaped biscuits! We were also privileged to have input at the preparation stage for the workshop from a service user, who herself has registered as a Dignity Champion. The reflection on her own experience helped to shape the work plan and provided really valuable opinions and insights into how patient and staff relationships are developed or perceived. Unfortunately for us, the service user was unable to join this session due to a previous engagement, though we are delighted to say that she has significantly contributed to more recent events.
Opened by Dr Patrick Geoghegan, then the Interim Chief Executive, he really captured the essence of what dignity means to him in considering his past and present roles, and as a person.

As often happens, people posed the question: ‘When did it all change and why do we need to think about teaching people about dignity?’ Some expressed their thoughts and views about this very issue, ‘it changed when people’s roles changed, there are no visible leaders any more’, though there were no real concluding answers. One interesting major discussion point was that whilst people find it hard to say what dignity means to them, it is very clear that people know when they have not been treated in a dignified way. Furthermore, it became clear that those who had come to the workshop saw dignity as an integral part of care and, as an outcome, felt more able to move this agenda forward within their own teams.

In emphasising dignity as important for everyone, scenarios had been developed as the basis for group work, which included a patient related story, a staff to staff dignity and respect issue, responding to a relative, and an issue relating to an entry in records. This led to a series of meaningful reflective discussions.

The group then considered what they would need in becoming a Dignity Champion, which involved a consideration of the qualities needed in a Dignity Champion (as summarised in Fig. 1) and touched on the supports required for fulfilling this important role.

**Fig. 1: Qualities & Supports required for a Dignity Champion**

- be knowledgeable about practice
- be enthusiastic
- set an example yourself
- be a good communicator
- give praise when needed
- be able to speak to the manager if support is needed
- to become a registered Dignity Champion
- to be respected as a Dignity Champion
- to be listened to when making generalised comments at team meetings
- to seek support from existing Dignity Champions / Leads

It was agreed that staff will need support to challenge practice, particularly if the concern is being raised about staff of a higher grade. However, it became apparent that this group of people would not ignore poor or disrespectful attitudes or behaviour and so a support mechanism would need to be put in place. It was suggested that the identified list of qualities needed to be communicated to team managers to ensure that the work of Dignity Champions would be acknowledged, and the group was reassured that they could contact the Dignity Leads (facilitators) to discuss issues or concerns.
The Ten Steps of the Dignity Challenge were introduced and staff discussed how they thought these could be met within the Trust. Though for some of the challenges there are related policies in place, the intention was to ask participants to complete these with their own teams and to provide feedback on progress at a later date. The challenges are not intended to require large scale pieces of work, nor do they need to be costly. In fact, the words of Clive Woodward, Manager of the England Rugby Team at the time of World Cup success in 2003, are worthy of reflection: *that the concept of success is not about changing one thing by 100%, rather it’s about changing 100 things by 1% each – small changes can make a big difference.*

**16 Small Steps towards a Big Change!**

To capture some future commitment, we asked each individual to use the heart shaped post-it notes to make their dignity pledge, which included the following:
- I will challenge inappropriate practice
- I promise to see you as an individual
- I will organise ‘No Entry’ signs for bedroom doors
- I will speak to the relatives more and be more active
- I promise to treat everyone the way I would like to be treated
- I pledge to speak up for my patients when they cannot speak up for themselves
- I pledge to get doctors and consultants to respect privacy by not talking to staff and service users in the corridors
- I pledge to discuss ideas to promote dignity in (my work place) with staff and service users and to be the person responsible for putting the ideas into action / visuals
- I pledge to discuss this day at the team meeting and to register as a dignity champion
- I pledge to ‘challenge’ any bad practice, to build confidence in yourself with support
- I promise to talk and listen to service users and not to walk away
- I promise I will try not to keep my clients waiting
- I pledge to make small changes through good, clear and effective communication at team meetings and patients feedback sessions
- I will lead by example, educate other staff, listen to patients’ concerns, maintain a sense of humour and show respect for others
- I pledge to support the Dignity Champions
- I promise to support all Trust Dignity Champions in their roles

**Following Up on Dignity Pledges**

The future for the Dignity Champions / Leads was discussed and it was agreed that we would make the time to meet again and review the progress of the Ten Steps of the Dignity
Challenge. Since ‘D Day’ in 2009, two further events have been held, in Sept 2009 and in May 2010.

We are delighted to confirm that many of the original participants, among others, have now themselves registered as Dignity Champions. At our most recent ‘D Day’, many of the local dignity initiatives progressed in practice settings were celebrated and shared, as showcased in Fig. 2.

**Fig. 2: Showcase of Dignity in Care Initiatives**

- in the CMHT, we have developed a personal information leaflet so that when a person goes into the general hospital, staff on the ward will not just know their personal details, but also their likes and dislikes, communication skills and behaviours.
- through the joint work of the Older Peoples & Learning Disability Essence of Care Groups, a series of Dignity in Care leaflets are being produced – the first is about oral hygiene.
- an informal *Dignity in Tea* session is now being held in some of the adult acute in-patient units, in raising the awareness of service-users and exploring dignity issues further.
- we have developed a team noticeboard dedicated to Dignity information in a prominent staff area.

Part of the forward plan will be to invite Michael Parkinson, Ambassador for Dignity, to visit the Trust.
Conclusion

Of course the Dignity Challenge is not limited to those who participate in our local events, but it is for everyone – we are all responsible for meeting this agenda and anyone can sign up to be a Dignity Champion through the Department of Health website.

Dignity is not just for older people, it is for everyone, and in the same way our patients and visitors deserve to be treated with dignity and respect, so too do staff. If something or someone makes you feel uncomfortable, your patient is probably feeling the same way. Let’s no longer turn away but let us put *Dignity at the Heart of Everything we do*.

If you have already made a change that improves the dignity of patients in your area, then please let us know, as we need to share good ideas and practice – *be proud and loud!*

References


Department of Health (2001a) *Essence of Care: patient-focused benchmarking for healthcare practitioners.* London: DH


RCN (2008) *Defending Dignity: Challenges and Opportunities for Nursing.* London: Royal College of Nursing


For *further information* on this initiative, please contact Komala or Sue:

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Welcoming and Informing the Service-User:
*a short case example*

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SEPT Providing Partnership Services in Bedfordshire, Essex & Luton

As part of the service development over the last year or so and as a way of improving the patient experience at the point of admission, the idea of having a welcome pack for each area of the acute crisis service was thought to be a possible way of achieving this. Feedback received from service user surveys, both locally and nationally, had given clear indications that service users and their families feel that admission is a particularly difficult and confusing time, and that having clear information to refer to would help the experience.

Following consultation with service user and carer groups, a small working team was established to progress these ideas. The group considered what should be included and how the information pack should be presented and, after many drafts and several proof readings, the pack was produced and then circulated for approval by stakeholder forums and by the Trust’s Acute Care Forum (pictures of excerpts of the Welcome Pack are shown on the right).

The Welcome Pack is written in clear simple language and all terms are explained, which can be reproduced in languages other than English if required. Indications are provided about what service users and their families can expect from the wards and crisis teams, what facilities and treatments may be available and, in return, what the services expect from the users of the service and visitors to the service. Information is included about service user and carer support groups, local faith and chaplaincy services, and who to speak to if wishing to make a compliment or express concerns that may arise as a result of contact with the service.
Every service user receives the welcome information pack at the point of admission to the individual service and, those who are admitted to the Mental Health Assessment Unit or to one of the Acute Treatment wards, is given a hospitality pack of toiletries.

Both informal and formal feedback provided by service users and their families to the wards and teams regarding the Welcome Pack have, on the whole, been very positive. This is supported by evidence received at stakeholder meetings from service user and carer groups.

For further information on this initiative, please contact Sylvie:

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The Conversation that went Somewhere: 
the making of a DVD about the Care Programme Approach (CPA)

Terri Dorman
Practice Development Nurse, SPLD
SEPT Providing Partnership Services in Bedfordshire, Essex & Luton

Introduction

How many times in your practice do you have a conversation about something that would really benefit people using that service? How many of those conversations actually achieve anything? This article will explore the outcomes of one such conversation that actually went somewhere and achieved our goal of making a DVD that explained the journey a service user would experience whilst supported under the Care Programme Approach (CPA) within the community. The project was ground-breaking, exciting and a huge learning curve for all who were involved.

A major piece of work was undertaken nationally by the Department of Health during 2007 which reviewed the Care Programme Approach (CPA): the process is used to ensure that people accessing services from specialist mental health or learning disability services are supported in a structured and supportive manner. The outcome of this piece of work, entitled Refocusing the Care Programme Approach: policy and positive practice guidance, was published in May 2008 – this had a big impact on our organisation, as the core business is supporting people through use of this framework.

