

# Clinical Engagement and Risk Assessment

Acute Mental Health Services  
Practice Development Project

**Centre for Research in Nursing and Midwifery Education**

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## Summary

This is a report from practice development work carried out between summer 2005 and spring 2007, developing a collaborative model of a mental health trust (Sussex Partnership NHS Trust) and a higher education provider (University of Surrey) integrating staff learning and service improvement, supported and documented through an action research approach.

The practice development focused on developing skills and clinical support practices around risk assessment and management, and the engagement skills of nursing staff in clinical one-to-one (1:1) encounters with patients.

The project addressed a number of key recommendations presented in the 2006 publication on mental health nursing from the Chief Nursing Officer: *From values to action* (DoH 2006). Among key concerns highlighted in the document and addressed in the practice development project reported on here are:

- The need to implement the principles of the Recovery Approach in every aspect of mental health nursing practice.
- The need for mental health nursing staff to be developing and sustaining positive therapeutic relationships with service users.
- The need for mental health nursing staff to increase the time (and the quality of this time) they spend in direct clinical contact.
- The need for mental health nursing staff to be trained in risk assessment and management and work closely with service users to develop realistic care plans.
- The need to develop structural and professional aspects of care provision and improvement, reviewing career structures according to local needs.
- The need to strengthen relationships between higher education institutions and service providers.

The report presents an innovative model of Trust-University collaboration to develop sustainable improvements with regard to the above issues. As such, it addresses the ambition presented in the publication from the National Institute of Mental Health in England (NIMHE) *Acute Inpatient Mental Health Care: Education, Training & Continuing Professional Development for All*:

‘The overall aim is to make in-patient services examples of lifelong learning cultures, which may improve service users’ expectations from an in-patient stay and help to retain staff or attract practitioners back into in-patient practice’ (Clarke 2004: 5)

The project took an action research approach to practice development and included three phases:

1. *Inquiry and preparation phase* where, in consultation with Trust and ward managers and staff, it was agreed for the project to focus attention on risk assessment/ management and strengthening engagement skills in 1:1 clinical encounters.
2. *Learning and intervention phase* to provide teaching interventions to support the development of skills identified as relevant to identified areas.
3. *Follow-up phase* to support the learning in practice and make sustainable their actual implementation in the clinical environment and care management.

The project provided a two-day workshop on risk assessment and engagement skills that was delivered to 77 staff, capturing all nursing staff. Individual follow-up in practice

was arranged to be 'cascading' through from more to less experienced staff, targeting Charge Nurses – 17 individuals were supported in this way. The process highlighted a need to strengthen clinical supervision for nursing staff and strengthen (or establish) career and managerial structures that explicitly value and support clinical engagement skills.

Concrete improvements in clinical work and organisational practice were achieved in these areas:

- Formalising and improving 1:1 nurse-patient sessions
- Freeing nursing staff to focus on patient contact
- Nurses involved in the Therapeutic Programme

Furthermore, the project highlights the need to further explore and develop structures that (more easily) facilitate Trust-University collaboration over the design, implementation and documentation of learning and support in the workplace that is 'tailor-made' to meet local requirements for service improvement.

The report presents these recommendations:

- Wards to continue developing and strengthening support for regular clinical support and supervision to staff on acute mental health wards, including suitable managerial and working structures (e.g. shift patterns and procedures/agreements to drive and document clinical supervision).
- Mental Health Trusts, wards and Universities to continue collaboration over developing teaching and learning opportunities and interventions that support staff's professional development and contribute to service improvement needs.
- Conversations to be had involving the SHA, Trusts and Universities over the practical procedures and financial and staff resources needed to support a more flexible and needs-adaptive approach to learning and practice development.

## **Introduction**

The project originated in the summer of 2005 on the background of conversations between the European Institute of Health and Medical Sciences at the University of Surrey and senior managers in the Sussex Partnership NHS Trust, particularly the then Acute Mental Health Services Manager (Alex Jones) who had previously worked as a Practice Development Facilitator assisted by the University team (Larsen et al. 2005b).

Some unused funding was available from this earlier collaborative practice development project, and the two parties intended to set up a focused intervention in North Sussex acute mental health services, including: Rose Ward (Horsham) and Villa Ward and Downsview (Haywards Heath). An important structural rationale for providing training and service improvement across different ward areas was to start developing an integrated clinical environment in preparation for the planned re-housing of all the North Sussex acute mental health services in new purpose-build facilities in Crawley in 2008.

From the beginning, the intention was to build on the previous experience and University-Trust relationships, as well as the existing evidence base in the literature, to facilitate changes in clinical working practices sustaining service improvement and better patient care.

## **Background**

Practice development initiatives have shown that although skills-focused interventions can have important effects in upgrading staff knowledge and capabilities, these and other valuable skills in the workforce are not always sufficiently utilised and implemented in the practice culture. Existing evidence suggests a need to shift from a technical to an emancipatory practice development approach (Manley and McCormack 2003). Similarly, a study of change and service improvement in medical practice recommended that:

‘[E]ducation providers should develop more multifaceted strategies, integrating their activities with the broad range of other factors that affect changes in clinical practice. Education should not be viewed as a stand alone activity.’ (Allery et al. 1997)

Another difficulty with practice development initiatives has been that rather than being experienced as a solution to the challenges of clinical practice, they can at times be experienced by staff as an extra burden in an already stressful work situation. By defining new aims and targets, practice development initiatives can distract staff from the day-to-day work and the all-important clinical engagement with patients. Such practice development initiatives are often driven ‘from the top’ by external policy demands in an attempt to introduce a ‘quick fix’. At times, the initiatives are not sufficiently followed through to secure sustainable implementation to improve patient care. As a result, staff may feel that their skills and practice are not being recognised and valued. While practice development initiatives seek to inspire, prepare and define improved patient care, they can, for these reasons, have the opposite effect of frustrating the workforce – with implications for staff morale and retention.

As pointed out in the NIMHE report *Acute Inpatient Mental Health Care* (Clarke 2004) on the needs for improvements in acute mental health education and Continuing Professional Development (CPD), there is a need to take a holistic, strategic and long-term perspective to make effective and sustainable improvements:

'Developing capacity for ongoing learning and development in acute in-patient care involves more than just changing processes and refocusing activity. A range of educational and learning activity is required to improve the skill and knowledge base of practitioners. Neither the education or service providers have significant amounts of capacity at present to meet these needs. A long-term view on how to develop and sustain learning activity is required.' (Clarke 2004: 33)

Experiences from work-based learning and practice development initiatives (Larsen et al. 2005a, 2005b) suggest that rather than taking a merely technical and skills-focused approach considerable attention must be given to address the clinical practicalities of care management (Richards et al. 2005). Staff need not only to have the necessary skills, but also to be in a position to use these skills in patient-work, and to have them recognised and valued in the team environment.

The project reported on here was set up in acknowledgement of the fact that it is necessary to provide a supportive culture of care, where the strengths of the workforce can be used to create benefits for patients. Furthermore, it was recognised that there is a need to provide an evidence base to support the design, implementation and documentation of the project.

### **Project objectives**

The objective for the practice development project was to investigate the skills and resources available in the workforce and set up a supported work-based learning programme to develop clinical practice in a supportive team environment. The project started from the assumption that valuable knowledge and skills are available in the existing workforce, and the intervention seeks to supplement and support these.

Utilising staff resources was thought to contribute to high-quality and sustainable practice development that is grounded in the team and driven by their interests and motivations. This practice development project would, it was hoped, be 'owned' by the team and contribute to boost morale and job satisfaction that are central to a therapeutic environment that is conducive to patient care and recovery.