Separate working groups were set up within each Directorate and I led the Learning Disability group. During one of the work plan progress review meetings with Bernie Harrison, the Trust’s CPA Manager, we discussed how useful a DVD would be for service users and their carers. Bernie reported that the Department of Health was due to release one which we could then use.

The Learning Disability working group produced some ‘Easy Words and Pictures’ leaflets, which we had published and disseminated across the county to all Adult Learning Disability Teams and in-patient areas. They were also shared with colleagues in other Directorates, as they may be useful to other service users who do not have a learning disability.

Part of this dissemination took me to the Bedfordshire Partnership Board in October 2008: this was a county-wide group of people which included service users, their carers and relatives, service providers, advocates and commissioners. It was established as part of the national programme outlined in Valuing People (DH 2001), which was the definitive document regarding services for people who have a learning disability in the 21st Century. I
reported on the work that had been undertaken, who had been involved, and the leaflets that we had produced. In the open forum the response was extremely negative, but the one very important thing that one person said was how the leaflets were fine if you could see and read, though if you could not, then they would be no good. It was suggested that a DVD on CPA would be more useful, not only for people who have a learning disability and their carers, but also people who have mental health issues, who, when in an acute phase of illness, may find it difficult to retain information that is written.

The Department of Health had released their DVD, though this was extremely disappointing and very boring. If we found it boring and unhelpful, then we were convinced that service users and their carers would find it equally unhelpful. The CPA Manager and I again discussed how good it would be if we could produce our own DVD, which brought the CPA process to life.

**Getting Started**

As the CPA Manager and I talked, the idea started to grow. We looked at the leaflet that explains the forms and agreed that this could be brought to life and give a really good idea of how the process works and the kinds of things that would happen with the person. How could we achieve this? A quote had been obtained in the past for £25,000: this was far too much money, and we would never get approval. What about media students, would they be able to produce something with us? I knew someone who taught media studies, so I agreed to contact them. Sadly they did not have the resources to be able to undertake such a project but agreed to speak with some people he knew, as he may be able to link us with someone who would be able to do this.

The next week came and my contact said that a chap called Peter was interested, that he had done similar work in the past. I made contact and set up a first meeting at the end of November 2008. Bernie was not available on this particular day and as the meeting was arranged to take place in a public house on a Saturday, she was insistent that someone came with me in accordance with the Trust’s Lone Worker Policy (2008). A colleague who lived locally to me agreed to accompany me and also became excited about the project.

The meeting took place with Peter, and I outlined my ideas and my vision for the DVD, talking through the process and using the leaflet to illustrate. Peter reported that he felt this would work. I felt elated. I gave Peter a copy of the Department of Health DVD and said we wanted something very different. The meeting concluded with Peter agreeing to draw up a contract outlining his costs and reported that he would need to be paid on completion of each stage. I reported that this project must be completed within the financial year, and so the deadline of 31st March 2009 was set and agreed.
By the beginning of the next week I had received a proposal from Peter – I could not believe it: £1000 for a hundred DVDs. I fed this back to Bernie and reported that I now had all the information to take to the next County Leads Group meeting in order to request funding, which was planned for the beginning of December 2008. This meeting was cancelled at the last minute and the Chief Operations Manager that we were going to approach for funding was not available throughout December. A real set back. I fed this back to Peter who reported that we still could meet the deadline.

Bernie reported that she had a scheduled meeting with the Chief Operations Manager during the first week of January 2009 and was happy for me to attend in order to put the case forward for the funding. We all met at lunchtime and I explained the project and showed the proposal to the Chief Operations Manager and reminded him that we had received an earlier quote for £25,000. He reported that he was very impressed and would discuss this with his colleagues and let us know the outcome as soon as he could. He stipulated that if the project was to proceed, then it must be inclusive of service users, carers and staff so as to be a true reflection of the Trust.

That evening, there followed an email telling us to get the cameras rolling! Funding had been approved.

I contacted Peter straight away and a meeting was set up for the next Saturday for us to meet with Bernie. We put some finer detail on the outline of the project and agreed that we would prefer to have a voice-over rather than have our volunteers / participants speak, as we felt this would put too much pressure on them. Peter agreed to arrange for an actress to do the voice-over and that this would be included in the costs.

The Next Stage

At our three-way meeting, Bernie and I agreed to draft a storyboard which outlined the content of the DVD. We had a joint appointment on the following Monday and agreed to spend the afternoon putting the storyboard together and getting the account opened on the NHS purchasing system with the Personal Assistant of the Chief Operations Officer, as per our instructions.

Once the account was opened, we proceeded to map out the story using flipchart paper and multi-coloured post it notes. We wrote the scenes on one colour, who would be included on another colour and the location on another. We moved these around until we were satisfied. Once agreed, we word processed the work onto a table. We agreed that we would revisit the work and make amendments and feedback to each other. Once agreed, this was forwarded to Peter for further work.
Bernie and I also identified that we needed to gather a group of volunteers as the cast. We agreed that we needed to put an advertisement in Trust Today, the Trust’s daily newsletter, which is emailed to every member of staff. This went out Trust-wide the next day. However, the response was very poor – we only had one volunteer! This meant that we would need to approach people directly. Bernie agreed to seek out a service user volunteer through a drama group. I firmed up our one responder from Trust Today and sought a carer through our carer forums. I also agreed to approach a doctor, who had said we could use the department’s premises for the filming, to encourage him to make the opening statements on the DVD which would be an introduction to the process and what the DVD would illustrate.

The feedback from Peter was very positive, but due to circumstances beyond our control, we had to delay filming until the last Saturday in March, such that our deadline slipped.

Bernie and I met the service user who had agreed to participate at the Trust’s Day Resource Centre and explained what we hoped to achieve through the DVD. The service user was really positive and he reported that he was looking forward to being part of the project, to give something back to the Trust after he had been supported for a number of years.

We then had a minor setback after agreeing rehearsal and filming dates in March: the doctor who had agreed to be part of the production and present the opening, was not available. Not only did we need to find another doctor but also a replacement location. Another doctor volunteered their services straight away.

I negotiated with our Service Director to use of one of the Clinical Resource Centres: this was a much better location as there were a variety of rooms available including a kitchen, which would lend itself to the reality of the situation.

It was pleasantly surprising to see how many people volunteered their services when approached directly and we ended up with a cast of eight, including a nurse, doctor, recovery workers, counsellor, carer, care coordinator and, of course, a service user.

Once we had our cast we were in a position to write the script, as we could visualise who would be in each scene. Bernie and I met during the first week of March to write the script. In one of our conversations by email, Peter made the suggestion that the DVD would appear more real if we could have the cast speaking at the beginning of each scene and then fade them out, then fade in the actress who would be providing the voice-over narrative. We followed the storyboard and wrote a few lines for each of the cast-members which was then picked up in the narration. In order to overcome the issue of losing our opening speaker, who was going to explain the CPA process and the content of the DVD, Bernie and I agreed to have a conversation at the start which would capture this information.
Once we had drafted the script we gave it to my line manager who acted as a ‘critical friend’, to read and give some feedback. This was extremely helpful as points were picked up that we had missed. The critical friend is really useful especially when you are entrenched in a project – it is very difficult to encompass all aspects and crucial points can be easily missed.

We made amendments and agreed the best way forward would be to bring the script to the rehearsal day and make adjustments following suggestions from the group.

**The Filming**

We agreed to meet Peter at the location to facilitate him in exploring the venue in order for him to plan the equipment that would be needed, and the camera shot angles.

The rehearsal day dawned and everyone that we expected arrived, though two of the cast could not attend due to work commitments but had said that they would be there on Saturday: one person gave up a day of their holiday to be there. Bernie and I explained to the group how this project was started and what we hoped to achieve through the production of the DVD and how it would benefit service users and their carers. Everyone reported that they were content to continue, and so we provided everyone with a consent form to sign, ensuring that we had met the Trust guidance on securing robust consent for people who would appear in the DVD. Slight alterations were made to the script and the final version was agreed. The group visited the Clinical Resource Centre to have a look around. The time to meet on Saturday was agreed along with other practical issues such as changes of clothing, as the DVD was to reflect a period of time.

The filming took place on Saturday 28th March 2009. The people that did not make the rehearsal were introduced to everyone else and given a consent form to sign. Everyone was given a copy of their consent form to keep. The day went extremely well and the filming was scheduled in order to release people as early as possible so they could enjoy the rest of their Saturday. Bernie and I took on the role of directors and supporters of the group whilst they were not filming. The final scene filmed was Bernie and myself giving the outline of the CPA process – we agreed that was the most challenging part of the day!