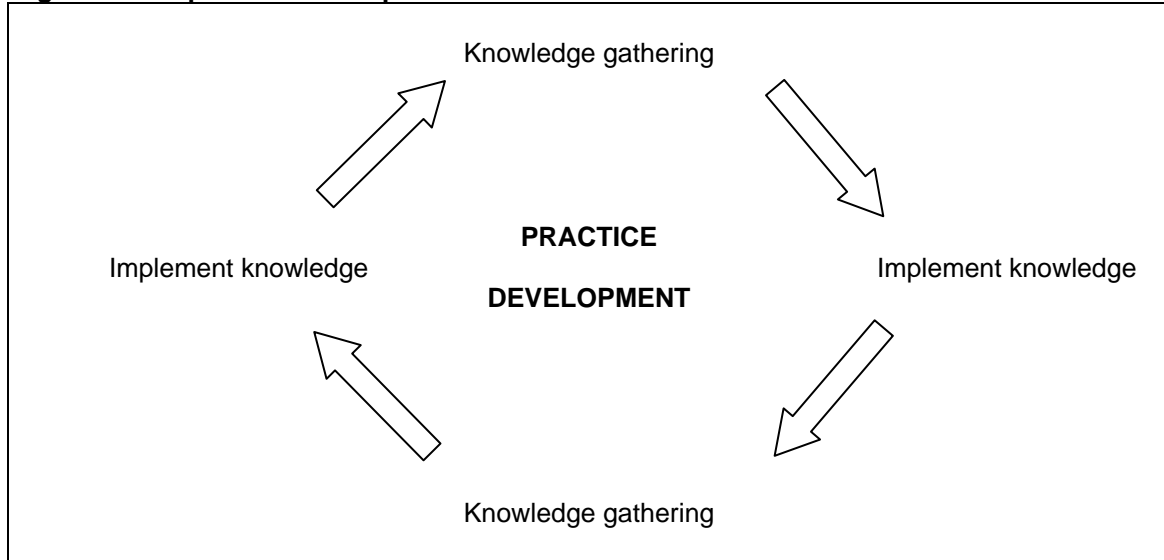
The aim of the project was to stimulate a practice culture where people's skills and resources were identified and supported in order to deliver effective patient care. This approach was expected to have further implications for the environment and treatment ideology in mental health services where the therapeutic work has a similar focus on helping to identify, value and utilise the resources and skills of patients to benefit their recovery (e.g. Barker 2001). The project sought to encourage and strengthen a practice culture that focuses on respect and positive recognition of individuals' resources in order to support these and let them be utilised in the wider environment.

### **Project design and implementation**

The project was designed in accordance with an action research and participatory approach integrating phases of clarification and knowledge gathering with phases of targeted implementation in a feedback circular movement towards practice development (Bate 2000). This approach is designed to draw on existing resources and utilise these to build further resources to achieve sustainable improvements of patient care. When

applied to the practice development process the action research circle takes the shape as illustrated in Figure 1 (below).

**Figure 1: The practice development action research circle**



The active involvement of staff at all levels was seen to be key to the success of the process, both in respect of knowledge gathering and the implementation of this knowledge to improve practice.

This collaborative approach to practice development and research sets up a structure to achieve and capture the higher levels (two, three and four) in Kirkpatrick’s (1967) model of educational outcomes, as illustrated in Table 1.

**Table 1: Kirkpatrick’s (1967) model of educational outcomes**

Level of outcome	Type of outcome	Description
One	Learner reaction	Learners’ views on the learning experience
Two	Acquisition of learning	Changes in knowledge, skills, competencies and attitudes
Three	Behavioural changes	Transfer of learning to workplace behaviour as a result of an educational intervention
Four	Changes in organisational practice	Changes to the organisation of professional practice as a result of educational intervention

(Referenced in Reeves [2001: 535])

The project included three key phases:

1. *Inquiry and preparation phase* where the project plan was decided in consultation with Trust and ward managers and staff.
2. *Learning and intervention phase* supporting the development of skills identified as relevant to the acute mental health wards.
3. *Follow-up phase* to support the learning in practice and make sustainable their actual implementation in the clinical environment and care management.



### *Inquiry and preparation phase*

In the first instance the project directed attention to map out the skills and resources of the team, in order to identify relevant areas of focused work-based learning intervention. This phase of the project was particularly prolonged as key changes were happening at managerial levels in the Trust. This meant that the University team on a number of occasions had to involve managers in the project and start afresh on developing a common agenda for the project's focus and objectives.

Through negotiations between the trust managers and the University team it was agreed for some initial funding to be provided for setting up a model for the educational provision and action research design. From August to December 2005 the project team held a series of project meetings with clinical managers and the Acute Mental Health Services Manager, where the project objectives were discussed. In addition, a University practice educator (BB) and researcher (JAL) conducted a series of individual interviews with staff on the three wards (Rose, Villa and Downsvie) to inquire about their practice development needs. Following this consultation process it became apparent that there was a need to focus on risk assessment/management and engagement with difficult patients.

This focus was further developed and consolidated on a workshop on 7 April 2006 for ward managers, charge nurses and senior staff nurses from the three wards. The workshop combined discussions in small groups divided across the wards with broader discussions facilitated by a University educator (KA) and researcher (JAL). Each group work lasted about 30 minutes and the first time the two groups were both asked to discuss and prepare presentations on: 'What does risk and engagement mean to staff and patients, respectively'.

The two groups wrote their ideas on flipcharts which were then presented and discussed in the larger group. The following key points emerged:

- There is a tendency for staff to approach risk assessment as a way to 'get something done' – to demonstrate and engage in activity.
- When completing a risk assessment there is a tendency for staff to assess the risk as higher rather than lower – 'to be on the safe side'. This relates to the way risk assessment can tend to be used to safeguard staff from litigation. There is a 'blame culture'.
- Risk assessment tends to be a 'here and now' situation where decisions are made about whether to admit a patient and how to keep the patient safe when admitted.
- Risk changes with time – 'you can't do a risk assessment every half hour!' – discussion about what this means to the assessment documentation's 'objective' value. In this sense, risk assessment is subjective – or reflects an 'educated guess'.
- It was suggested that 'safety panels' where risk assessment and risk management is planned in a multidisciplinary group might facilitate the therapeutically necessary 'positive risk-taking', and take some of the litigation pressure off the individual staff member.
- Having 'inappropriate patients' on the ward can complicate the risk management work – need for better referral procedures. Working with only one consultant on a ward is likely to improve this situation, while also providing better continuity of care (at the time of the workshop Rose Ward was working towards this more ideal situation).
- Risk assessment tends to be 'doubling up' on the care plan which creates perhaps unnecessary extra work and double documentation. At the same time

the risk assessment procedures are rarely sufficiently developed to a risk management plan that is integrated with the care plan.

- The risk assessment form 'cuts off creativity' – there is no space to write about issues that relate to the patient's care or therapeutic needs.
- Patients generally experience risk assessment as threatening and intimidating – issues of power – not clear to the patient how the risk assessment procedure might benefit the patient – is rather presented as aversive to the patient.
- It is possible that some of the measures staff take to manage risk in fact can increase or trigger risk – such as locking up patients.
- The patients request more 'me time'.
- There is a tension between 'observation' and 'engagement' in clinical practice – positive experiences with shifting from observation to engagement, but this approach is very vulnerable to the predominant 'blame culture': if there is an incident the focus on engagement is shifted to the defensive approach of observation.
- The role of 'paperwork' and notes – how can the documentation be used as a positive tool in engagement?

Key recommendations/suggestions arising from discussions on the workshop:

- Risk assessment needs to be an integrated part of the care plan – risk is from the perspective of the patient also an issue of need for safety and need for care.
- Staff need to be able to use the risk assessment and development of the risk management plan as part of the care and support for the patient – will then also be better to communicate the constructive therapeutic/care approach to the patient.
- The staff's engagement with patients, also around risk assessment/management, has to be based on a dialogic approach – that is, build in and accept 'not knowing' as part of the approach. This means that the staff approaches the patient with curiosity and a willingness and ability to explore and engage with the individual patient's perspective. In respect to the issue of risk there is a need for staff and the patient to agree on issues of risk/safety – not just to be an issue of the staff's judgement. The documentation/ 'paperwork' needs to be an integral part of this.
- Need for careful consideration not to take such undue measures of risk management (e.g. locking people up) that is detrimental to the therapeutic work and patient recovery – and to allow necessary 'positive risk taking'.
- The 'blame culture' needs addressing and reversing – involving structural changes (e.g. 'safety panel').

In the afternoon of the workshop the participants broke up into two new cross-ward groups to discuss how to take forward the day's discussions. The following suggestions arose:

- There is a need for training around risk assessment, e.g. using case studies to explore examples of good practice.
- The consultants, as key clinical colleagues whose decisions are of crucial importance to the work on the wards, need to take part in the training, and this needs to be arranged.
- The care plan needs to include safety planning (risk assessment/ management) – it needs to be used more actively as directive for therapeutic work with patients.
- There is a need to develop better practices of communication involving patients and securing meaningful engagement.
- It would be good to share information and experiences across wards and Trusts.

Following this consultative inquiry the project team started designing a practice development intervention programme with emphasis on building clinical supervision skills supported in the practice environment by the Charge Nurses, who would be supported by a peer-group led by the Modern Matrons.