**Delivery and Distribution**

Following the filming day, Peter edited the captured film and put it together with the voice-over to tell the story. A couple of drafts were sent for review by Bernie and myself, leading to suggestions in clarifying and improving the DVD. Peter wrote the accompanying music and designed the cover for the DVD which we agreed with members of the cast, to ensure the wording was approved by all who took part. A final draft of the DVD was delivered and
Bernie and I arranged to meet members of the cast in order for them to see the DVD prior to it being distributed across the Trust. Once the initial embarrassment of seeing yourself on film was overcome, everyone agreed they liked the final DVD and the agreement to proceed in creating one hundred copies was given to Peter.

Peter delivered the DVDs in July 2009, by which time our deadline had slipped considerably due to unforeseen events. However, at last we were ready to hold screenings to launch the DVD prior to distribution. The Trust’s Communications Team were contacted to take this forward but we had to wait until the Communications Strategy Meeting was held in September 2009. We presented the DVD to the group and awaited their feedback, which was not forthcoming. After pursuing the feedback, due to confusion within the Department, Bernie and I distributed the DVDs across the Trust and to our colleagues in the Local Authority, with a letter reporting that we would be available to provide a short presentation to team members and service users upon requested.

We have not been asked to attend any team meetings and a piece of work in the future will be to ascertain the usefulness of the DVD. We have the facility to be able to have the DVD translated into different languages should that be requested. One group of service users who watched the DVD said that sign language might be useful for people too.

Of the notable and positive feedback that we have received, was that the service user who appeared in the DVD reported that his level of confidence had really improved since he had taken part in the project.

**Conclusion**

This project illustrates that conversations can go somewhere if you have the foresight and determination to see a project through to its conclusion. This has been a huge learning curve for me: I have learnt how to put together a storyboard and how to write a script. I have had the opportunity of influencing the filming process and how the final product will appear.

Having undertaken this project, I feel that I have also reinforced my project management skills, which has also added to my personal continuing professional development.

Everyone involved in this project has been committed, giving up their own personal time and putting themselves in the spotlight. This has taken them out of their usual comfort zone and it was a privilege to be a part of the whole experience.
References

Department of Health (2008) *Making the Care Programme Approach work for you (Booklet and DVD).* London: DH

**National CPA Association Awards 2010**

Award of ‘*Excellence in Providing CPA Information*: CPA DVD, written, produced and directed by Bernie Harrison and Terri Dorman.

This involved: Karen Moore, Graham Munns, Earlice David, Harjit Khaliwall, Dr Ayema Lewin, Marcus Booth and Chris Hart.

For *further information* on this initiative or for details on how to access a copy of the DVD, please contact Terri:

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The Productive Mental Health Ward (PMHWd) Programme: 

*a journey in releasing time to care*

John Butler¹, Debbie Buck² & Jason Matthews³

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SEPT Providing Partnership Services in Bedfordshire, Essex & Luton

**Introduction**

The Productive Mental Health Ward (PMHWd): *Releasing Time to Care Programme* builds upon the success of the Productive Ward programme. Promoted and supported by the NHS Institute for Innovation and Improvement, the PMHWd programme is designed to assist nurses and therapists to increase the quantity and quality of direct care time for service-users in mental health wards, primarily through improving the effectiveness, safety and reliability of mental health wards.

The intention of the programme is to help a team to understand their own issues / problems and to develop their own solutions – importantly, this involves recognising and sharing areas of existing positive practice.

The PMHWd programme focuses specifically upon acute in-patient mental health, and involves working through a programme of three foundation and eight process modules, each focusing upon a specific key activity area:

- **Foundation Modules:**
  1. Knowing how we are doing;
  2. Well-Organised Ward;
  3. Patient Status at a Glance

- **Process Modules:**
  4. Safe & Supportive Observations;
  5. Admissions and Planned Discharge;
  6. Shift Handovers;
  7. Meals;
  8. Medicines;
  9. Ward Round;
  10. Therapeutic Interventions;
  11. Patient Well-being

All participating wards / units are first required to complete the three foundation modules, then selecting and working through the process modules as a more flexible programme.

The progress and outcomes of the PMHWd programme within Bedfordshire and Luton is summarised within this paper.

**PMHWd Programme: progress within Bedfordshire & Luton**

Though commencing at two pilot sites from Feb 2009, with the aim of developing two showcase wards (Oakley Court and Townsend Court), the PMHWd programme is now being facilitated with nine wards / units within Bedfordshire and Luton and one Crisis Resolution &
Home Treatment Team (CRHT). Nine participating wards / units / teams have now completed the three foundation modules and have either completed or are currently progressing at least two selected process modules, whilst the tenth unit has only recently commenced the programme. Importantly, as wards / units complete a process module, this learning is shared with other wards / units.

The PMHWd programme has been driven and coordinated by a Project Lead and a Programme Facilitator, in supporting and enabling local ward / unit PMHWd teams to own the initiative and to progress through the modular programme (five team-members in each team are identified as PMHWd Champions).

The progress and development of the PMHWd programme within Bedfordshire and Luton has been supported through facilitated PMHWd team progress / review meetings and through a six weekly PMHWd Steering Group, chaired by the Interim Executive Director of Clinical Governance and Quality, or by the Consultant Nurse (PSI).

**PMHWd Programme: monitoring outcomes through measurement**

With the principle aim of releasing time for direct care, it has clearly been important to introduce a measurement method in demonstrating the outcomes of the PMHWd programme, which is a requirement of the first foundation module.

One of the principle methods of evaluating the impact of the PMHWd programme in demonstrating the aim of releasing time for direct care involves the activity shadow, though it must be realised that this method also has a number of limitations. In moving forward, it was agreed to conduct activity-shadows of Band 2/3, Band 5 and Band 6 team-members at each ward / unit at three different stages of the programme: (1) foundation module stage; (2) on completion of 3 – 4 process modules; (3) upon completion of all relevant process modules. Furthermore, % Direct Care Time targets have been set locally for different Bands of staff:
- for Band 2/3 = 60-80% *(refer to Chart 1)*;
- for Band 5 = 50-70%;
- for Band 6 = 40-60%.

Of a total of 36 activity shadows conducted across the participating units to date, 14 have met, and in some cases significantly exceeded, these locally agreed and challenging targets for direct care time (with a further 4/36 activity shadows being very close to the set target).
Indeed, measurement is an integral feature of the PMHWd programme, being used to drive forward innovation and quality improvement. This has involved the establishment of a number of local patient and staff measures, selected and often designed by the participating wards / teams, as summarised in Table 1.

An important learning point has been the realisation that it is critical to focus upon the use of the findings and not simply upon data collection and analysis, if data completeness is to be achieved. Furthermore, some patterns seem to be emerging: it would appear that staff-reported stress levels are most associated with staff perception of how incidents are managed and with the visibility of the ward manager / senior support, rather than directly with the number of incidents. Though this finding requires further testing, this has interesting implications.

A focus on these local measures is helping to challenge the perception that these units are unsafe, always stressful and un-therapeutic. It is interesting to note that when originally discussing the measure of individual sessions, staff and service-users differed in their perceptions of what constituted a therapeutic intervention: staff identified medication, giving information, and attending therapy as examples of therapeutic interventions; service-users identified meaningful interventions as being enabled to attend to personal hygiene, having access to local amenities with staff support, and being encouraged to become involved in the unit.
Table 1: Summary of Selected Local Measures / Metrics

<table>
<thead>
<tr>
<th>Measure / Metric</th>
<th>What</th>
<th>Why</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Cross</td>
<td>use of a simple visual monitoring tool: a RED cross indicates the occurrence of a 'violent incident'; an AMBER cross indicates a 'verbal incident' (adapted for slips, trips and falls); a GREEN cross indicates that there were 'no incidents'</td>
<td>to test the perception that a lot of violence and aggression occurs at the unit; Is there a relationship with staff stress levels?; What happens as other changes are made (e.g. re-locating the clinic room)?</td>
<td>monthly metrics can be displayed on the PMHWd Information Board; team reflective discussions; influencing decisions</td>
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<tr>
<td>Staff Stress</td>
<td>an anonymised staff-member view of stress levels for a shift, reported as % no. of good versus bad days per ward per month</td>
<td>to test the perception that the unit is a difficult place to work; Is there a relationship with incident levels?; What happens as other changes are made?</td>
<td>monthly metrics can be displayed on the PMHWd Information Board; team reflective discussions; influencing decisions</td>
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<tr>
<td>Individual</td>
<td>involves recording the number of individual sessions undertaken with service-users, of at least 15-minutes duration</td>
<td>to test staff perceptions, such as: we do it, but no-one acknowledges it; there’s not enough time for this this is recognised as an important indicator of meaningful intervention by unit teams, and a good indicator of ‘Releasing Time to Care’</td>
<td>monthly metrics can be displayed on the PMHWd Information Board; reflective discussions within team meetings and within the supervision setting</td>
</tr>
<tr>
<td>Sessions</td>
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</table>

Recognising Outcomes

Some of the key outcomes, thus far, have been summarised in Table 2, in considering the completion of different PMHWd modules.

The PMHWd programme is helping to realise a number of important outcomes in achieving and demonstrating the ‘Releasing Time to Care’ principle:
- an increase in the % time for patient communication by Band 6 team-members;
- an increase in the % time for care planning with the patient and a reduction in the % time for care planning away from the patient;
- at meal-times, an increase in the % direct time with service-users;
- a significant reduction in the time spent walking around the ward / unit, looking / collecting or returning patients or equipment by Band 5 & Band 6 team members;
- a significant reduction in the number of interruptions of Band 2, Band 5 & Band 6 team-members when providing direct care.
### Table 2: Summary of Outcomes for Selected Modules

<table>
<thead>
<tr>
<th>Category</th>
<th>Outcomes</th>
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| **Knowing how we are doing**           | - all wards / units have identified a local PMHWd team (champions)  
- all wards / units have developed and agreed a team vision statement  
- each ward / unit has agreed and is now monitoring a staff measure (stress levels) and a patient measure (individual sessions with service-users; incidence of aggression / violence) |
| **Well-Organised Ward (WOW)**          | - each ward / unit has 'WOWed' a number of rooms / areas within the care setting, in improving their organisation, which has had a demonstrable impact upon releasing time to care – this has involved use of the 6S technique (sort, set in order, shine, safety, standardise & sustain) |
| **Patient Status at a Glance**         | - patient information boards have been renewed / re-designed in promoting ease of access to accurate summary information relating to each patient’s care, which is supporting team communication and reinforcing the focus upon risk issues and patient safety  
- in some wards / units, the information board has been structured to reflect the layout of the ward, enhancing communication in the event of safety concerns |
| **Medicines**                          | - the re-design of medicines rooms has not only led to a better organised layout, but to a demonstrable reduction in the time taken for completing medicines rounds – this has involved use of the Spaghetti Technique *(a simple mapping tool to establish the optimum environmental layout, thus reducing waste)*  
- the re-location of the medicines room at Oakley Court has resulted in a significant reduction in verbal and physical aggression related to the medicines round (with no such related incidents since the re-location of the medicines room)  
- units / teams have developed and implemented standards relating to medicine administration, with a demonstrable reduction in interruptions to the medicine round, thereby enhancing safety during the administration of medicines, and the provision of a more personalised service |
| **Shift Handovers**                    | - the review of the shift handover has led to the introduction of a more focused handover, involving direct reference to the Patient Status at a Glance Board, and minimising interruptions  
- in some wards / units, there has been a reduction in the time spent within handover, thereby raising the efficiency of this team communication process  
- in some wards / units, changes have been made to the timing of the handover to maximise participation and promote access to service-user records / ensure access to an update on the service-user’s care  
- some wards / units have developed and implemented standards for practice in conducting handovers, thereby enhancing efficiency and effectiveness – for example, the handover at 105 London Road now commences with priority issues / service-users  
- at the Luton Mental Health Assessment Unit, the positive outcomes of improving the structure to the shift handover and
enhancing team communications, as a consequence of implementing quality practice standards, has been captured through a staff team survey

**Therapeutic Interventions**
- as a consequence of this module, the Townsend Court team have restructured their therapeutic programme, which involved a survey of service-user opinion on the content and timing of the programme, leading to demonstrable changes, thus enhancing access to a more meaningful programme

**Meals**
- as a consequence of this module, the Bedford Mental Health Assessment Unit (MHAU) changed practice in ensuring that service-users now receive meals within the MHAU rather than attending the main Unit dining room, and consideration is now being given to nutritional issues

*Releasing Time to Care*, achieved in part through more efficient and effective processes, is now being demonstrated as shown by the following two local examples:

- **the Medicines Round:**
  - at Townsend Court, the *time to prepare the medicines room and administer medicines to one service-user* reduced from 14mins : 49secs to 1min : 3secs
  - at Oakley Court, the *time for the full medicines round* reduced from 57mins : 23secs to 38mins : 13secs

- **the Shift Handover:**
  - at the Luton Crisis Resolution & Home Treatment Team, the *time for the Shift Handover* reduced from 47mins : 47secs to 30mins
  - at the Luton Mental Health Assessment Unit, the *time for the Shift Handover* reduced from 16mins to 11mins
  - at Townsend Court, the *time for the Shift Handover* reduced from 46mins to 30mins

For a number of the modules, the PMHWd programme has involved the design and implementation of brief audit tools with the ward / unit team, in demonstrating compliance with agreed standards for practice, as shown by the following examples:

- Patient Status at a Glance audit – at the two show-case wards / units;
- audit of Safe & Supportive Observations – at 105 London Road (recovery unit);
- audit of Shift Handovers – at several wards / units;
- audit of the Medicines Round – at several wards / units;
- audit of the Ward Round – at Townsend Court.

The design and use of such local audit tools, which are then shared with other wards / units, is assisting in the demonstration of compliance with some standards, and the identification of areas for further improvement, in other cases.
Further outcomes relating to the local PMHWd programme have included:

- the design and implementation of standardised care plans focusing upon aspects of assessment within the Assessment Units, which have recently been positively evaluated (March 2010);
- the design and use of specific zoning tools (a well-known clinical risk management method), which involves a daily review of each service-user’s risk status by the multi-disciplinary team, reinforcing a focus upon risk and patient safety and promoting the specific consideration of criteria that inform clinical decision-making in identifying and responding to risk – the service-user’s zoning status (based upon a traffic light method) now forms part of the information recorded on the Patient Status at a Glance Board, and an evaluation of this tool was recently completed (September 2010).

**PMHWd Programme: sharing learning (December 2009 – July 2010)**

One of the aims of the PMHWd programme is to share positive practice and learning, which has been achieved through contributing to a number of recent events / developments, including:-

1. **December 2009:** two workshops on the Medicines process module were facilitated by the Trust’s PMHWd Project Lead, PMHWd Programme Facilitator and the Unit Manager for Townsend Court at the first National Conference on the PMHWd Initiative, as organised by South London & the Maudsley NHS Foundation Trust.

2. **January 2010:** the Trust’s PMHWd Project Lead contributed to the PMHWd Conference organised by the NHS Institute for Innovation & Improvement.

3. **February 2010:** the Trust’s Acute & Crisis Mental Health Service was short-listed for a National Patient Safety Award 2010, for a submission (‘It’s better in Bedfordshire’) based upon three notable local initiatives: the PMHWd Initiative; the establishment of the Acute Assessment Units; and, delivering same-sex accommodation.

4. **February 2010:** the Townsend Court team were involved in the development of a new PMHWd module, entitled: Privacy & Dignity – delivering same-sex accommodation – this has now been made available as a series of supplementary module guides by the NHS Institute.

5. **March 2010:** the Trust’s PMHWd Programme Facilitator and the Interim Unit Manager for Oakley Court facilitated a series of discussions at a market-place style educational event on the PMHWd Initiative for the SDO Network, as arranged with the NHS Confederation – the local booklet that was prepared to show-case the PMHWd programme in Bedfordshire & Luton is now available through the NHS Confederation...
6. **March 2010:** publicising the progress of the PMHWd programme across the Trust within the NHS Institute PMHWd Series Newsletter (No. 7), with specific reference to the short-listing for the National Patient Safety Awards 2010.

7. **April 2010:** the NHS Institute for Innovation and Improvement visited Townsend Court in preparing a short film that show-cases the impact of the PMHWd programme – this film is now available from the NHS Institute web-site: [http://www.institute.nhs.uk/quality_and_value/productivity_series/delivering_same_sex_accommodation.html](http://www.institute.nhs.uk/quality_and_value/productivity_series/delivering_same_sex_accommodation.html)

8. **May 2010:** a number of wards / units prepared and displayed poster presentations to mark and celebrate International Nurses Day, and a poster was displayed in the reception area of the Trust’s Luton-based Offices, incorporating a summary of the local PMHWd Programme.

9. **July 2010:** International Visit to Townsend Court (show-case ward) by Dr Philip Tunes (Executive Director of Psychiatric Services / Acting Chief Medical Officer, Bendigo Health Care Group, Australia).

10. **July 2010:** a presentation on the Trust’s PMHWd Programme was facilitated at the Trust’s Nursing Forum, focusing upon sharing learning and the impact and outcomes of the programme to date. A local PMHWd Information Booklet was produced and made available for this event.

**Conclusion**

As summarised within this short paper, progressing the PMHWd programme within Bedfordshire and Luton is assisting wards / units to realise and recognise evident service improvement.

The expected benefit of releasing time for direct care is beginning to be realised and though further focused work is still required, this should be considered a credit to the participating teams, the local PMHWd Champions, the Trust’s PMHWd Programme Facilitator and the PMHWd Project Leads.