Independent of these preliminary inquiry activities other resources for acute mental health services practice development had been secured through the establishment of an Acute Care Partnership Project, funded on a temporary basis by the Surrey and Sussex SHA. This involved the employment of a North Sussex based Practice Development Facilitator (Anne Steele), who worked in close collaboration with the Sussex mental health Nurse Consultant (Theresa Dorey). Part of the task was to implement and provide staff training for new assessment documentation (or 'paperwork') developed in South Sussex across acute mental health services in Sussex. The University of Surrey had a parallel role in supporting an evaluation framework for this project (involving MV and JAL). Supported by the Nurse Consultant it was agreed to join the two projects, allowing further training input by working in collaboration with the Practice Development Facilitator (PDF). At this stage it was also decided to include staff from the North Sussex Crisis Team in the training.

This collaboration was able to secure a more solid backing from the Trust managers to continue funding for the project. Initially, concerns had been raised over intentions in early project proposals to apply and develop a participatory ethnographic methodology (Sharkey and Larsen 2005) involving staff as 'practitioner ethnographers' – particularly that too much attention would be given to building a knowledge base rather than providing training. It was felt that, rather than aiming for setting up a system of clinical supervision led by the Charge Nurses, a focus on the implementation of new assessment documentation offered a more tangible and outcome-focused intervention that provided a clear rationale for funding.

It was decided that the learning and training intervention would consist of a series of two-day workshops aiming to provide training on clinical one-to-one (or 1:1) engagement skills and use of the new assessment paperwork.

#### *Learning and intervention phase*

From October to December 2006 a series of two-day workshops were provided by the PDF (AS) and the University educators (BB and KA). Each workshop had 8-12 participants drawn from the four services: Rose Ward, Villa Ward, Downsview and Crisis Team. The rationale for this arrangement included practical, pedagogical and strategic considerations. In terms of arranging the shifts it was most practical and less disruptive at any time to take only a couple of members of staff from each work environment. Secondly, it was thought that the learning would be more focused and able to draw on different clinical experiences when participants were not already personally familiar with each other and attended from different wards. Finally, and closely related to the previous point, bringing the different staff together could initiate a mutual curiosity and wider sharing of a professional 'community of practice' (Wenger 1998), in anticipation of the future co-habitation in Crawley in 2008.

The first day of the workshop was facilitated in collaboration between the PDF (AS) and one of the University educators (BB or KA), and it focused on clinical engagement in assessment and 1:1 therapeutic conversations. First, an introduction to the clinical and research literature on engagement and 1:1 work was given, allowing discussions and questions from participants. In order to give a 'real life' feel for the issue of 1:1 engagement in relation to assessment, the educators role-played first a 'not so good'

and then a 'better' session – one playing a clinician and the other a patient. In the 'not so good' example the clinician took a very instrumental approach to asking questions as stated on the assessment form – expressing a friendly, but not very empathic attitude. Participants were encouraged to put forward suggestions and discuss strengths and weaknesses of the clinician's behaviour and clinical skills. The educators then also role-played a 'better' example, where the clinician demonstrated a more emphatic, person-centred and flexible approach to investigate the concerns of the patient – both gathering information and building a therapeutic relationship.<sup>1</sup> In smaller groups the participants discussed ways of working with assessment and 1:1 engagement.

The second day of the workshop was facilitated by the PDF (AS) and focused on introducing the new assessment documentation ('paperwork'). Participants were offered opportunities to ask questions and discuss the practical implications of using the new paperwork.

A total of 77 staff attended the workshops (see breakdown in Table 2), capturing all nursing staff working at the time in the North Sussex acute mental health services.

**Table 2: Staff attending the two-day workshop**

Profession/ Role	Rose Ward	Villa Ward	Downsview	Crisis Team	Total
Nurse (Band 2)	1	9	5		15
Nurse (Band 3)	1				1
Nurse (Band 5)	8	6	7	1	22
Nurse (Band 6)	3	1	2	9	15
Nurse (Band 7)		1	1		2
SNP				5	5
Modern Matron	1			1	2
Integrated Team Manager	1				1
Psychiatrist (Staff grade)				1	1
Consultant Psychologist	1				1
ASW				2	2
SSW				1	1
STR (Band 3)				6	6
OT	2			1	3
Total	18	17	15	27	77

On completion of the workshop participants were given a signed certificate to document their attendance (see appendix).