The PMHWd programme is proving to be a creditable example of implementing the 7 elements of the nursing roadmap for quality, driving forward quality improvement (DH 2010).

Some of the key strengths of the programme appear to be: the involvement of practice teams in implementing their own solutions; the focus upon agreeing practice standards and
implementing simple work-place audits; the focus upon measurement as a critical and integral component of quality improvement; supporting the development of meaningful local measures / metrics; enabling and strengthening the role of the ward sister / charge nurse; and, providing opportunities for the team to widely market and publicise positive practice, thus gaining recognition.

The next phase of work will be to enable the original show-case wards to progress the remaining process modules and then to move back through the service improvement stages independent of facilitation, sharing their knowledge and expertise with other wards / units across the Trust. Furthermore, the PMHWd programme is now being extended to other wards / units across the Trust.

Reference

For further information
1. http://www.institute.nhs.uk/

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Implementing the Star Wards Programme: the journey within an acute in-patient ward

David Roberts
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Star Wards is a project that supports wards to enhance the daily experiences and treatment outcomes for service users within in-patient services. Keats Ward has been progressing this programme over a three year period. Measuring service user experience of care has its challenges and the Star Wards programme provides a framework of good practice for in-patient mental health services (Janner 2006, Janner et al 2008).

The local Star Wards programme now recognises 108 good practice ideas which are integrated within a benchmarking tool. Use of the tool involves grading implementation by the ward using a simple traffic light scheme, where: red = not met; amber = partially met; green = fully met. The assessor works in conjunction with a member of staff. Though some of the evidence is anecdotal, some is based upon written evidence and some is verified through interaction with other staff and service users.

Keats Ward has been working towards meeting Star Wards good practice criteria, and though this journey has had its ups and downs, there have been identifiable improvements over the last year or so. During 2009, the team increased their implementation of Star Wards good practice ideas, moving from implementing only 38 in 2008 to implementing 63 good practice ideas in a re-assessment in Nov 2009. A number of improvements are highlighted in Table 1.

The changes observed at Keats Ward have been accompanied by a major management restructure and physical improvements to the ward environment. Furthermore, the ward is now participating in the Productive Mental Health Ward Programme. These work streams have positively impacted upon the improvements which have observed, though the commitment of the staff team to service improvement must also be acknowledged and commended.

Continued improvement in key areas is needed and a small team of staff on the ward agreed to take the lead in continuing the developments over the ensuing twelve months. Furthermore, more recently, it was agreed to integrate the Star Wards programme into the Productive Mental Health Ward programme.
**Table 1: Star Wards Good Practices at Keats – Improvements**

<table>
<thead>
<tr>
<th>Star Wards Good Practice Ideas</th>
<th>Local Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artwork commissioned, borrowed and displayed</td>
<td>Artwork produced by the service users is displayed in the notice-board.</td>
</tr>
<tr>
<td>Activity Coordinator assigned for Ward</td>
<td>Activity Coordinator is allocated on some shifts and a Star Wards Coordinator was appointed.</td>
</tr>
<tr>
<td>Patients can meet individually with a Pharmacist and Dietician</td>
<td>There is evidence of this occurring for appointments with the dietician.</td>
</tr>
<tr>
<td>Walking Group</td>
<td>This has improved over the two years since the first Star Wards Audit, with a walking group offered each morning.</td>
</tr>
<tr>
<td>Protected, Therapeutic &amp; Engagement Time for Nurses</td>
<td>Protective meal times and activity times are implemented.</td>
</tr>
<tr>
<td>Gender Specific Groups on the Ward</td>
<td>The Gender Separation policy has lent itself to providing care in separate areas.</td>
</tr>
<tr>
<td>Individual Ward Assistant Psychologist / Practice Development Worker</td>
<td>The ward has dedicated Clinical Psychology time.</td>
</tr>
<tr>
<td>7-day Therapeutic Interventions and Activities Programme is implemented</td>
<td>As part of the development of OT and Star Wards, individual plans are in place, though further development is needed.</td>
</tr>
<tr>
<td>Different Faith Festivals are Celebrated</td>
<td>This now occurs, reflecting the service users on the Ward at the time.</td>
</tr>
<tr>
<td>Patients have the option of doing a daily / weekly self-review (linked to weekly care review preparation)</td>
<td>This is linked to the revised procedure for weekly care reviews and review preparation.</td>
</tr>
</tbody>
</table>

**References**


Reflecting on the Capable Residential Team: 
the experience of a recovery service – 105 London Road

Harry Sookraj¹ & John Butler²
¹Unit Manager, ²Consultant Nurse (PSI)
¹Recovery Services, ²Practice Development Unit
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As the 105 London Road Team in Luton has recently been recognised as a highly performing team within the Trust, the Team Manager agreed to participate in a working group discussion to identify some of the important elements in ensuring effective team work. This service offers 12 beds for recovery and two respite beds.

Through a facilitated reflective discussion with the Enhancing the Patient Experience of Direct Care Working Group, the following key elements were identified in reflecting upon the ingredients of a capable and functioning team:

1. the team was formed from two previous teams (staff from both Leagrave Lodge & the former 105 London Road) which presented an initial challenge for the Team Manager – team-members were therefore actively involved in introducing a common system of working practices, focusing upon implementation of the recovery model;

2. staff-members are approachable and are described as going the extra mile;

3. responsibilities are shared between team-members through the adoption of lead / champion roles for a number of key practice initiatives, and contributions are valued, which has become an attitude that is now taken with service-users – this includes the active involvement of students, for example, in recently conducting the service-user survey and auditing of records;

4. the team budget is openly discussed within the team, with ideas from team-members being actively encouraged;

5. systems of practice which assure the quality of practice have been established – for example, record-keeping is of a high standard, with practice standards being directly monitored and quality assured through supervision as a routine practice, and, most recently, with the review of performance in care planning involving a component of self-assessment;
6. named nurses tend to work with about three named service-users at a time, thus managing and equitably sharing the team workload;

7. the team has a number of staff who may be described as *Star Performers*, which has been helped through an encouraging and motivating approach by the Team Manager & Deputy Manager, rewarding effort and effectiveness through feedback, praise and recognition, and through team social events;

8. active efforts are made to give attention to addressing even the minor issues that come to light, such that major issues do not even develop;

9. the team benefits from having strong administrative support;

10. the unit environment was re-decorated and refurbished to a high standard, being colour coordinated – it is now perceived as welcoming;

11. service-users have individualised programmes and daily meetings, which provides a strong focus for care;

12. coffee mornings are held for those service-users who have been discharged;

13. the Team Manager models a relaxed leadership style and positive behaviours, emphasises the need to develop and maintain good relationships / rapport and links with others, and adopts the principle of *don’t expect others to do something you wouldn’t do*, whilst empowering other team-members to lead on the completion of particular roles / activities (delegation), with effort and contribution being supported and reinforced though calm and positive feedback;

14. the Team Manager has good support from his own manager;

15. the Team have opportunities for team development through regular away-days;

16. visitors and children are invited to the Unit as an educational opportunity.

Providing the above ingredients means that the service is enjoying positive feedback from service-users and carers alike. More recently, the team joined the Trust’s Productive Mental Health Ward programme.

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Implementing a Carers Education & Support Group

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Introduction

The rationale and evidence base for establishing and facilitating a Carers Education and Support Programme for carers of people with mental health problems has previously been explored (Perkins & Martinez 2008). This is reinforced by a key recommendation of the Department of Health (DH 2009) that the training available for carers should be further developed.

In this paper, following the review of a successful pilot programme within the Luton People of Working Age Directorate between September and December 2009, the resources that may be needed to further develop and implement this programme is explored.

Background

My experience in facilitating Carers Education & Support Groups began during a previous role as a Specialist Carer Worker, employed by the Local Authority, in a Community Mental Health Team. Being one of only four such workers in the county, the main purpose of the role was to complete carers assessments and to provide ongoing support to carers in helping them to achieve the outcomes identified within their ‘carers care plan’.

In 2003, the Local Authority workforce development team commissioned a training package from Rethink (Carers Education and Support Programme), which included training in group facilitation for professionals and carers, training materials and supervision. In addition, the Mental Health Trust had been implementing family work (the Behavioural Family Therapy approach, using the Meriden Model (Fadden et al 2009)) since 1997, which had raised the profile of families and carers within the organization. Having the full support of the Trust, it was possible to roll out the courses across the organisation. After a year, the programme was managed independently from Rethink, and the structure and content was modified to meet local needs. At least one cohort of carer training was subsequently delivered in each locality, each year, which contributed to witnessing transformations for individual carers, for service users and for the service itself, as carers became better informed, supported and included.
Upon commencing my post as a Carers Worker in Luton from March 2009, I hoped that Luton carers would be able to benefit from a similar programme. Based upon my previous experience, I held three principles which I believed were necessary for a successful implementation: ownership of the programme by the organisation; carer involvement in planning and facilitation; and, facilitator training.