#### *Follow-up phase*

It was arranged for the practice educators (AS, BB and KA) to provide individual follow-up support and supervision in practice, working with individual clinicians. The rationale behind this approach was to make sure that the teaching provided on the two-day workshop would be supported in practice, working with patients.

In order to provide a common structure for the follow-up sessions the project team developed a clinical follow-up form (see appendix) divided in the three key areas: 1) rapport-building and engagement, 2) information sharing and 3) developing an action plan. It was thought that the form would provide a structure and focus for the feedback and offer a written outcome that the clinician should take away from the session. A

<sup>1</sup> In a spin-off from the project the educators are developing a DVD with these role-plays and an accompanying resource pack with questions for students. The material will be provided to the Trust and the individual wards as an educational tool for staff development, and potentially also be used in the teaching of mental health student nurses at EIHMS, University of Surrey.

secondary purpose of the form was to provide data for the evaluation, and it was agreed to include a 5-point scoring from 'not quite there yet' to 'excellent'. It was deliberately chosen to use labels in the scoring that would not be discouraging for staff (e.g. avoiding a bad-good continuum).

Some concern was raised in the project group over the possibility that the form could be used as – yet another – document to monitor staff performance. Others, taking the opposite view, felt that it might be useful as a tool to document the 1:1 activity and ensure the quality of this practice. It was agreed that the form would in this project only be used for giving written follow-up to the staff and a copy in an anonymous form to be provided for the researcher (JAL). At one project meeting a ward manager stressed that it would be necessary for the project educators to report clinical malpractice if observed. It later was revealed that this discussion had led to some concern and speculation over the actual purpose of the follow-up sessions. Rather than being seen as clinical support it had among some staff come to be understood as critical assessment with the possibility of reporting and reprimand.

It proved to be more difficult to arrange individual clinical follow-up sessions than initially anticipated. This is connected to the rumours and lack of clarity developed as a result of the discussions reported above. It also appeared that although the project from its very beginning and conception had intended to secure staff and ward manager 'ownership' of the objectives, it was not all who felt equally involved in seeing the project as a positive opportunity to change and improve practice and established routines. This is likely to be due to the intention of the project to work across several work environments and the possibility that in different local work cultures staff may have particular felt needs that were not addressed individually. But it is also likely that some of the difficulty relates to a more fundamental uncertainty regarding clinical supervision (see the section below on staff experiences and perspectives).

It had initially been agreed to target the Charge Nurses for the clinical follow-up in order to set a system in place that would allow the support to 'cascade' through from senior to junior roles. As per 28 February a total of 17 individual follow-up session had been provided:

Rose Ward: 11  
Villa Ward: 3  
Downsview: 3

The experiences of using the clinical follow-up form suggested that while the 5-point scoring could be useful as a tool to engage staff in a critical reflection on own performance and possibilities for practice improvement, the scoring had less value as an evaluation tool. Two main issues emerged. Firstly, that the explanatory text in respect to rapport-building and engagement should not stress working with 'surface feelings' in contrast to 'deeper feelings' as indicating the quality and level of engagement work. At times it may be most appropriate – and best clinical practice – not to work therapeutically with 'deeper' feelings, depending on the current needs of the patient and the actual history of the staff-patient relationship.

Secondly, it was felt by the practice educators that the aim of providing constructive feedback had to take priority over attempts at objective assessment, which, it was felt by some, could be detrimental to the purpose of staff development and encouragement. Others were of the opinion that it would be possible to have a valid tool for assessment to go hand-in-hand with constructive feedback. The most likely explanation for these various views is possible differences in the approach taken by individual educators to

providing supervision and support. Nevertheless, for reasons of questionable validity and inconsistency the scoring is not included as part of the evaluation data in this rapport. The problem highlighted here of finding a constructive integration of assessment and support when working with staff learning and practice development, interestingly, also raises more general questions about the therapeutic value against the 'objective validity' of assessment documentation used in staff-patient encounters.

### **Staff experiences and perspectives**

A series of individual interviews with staff were carried out by the researcher (JAL) in order to capture their experiences with and views on the project. A further rationale was to allow an opportunity for staff to raise issues that may facilitate or represent a barrier to achieving the sustainability of the service development.