It was important that the organisation had ownership of the project, to avoid it being dependent upon or viewed as a project provided by one person. My line manager supported the implementation of the project and enabled me to request support from team members, which was provided by two team members who would be available for most of the sessions, and from clinical psychologists and psychiatrists who would facilitate discussions about treatment.

It was important to have a carer involved from the outset throughout the planning process, in ensuring a strong carer focus and perspective. I was pleased to be able to identify a carer who was able and willing to be involved as a co-facilitator, and she was included in the planning meetings. The carer was offered payment in accordance with the Trust’s User and Carer Involvement Policy.

Based upon my previous experience of receiving training in group facilitation, I felt this would be necessary for all group facilitators on the programme. I was also concerned about developing course materials as, again in my experience, we had provided participants with manuals containing educational material and other information. Though this seemed to present resource implications, discussion with my line manager helped me to realise that I possessed both the necessary skills to lead a team of colleagues in group facilitation and the knowledge of or access to the educational information required for the content of the programme. I had obtained agreement from my former employer for the course materials we had previously developed to be used for the programme in Luton, and started planning for a group to run during the autumn of 2009.

**Facilitating a Carers Programme: practice and resource considerations**

*Planning Meetings*
A series of planning meetings are needed before the course commences in working through the detail: the timing and content of each session; and, the role of each facilitator during the session. Ideally, a carer should be included in this as co-facilitator. Outside speakers need to be negotiated at this stage. It is useful to have a planning session half-way through the programme to modify any planned content in meeting the emerging needs of the group.

*Debriefing*
It is useful to make time for a debriefing session with the facilitators after each session, to reflect upon and review the evaluations from each weekly session.
Information
Information about the programme needs to be given to team members so that they can pass this information onto carers. Identifying carers to attend the group should ideally be conducted through carers assessments. Those carers who express an interest at the time of assessment can be asked about the time of day that would suit them and whether they are able to travel to venues, in order to plan a group accordingly. Consideration needs to be made for an evening group if carers are working during the day. If carers need to make alternative care arrangements for the person they care for or for others (for example: children) in order to attend the course, support for this could be considered through the use of a carers grant payment.

Venue
The optimum number for a group is between 8 and 12 carers, and the venue needs to be large enough for them to work in small groups. It is helpful if there is a facility for a second ‘breakout’ room which can be used if a carer needs to spend time by themselves. Sometimes it is helpful to hold the meetings in a non clinical setting, although there may be a cost to this, and practical considerations such as public transport and car parking need to be addressed. Consideration also needs to be made for the provision of refreshments, and from which budget it will be funded.

Course Materials
These can be developed from various sources including using knowledge from within the team, and can be provided as session handouts for the carers to retain in a folder. Carers will have different needs about the type and level of information to be provided, and access to the internet will be varied. It is also helpful if a library of books and other materials can be provided for the length of the course – for this group, it was fortunate to have on loan a selection of relevant books from the Luton Carers Centre, which were well used. Currently, there is a limited range of DVD material to support carers education, though this is constantly developing. Planning for and preparing technical equipment is also necessary.

Outline Content and Structure of Programme
As shown in Table 1, a 10 session programme is provided, incorporating a break at the midpoint (it is often helpful if this falls in school holidays). Each session lasts for 3 hours, with a break. In general, this has been a comfortable time span to which participants are willing to commit.

The first session is spent agreeing ground rules, understanding and agreeing confidentiality, before each carer talks about themselves or the person they are caring for. Hopes and expectations for the group are then established, which are revisited at the end of the programme. For most participants, it is the first time they have met other carers and, once people feel safe, they can relate to each other and discussion is usually spontaneous. This
is further encouraged by showing a DVD of carers telling their stories and experiences (Wakefield 2009), then setting the scene of the topics for discussion in the programme.

Table 1: Group Programme

| Session 1 | Ground rules and confidentiality.  
|           | Introduction to each other and the programme.  
|           | Hopes and expectations.  
|           | DVD: ‘A carers’ experience’ |
| Session 2 | A presentation by a mental health service user in recovery.  
|           | Definitions and Causes of Mental Illness. |
| Session 3 | Treatments for mental illness, including medication and talking therapies.  
|           | The Recovery Model. |
| Session 4 | ‘The Carers Journey’ – led by a carer facilitator.  
|           | Dealing with loss and grief, developing hope and coping strategies. |
| Session 5 | Stigma and stereotypes - service users, carers and professionals.  
|           | Partnership Working.  
|           | Local Mental Health Services.  
|           | The Care Programme Approach. |
| Session 6 | The Impact of caring.  
|           | Changes in role.  
|           | Communication skills.  
|           | Relapse management and coping with uncertainty. |
| Session 7 | Setting your goals and how to achieve them.  
|           | Problem solving.  
|           | Coping with a crisis. |
| Session 8 | Open Session: used for a speaker or an activity, as requested by the group (for example: drugs and alcohol / dual diagnosis, personality disorder, self-harm, experiential exercise on ‘hearing voices’, psychotherapy, rehabilitation services, ECT, support for young carers, personalisation). |
| Session 9 | Caring for Ourselves – action planning.  
|           | ‘Carer Involvement’ in stakeholder meetings, staff training etc… |
| Session 10 | Follow Up Session (held about 6 weeks after session 9)  
|             | This can involve a Q&A session with Managers.  
|             | Planning the future of the group. |

The second session begins with a service user who is recovering well coming along to the group to talk about their experience. This is intended to give carers hope about the prospect of recovery, as many carers will not have experienced it with the person they care for. Fortunately, a service user was found with the help of Impact, the local service-user network, and although he had not done anything like this before, he was able to talk about his experience of being unwell, speaking positively of his involvement with services. He also spoke candidly about his mother’s response to his illness when it started, which was not helpful, then showing how this changed and how it contributed to his recovery. The service user was paid in accordance with the Trust’s Policy.
The following sessions focus on the service user’s experience – for example: mental illness; treatments (with presentations by clinical psychologists and pharmacists); and, the Recovery Model.

In the fourth session there is a shift to focus on the carers and their needs. This was facilitated by the carer facilitator describing her ‘journey’ as a carer, the different feelings she had and how she coped, and her experience of contact with services. This helps carers to reflect on their own experience and emotional journey. During the following sessions, this is explored in more depth, introducing ideas of loss and grief, changes in role, the response of other family-members and wider society, and stigma.

In order to support carers from the ethnic minorities in the group, support was provided from a worker from the Roshni Asian mental health service, helping participants to feel confident in talking about the difficulties they have had arising from different understandings of mental illness in their community, the role of religious or traditional advisors and the advice they give, as well as the specific stigma of mental illness.

Other sessions provide opportunities to develop skills in managing the caring role through enhancing communication skills, through role play and using case examples to practice problem solving techniques. A workshop on stigma and the stereotypes of service users, carers and mental health professionals was facilitated in highlighting that by being aware of and challenging these barriers and developing partnership working, there are better outcomes for all involved.

The final session is fully focused on the needs of the carer, with the opportunity to write down their SMART (Specific, Measurable, Achievable, Realistic & Timed) action plan, and there is a meeting with the Stakeholder Manager to inform carers about the various ways they can be involved in planning and developing services.

**Evaluation**

A modified version of the Trust’s training evaluation form was used to evaluate the programme. This was used at the end of each session in gaining feedback every week. This weekly feedback proved to be very positive. Furthermore, an overall programme evaluation was conducted at the end of session 9, which similarly reflected the positive value of the course.

The original Rethink model has a final ‘Panel Meeting’ conducted 6-8 weeks after the end of the programme, when various significant representatives in the Trust or community organisations are invited to answer questions from speakers. However, if there is significant involvement from these individuals in the programme itself, this may not be needed, and particularly if carers are aware of and invited to any existing forums to approach the decision makers in the organisations.
It is very common for the group to want to continue to meet after the final session. This may be informal for friendship or support for that cohort, whereas others may develop a wider support group or campaign organisation.

After the end of session 9, the carer participants made the following statements as part of their evaluation:
- ‘There are others like me!’
- ‘I found out I am not alone and it’s good to talk and listen to other carers.’
- ‘I learned good ideas from others carers views and experiences.’
- ‘There are experiences of others that seem more to cope with than myself, which gives me strength.’

**Comment from Carer Facilitator**

‘As a carer, these groups are essential. I have learnt so many aspects of mental illness from the effects it has on the individual, family and friends, who to contact in an emergency to what benefits a carer can claim. By having guest speakers e.g doctors, pharmacist, psychologist, members of the crisis team, all help towards understanding mental health. It is about putting questions to the people who understand the medicines and the various treatments involved in making the service user feel better and start to build their confidence and to start enjoying life again. The groups also make you realise that there are other people in the same position and you are not alone, and from this knowledge you can be stronger and build a network of new friends.’

The group which had been meeting in Luton, met again in January 2010 for their last session. There was already a strong commitment from the members to keep the group going and for it to be the start of a support group for other carers of people with mental health problems in Luton. There has been a lot of support from the statutory and voluntary sector for this group, that it will be the start of a strong independent support group and voice in the town for carers of people with mental health problems.

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For further information, please contact Catherine: [Catherine.Aganoglu@sept.nhs.uk](mailto:Catherine.Aganoglu@sept.nhs.uk)
The Emerging Use of Football within Mental Health:  
*uniting people towards a common GOAL!*

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**Introduction**

Legendary football manager Bill Shankly is famously quoted as saying that football is more important than life or death. He probably said this tongue in cheek, but nevertheless his words bear some relevance today as emerging literature shows that football can have a major impact on mental health, improving lives and in some cases saving them.

Shift is an initiative that was established in 2004 as part of the Care Services Improvement Partnership (CSIP). It is a government funded organisation designed to break down stigma and discrimination in mental health. A strong partnership has been formed between Shift, the Professional Football Association, the Football Foundation (FF), the Premier League, the Football League Trust, Sporting Chance and the University of Derby, which has resulted in the *Mad About Football* campaign. In 2008, *Mad About Football* held a conference and a tournament. The conference was attended by, amongst others, BBC’s Ray Stubbs, former professional footballers and Louis Appleby, the former Department of Health’s National Director of Mental Health. The tournament comprised of 32 teams from all over the country. Speaking at the tournament, former England captain Tony Adams said that football had saved his life on many occasions. He also said, on a more simple level, that football is about helping out your mate ([www.shift.org.uk](http://www.shift.org.uk)).

Various football initiatives have taken place within mental health for some time, and not just in the United Kingdom (UK), but globally. In the UK, for example, there is the CSIP league in Manchester which formed in 1999 and comprises of thirty teams from the North West of the country. In Italy, there are fifty teams from across the country playing each other regularly as part of the Gabbiano club, formed by the psychiatrist Mauro Rafaelli in 1993. Half of those taking part now need less antipsychotic medication than they did previously (FIFA 2008). Football initiatives within mental health are springing up all over the country. These initiatives include watching football matches, social ‘kick abouts’ or more competitive leagues and cup competitions.

Participating in something which young people can connect with normalises the point of contact and, as a result, many modern Early Intervention Services in England are developing football groups and teams. Young men often find it hard to ask for help when
they have mental health problems. Men have a tendency to externalise their problems, perhaps through crime or violence (Prior 1999). Low rate of contact can mean high risk to life. Football can break down barriers and bring people together – it can provide a vast array of other benefits as well. It has the physiological benefits of reducing weight gain, improving cardio-vascular efficiency, releasing endorphins and improving posture. It has social benefits such as meeting new people, integrating into a kind of family within which they feel a sense of belonging and safety. It can unite people towards a common goal, providing psychological benefits such as improving self-esteem, helping people to respect themselves and others. Inclusion, human dignity, hope and self-directedness, concepts fundamental to the recovery model, can so easily be applied to those taking part in football (Clarke 2009).

It may not be long before football is recognised as an essential part of mental health care. Those involved are already frustrated that some see it as just an ‘add on’ to the service already provided (Pringle 2009). Not only can it be used as a means of engagement for young people but some services are taking things one step further and using football as a metaphor for group work. This idea was originally piloted in the Moss Rose stadium, home of Macclesfield Town, encouraging young men to think about how they act and interact on the playing field and relating this to their life outside of football (Pringle 2004). This scheme has been expanded and now runs also at larger clubs such as Plymouth Argyle and Manchester United.

The idea of football as a metaphor is not a new thing. As discussed by Clarke (2009), the existentialist philosopher and writer Albert Camus, himself an accomplished goalkeeper in Algeria, frequently used his football experience to describe the absurdity, the morality, and the unpredictability of life and from it how we learn about respect, personal integrity, and helping each other out.

It is poignant perhaps that the 2010 world cup was held in South Africa. Football has already been used successfully to address racism and violence throughout the world. Perhaps in the years to come, the power of football can be used to combat discrimination in mental health in the same way it has helped to fight other prejudices.

**The Luton Town Onetouchables – the Early Intervention Football Group**

The Bedfordshire Early Intervention Service (EIS) Football Group, now part of South Essex Partnership University NHS Foundation Trust (SEPT) began in Spring 2009. It came about because many young men were telling their EIS care coordinators that football was one of their major passions and one which they had been unable to take part in for different reasons. The first game involved three staff members and service users making up two five a side teams and playing each other outside on artificial grass. After immediate success, games took place on a fortnightly basis. Post-match socialising in the sports bar for a re-hydrating drink and a game of pool have now become the norm.
The ethos of the group is providing a supportive environment in which young men with an interest in playing football come along and feel accepted. Some of the many benefits of football have been discussed above. Another aim of the group is to provide a starting point whereby participants can build their confidence to either join a mainstream football team or achieve other life goals. For example, two participants have since found full time work, two have joined main-stream football teams, two have stopped smoking and several have lost weight and feel fitter. Twenty three young male service users have participated at some level since the group’s inception.

We originally made contact with the Bedfordshire Football Association (BFA) through Luton Town Football Club (LTFC) and have now formed our own club, The Luton Town Onetouchables, affiliating it to the BFA. The BFA Community Disability Coach, Les Dedman, has begun to run training sessions which are improving players’ skills in a fun environment and we are also attempting to get a women’s coaching session off the ground. We have also recently joined the BFA Ability Counts League where we play competitive games on the last Friday of the month. The league runs through from May to November and the feedback from the players thus far has been excellent. The BFA have also been supportive in discussions for some players to complete a first level FA coaching course, which will allow the players to run the group themselves or coach junior players at a main-stream club.

On March 28th 2010, the Bedfordshire EIS organised a five-a-side football festival, the Anglian Cup, which was first held at the University of East Anglia in 2009. This involved fourteen teams of services users and staff from across the South Eastern region of England. Many of the teams were from EIS’s, but other mental health services and local homeless services were also represented at the event, which took place at Playfootball in Stopsley, Luton. The success of this tournament, supported by Shift, LTFC and BFA, has been widely reported in local press releases and an article appeared in a LTFC match day programme. We were lucky enough to have LTFC favourite, Keith Keane, on hand to present the trophies and medals on the day, and The Onetouchables were given a loan of a LTFC kit to wear. Making local partnerships with professional football organisations has proved invaluable and other EIS’s have done likewise. Ipswich Town will support Suffolk EIS in next year’s Anglian Cup, which has the potential to become a national event.
Matt’s experience of the football group

I joined the football group in around March 2009. Going out to play football is perhaps a bit daunting but the football group provides a relaxed environment with people who may have similar problems to yourself. Low confidence and stigma may hold back people from joining such groups as the football one, but I am glad I joined. The most comfortable aspect to the group is perhaps the relaxed environment as I did go to a different football group as well but the atmosphere was different for me and was not right at the time. The EI team football group was a good beginning for me as it had a good starting atmosphere.

There are usually enough players to form a team for tournaments. The EI staff sometimes play as well as service users. We usually meet at the Brache in Luton to practice and every now and then the group enter a football tournament.

There was the tournament in Norwich at the University Sports Ground in the Spring of 2009. We started in a sort of group league and played three games and advanced before winning the semi-final. We played the Norwich team in the final and despite a good start we went on to lose the final 5-3, which was our only loss in the tournament. It was a good day overall and I enjoyed it. It was for me the first time I had felt part of a team for a long time and there was added camaraderie in that we travelled to the tournament together in a mini-bus, so it was more of a shared experience.

We also played in another tournament back in October 2009, which was part of the Well Being Festival which coincided with World Mental Health Day. The tournament took place in Marston Moretaine. We played various games, finishing 3rd overall, which again was a tournament I enjoyed. In the future there is an upcoming friendly to be played before Christmas as well as perhaps another tournament that will take place locally and will be played next year.

It is tough sometimes to get exercise if you are often indoors for long periods of time. The football group has improved my fitness greatly. When I started I could play only five to ten minutes before needing a rest and my muscles would hurt for days afterwards. Now I can play for 40 minutes to an hour without any muscle pains in the following days.
We have recently had professional coaching from a certified FA coach which I hope will improve my play. In the future there may be an opportunity for team members to gain coaching badges and qualifications.

I have found many benefits in being in the football group. I used to be picked up to go to football but have enough confidence and motivation to make my own way there now from 25 miles away. It provides an escape from everyday life and thus it is something to look forward to and I would definitely recommend the group to others, whether they are looking to increase social skills, get more exercise or just get out and about a bit more.