Interviews, which were arranged flexibly not to interfere with clinical practice, took place in undisturbed rooms and lasted 30-80 minutes. Notes were taken to document the conversation. Research ethics and R&D approvals had been obtained. Prior to formal interviews being conducted the information sheet was reviewed and participants signed consent forms.

Twelve individual in-depth interviews were achieved in the period 9-23 February 2007, and included Charge Nurses (n = 3), Staff Nurses (n = 4) and Nursing Assistants (n = 5). At least one from each category was interviewed on the three wards: Rose Ward (n = 4), Villa Ward (n = 5) and Downsvie (n = 3). In addition to these formal interviews, a number of informal conversations with other staff were achieved while 'hanging around' and waiting for an opportunity to conduct formal interviews.

The interviews were semi-structured and addressed staff experiences with and views on five key issues:

- 1) Two-day workshop
- 2) New paperwork
- 3) Individual follow-up in practice
- 4) Experiences with and need for clinical supervision
- 5) Risk and engaging with difficult patients

#### *Two-day workshop*

Staff felt that the workshop had been informative and useful, providing practical information and an opportunity to reflect on practice. The role-play presented by the practice educators was highlighted as a very illustrative method of demonstrating good clinical practice. However, some staff said that they had been concerned over the possibility that they might themselves be asked to be involved in doing a role-play in front of colleagues and the educators.

There was also a general appreciation of having been introduced to the new paperwork. However, one staff pointed out that the introduction had not covered all aspects of the paperwork, as it had not been in the final version at the time of the workshop.

One member of staff mentioned that it was a long time to sit down and 'take in'.

Another interviewee suggested that it would be useful to be provided with some evidence-base for the psychosocial approach that was taught in the project. The interviewee pointed out that the medical psychiatric approach is dominating on the ward

and that it would be good to have some research and journal papers to refer to. In response to this observation the PDF (AS) would, in consultation with the University educators (BB and KA), compile a reference list of relevant literature – possibly to be placed as a reference pack on each ward.

#### *New paperwork*

Views were quite divided on the quality and usability of the new paperwork. In general, staff on Rose Ward were very positive and emphasised that the paperwork is a clear improvement – leading to less repetition and encouraging multi-professional team working. In contrast, interviewees from Villa Ward generally expressed the opposite view: that the new paperwork has led to an increase in the amount of documentation and that there is considerable repetition.

It was highlighted that some of this disagreement about the value of the new paperwork might be related to a need for its usage to be supported and demonstrated in practice, on the individual wards. This issue was discussed when presenting the findings on a workshop on 28 February 2007 involving the project team (AS, BB, KA, JAL and TD), Charge Nurses from Rose Ward, Villa Ward and Downsview and the Ward Manager of Downsview. It was agreed that the PDF (AS) would visit Villa Ward to go through the correct usage of the paperwork in practice.

Another critical issue concerned the multi-professional character of the paperwork. Nursing staff had experienced that Doctors were unfamiliar with the new paperwork and had resisted using it. It was suggested that some Doctors would find it unusual and professionally compromising to be required to write in the same document as other members of the team. Apart from highlighting a need for better introduction of the paperwork to the Doctors, the issue points at a possibility of a need for a culture change to address traditional professional hierarchies in medical practice.

Interviews and the following workshop discussion highlighted more fundamental inadequacies in the new paperwork regarding the information collated on risk. The paperwork suggests an essentialist approach to considering risk as an inherent and static characteristic of individual patients. This approach – and the structure of the assessment paperwork – is in opposition to the recovery approach, advocating the possibility and therapeutic desirability of change and improvement. Perhaps more importantly, it contradicts clinical experience of the way in which risk fluctuate and change over time for each individual. As such, the assessment is not of much value in cases of referral where the clinical knowledge of individual patients' changes in risk status cannot be properly documented. Improvement of the form needs to be considered.

The data suggest a need to reconsider the current practice on North Sussex wards of nurses conducting a risk assessment after a decision has been made by the doctor to discharge a patient. It was felt that the risk assessment under these circumstances has no real value and there is a possibility that it becomes a therapeutic irrelevant 'tick-box exercise' with no other purpose than to provide retrospective legal, documentary validation of the discharge decision to protect against litigation. There was agreement that it would be advisable to change this practice – perhaps by finding inspiration in practices in some acute wards in Surrey where the risk assessment was conducted jointly by a nurse and doctor preceding any decision on discharge (see a similar point being made on the 7 April 2006 workshop in the project's first phase).