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Discussion Paper

Practice Assessment: supporting and assessing mental health student nurses in a constantly evolving practice environment

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Introduction

All students undertaking the mental health nursing programme for registration are required to demonstrate a range of skills together with associated knowledge to enable evidence of their progress to be formally assessed and recognised. One of the most challenging aspects of this process is that of assessment within a range of practice placements throughout the programme. The responsibility for this lies primarily with mentors who have been prepared through a programme of study to enable them to facilitate this process.

As practice accounts for 50% of the formally recognised credit for the programme, it is important that this process is seen to be rigorous, appropriate and supportive in enabling the student to develop and subsequently demonstrate the knowledge and skills to provide the evidence necessary for the assessment process. It is also important in ensuring that the student develops sufficient knowledge and skills to practice as a competent mental health practitioner beyond the point of registration as a qualified practitioner.

A challenging issue for both universities and practice placements that has arisen as a result of the changes in mental health provision is that of a continuing reduction in this provision, specifically in the area of acute units. Between 2000-01 and 2005-06, there was a reduction of 18% in bed availability in mental health provision (www.parliament.uk 2007) although the number of mental health nurses entered onto the NMC register increased: to 87,739 in 2006 (Longley et al 2007). The organization and management of student practice has become a problematic area in attempting to ensure that nursing students receive an appropriate and effective range of placement experiences. It may be pertinent to acknowledge that Patzel et al (2007) have noted a similar challenge in the US where a shortage of nurses has led to an attempt to increase numbers (including in mental health) but this is proving problematic given a continuing reduction in acute care settings in mental health.

An associated issue is the ongoing debate in this country regarding whether a generic programme of preparation for nursing practitioners is ‘best’, with notable differences in the approach within the US, UK, Ireland and Australia, as examples where a range of models exist. The one-year Common Foundation Programme (CFP) plus two year specialist Field Programme favoured in the UK has both supporters and detractors. Snelgrove (2004), in a
small study, suggested that students initially appeared motivated just to ‘get through’ early in the programme. Students undertaking mental health nursing were identified as primarily deep learners, with more surface learners in the adult group. Delacour and Curry (1991) indicate their concerns regarding the introduction of the generic model in Australia as ‘psychiatric nursing has been devalued and seriously marginalized’, and they suggested that practice in adult compared to mental health differed by a ratio of as much as 5:1.

**Practice Assessment**

The ultimate responsibility for determining that the student has demonstrated evidence in mental health practice that is related to their knowledge and skills lies with the mentor within the practice area. They can however call upon a number of other individuals for advice and support as required, including: co-mentor; practice colleagues; link lecturer; practice educator / practice education facilitator.

Despite the support available and responsibility imbued in this role, criticism has previously been directed at the difficulty that some mentors have appeared to encounter in assuming responsibility for referring students who have not provided sufficient evidence to enable them to be awarded a pass grade (Duffy 2003). This is an area that has attracted a large degree of attention and is quite effectively addressed in the work by Marsh et al (no date) as part of the Making Practice-based Learning Work project. Evidence suggests that providing students with a positive outcome regarding their practice assessment evokes few problems for mentors (Welsh 2003) but assuming responsibility for failing a student in their practice assessment appears to be more problematic (Duffy 2004). The Nursing and Midwifery Council (NMC 2008) also recognise that mentors may find failing a student within a practice placement difficult but indicate that whatever the decision reached, it must be evidence-based.

Allan and Smith (2009) suggest that the student’s differing perception of what nursing is compared to the qualified nurses they gain their practice experience with is also an issue of concern. The continuing change in emphasis with the focus on ‘recovery’ (Longley et al 2007) adds to the need for continued support for both students and practice colleagues throughout this transition.

Consideration must also be given to the range of practice areas within which the student will be undertaking their experience. The student will encounter a large range of practice areas, service users and practice staff over the course of the three years. By contrast, the number of university staff they meet is likely to be much smaller and generally consistent throughout the programme. This is an important element when considering the degree of support that students may require in practice, particularly during the early part of the programme. Higgins and McCarthy (2005) emphasise the importance of supportive mentoring in the student’s first practice experience. As an adjunct to this, Wilkinson (1999) comments on the importance of an effective link between the educational institution and the practice learning
setting. The developing role of personnel such as Practice Educators (PEs) and Practice Education Facilitators (PEFs) is in recognition of this need and assists in reducing the academic site – practice placement divide.

Chambers (1998) noted that the assessment of students in practice contained a major element of subjectivity given the lack of consensus about the meaning of competence. The perception of some students is explored by Calman et al (2002) who, in their article, indicated that the students perceived that assessment was open to bias and ‘the over-riding comment was that the assessment provided depended on “how well you fit in”’ (Calman et al 2020: 521). This theme is prevalent in the literature and the ethics of passing students who have not provided evidence of competence is explored in some detail by Gopee (2008). An alternative view is presented by Cassidy (2009: 38) who explores the idea of valid subjectivity and a partnership based relationship between the mentor and student to enable ‘a more comprehensive assessment of practice outcomes’.

The interactions between students and staff, including mentors, is regarded as critical in assisting students to cope with the myriad of situations, including challenging ones, that they will encounter during their practice placements (Stuart 2006). Initial impressions at the commencement of a placement may also support or hinder this process (Wallace 2003). Wood (2004) highlights the perceived difficulty that many mentors had in finding sufficient time to support their students due to their practice workload. This could be particularly problematic in the student’s final practice placement, given the additional responsibility and criteria that the sign-off mentor has to meet regarding responsibility for determining the student’s proficiency (NMC 2008).

In her essay on the experience of being a student nurse, Greenwood (2003) indicated one of her ‘guidelines’ to be: ‘I would like those in the clinical settings to be encouraging students rather than attempting to degrade their efforts by dismissing their academic research based interest in the subject of nursing’.

Price (2007) explores the complexity of assessing the student in practice and the need for clear guidance regarding what should be assessed, when, how, and to what standard. It might also be prudent to identify the developmental sequence of this activity – for example: the importance of an initial meeting between the mentor and student to identify the current experience, expectations and possible reservations of the student upon entering the placement. Gray and Smith (2000) indicated that students stated that a ‘good’ mentor would explore with them their abilities and planned outcomes for the placement on the first day of the experience. If this is not possible, for whatever reason, it should be completed as close to the commencement of the placement as possible.

Schostak et al (1994), in the ACE project, indicated that: ‘Most assessors have had only limited training for their role, and are unused to discussion of the relationship between the principles of practice they apply in their own clinical area and the operation of those
principles elsewhere’. This concern was based on the premise that assessors have an understanding of their own specific place of practice, but little regarding the student’s previous and subsequent experiences to enable them to support the student’s transfer of knowledge and skills contextually.

A different approach to practice assessment has been attempted with the introduction of service users as assessors. Stickley et al (2010) identified both positive and negative reactions to this approach. Some of the reactions were considered to be partly as a result of the student’s feelings of powerlessness and, in their summary, an interesting observation was made: ‘Academic teachers and health professionals need to be more aware of the felt vulnerability of their students and to devise ways of bolstering their confidence and resilience’ (Stickley et al 2010: 24). A practical approach is taken by Illingworth and Singleton (2010) in their book exploring mental health nursing and, in particular, the various components of a programme that students undertake in preparation for registration. They highlighted an important point: ‘Do (although it may not be possible on every placement) try to spend time with service users before reading their notes as you can form preconceptions that affect how you behave around or think about someone. Getting to know service users challenges these perceptions’ (Illingworth & Singleton 2010: 109).

Vulnerability is another theme identified by Ferns and Meerabeau (2008, 2009) in their research into verbal abuse and the reporting behaviours of students who experienced abuse. It is important to emphasise that although the mental health practice environment was mentioned within one article, it was not the only area in which students experienced abuse, with others including general medical and surgical environments. This is important to ensuring that a balanced perspective is retained as, anecdotally, mental health environments are thought of by some individuals as the areas where students are most likely to be at risk.

Conclusion

As the practice of mental health nursing continues to evolve and become more complex in its demands on those providing support to services users with mental health problems, then it is imperative that the next generation is ‘fit for purpose’.

As a greater proportion of care is now delivered in a community-based setting, including the service user’s own home, the ability of the mental health nurse to have the knowledge and skills to assist and support both service users and other professionals in these settings is essential. Leach (2009) identifies the constant change in dynamics between professional groups and service users and, therefore, there is a need to be flexible in delivering a curriculum that enables the encapsulation of this change. The three years that a student currently undertakes their preparatory programme allows them the opportunity of acquiring the rudimentary knowledge and skills to start practice as a safe practitioner. Universities and practice areas share the responsibility of ensuring that everyone involved with the student in
their preparatory journey has the necessary knowledge, skills and confidence to appropriately support this process.

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