### *Individual follow-up in practice*

Asked about their views on the planned follow-up in practice for clinical educators (AS, BB and KA) to observe and support staff when working 1:1 with patients, all interviewed staff confessed that they felt uncomfortable and stressed by the idea. There was a shared unfamiliarity with having their clinical 1:1 work with patients critically observed and commented upon by a colleague.

However, there were clear dividing lines in how staff dealt with these emotions in coming to the contrasting conclusions that they would either welcome or resist the offer of an individual follow-up session. Those who were for, pointed out that it would be a good opportunity to reflect on and improve own practice. Those who were against, presented the opinion that it would be unnatural and 'intruding' in the staff-patient relationship, and that it would be 'intimidating' and 'belittling' to be assessed and judged. The uncertainties centred on a perceived privacy of the therapeutic relationship and a lack of trust that the clinical observer would have sufficient appreciation of the history of the individual staff-patient relationships.

Among the twelve staff interviewed only two (one Charge Nurse and one Staff Nurse) had experienced a follow-up session. Both said that they had been positively surprised about the benefits of having an opportunity to discuss their therapeutic and engagement work with a colleague. Two others (both Charge Nurses) had planned for follow-up sessions, and they were both anticipating it with predominantly positive expectations (although they also reported feeling uncomfortable about the prospect). Two other experienced Staff Nurses explained that they had been offered individual follow-up sessions, but had refused the opportunity – for the reasons mentioned above.

Some staff pointed out by that it would have been better if the follow-up sessions could have been arranged sooner after the workshop – when the issues discussed were fresher in mind. At the workshop held on 28 February 2007 it was agreed that shorter time between the workshop and the follow-up would have been ideal. However, the aim to provide workshops to a high proportion of staff had taken priority in the project design. When discussing the follow-up the practice educators pointed out that they felt it would have been better if it would have been possible to provide two or three sessions with each clinician. Just giving one follow-up session did not appear to fulfil the potential to really help the clinician to develop their practice under properly supported and supervised conditions.

### *Experiences with and need for clinical supervision*

The conversations about the individual follow-up sessions led to a wider consideration of clinical supervision. It was apparent that currently the provision of clinical supervision is generally not a high priority. As one Charge Nurse put it: 'it is not on the list of necessary things to do'. In support of this view, staff told about how they have arranged supervision outside working hours. It was not uncommon for staff to have half a year between supervision sessions – a few more experienced staff had not received clinical supervision for years: they 'haven't had the need'.

Staff reported that it is their own responsibility to request supervision 'when I need it'. It was apparent that this practice of placing the responsibility for arranging clinical supervision on the staff themselves contributed to a widespread sensation that 'you should only request clinical supervision if there is something you cannot handle yourself', and ultimately 'only you are to blame if you do not receive supervision'. Hence, the data gave strong evidence of an institutional disregard for the need for clinical supervision. Of



the twelve staff interviewed, only two received clinical supervision on a regular and frequent (monthly) basis.

When discussing the need for clinical supervision some staff revealed a common practice of informal support in the staff peer group: 'putting the kettle on'. While the positive value of this type of emotional peer-support was pointed out, there was also a general recognition that it might not always be sufficient. One interviewee talked about how a particularly distressing experience with a self-harming patient for a longer period had caused severe concerns and it was emphasised that better resourced clinical supervision could have avoided 'taking home issues'.

When discussing these staff perspectives on the 28 February 2007 workshop it was pointed out that there are two key functions of clinical supervision: restorative and formative. The *restorative supervision* is about helping the individual to deal with difficult experiences and address emotional difficulties related to personal biographies. The *formative supervision* has a stronger focus on developing clinical skills in a supportive environment of a trusted fellow clinician. Both types of clinical supervision may be needed. Unfortunately, it seems that neither are currently universally provided in any systematic fashion. In particular, there seems to be a need to strengthen the clinical supervision which can assist staff in developing their clinical skills and improve patient care.

#### *Risk and engaging with difficult patients*

Interviewed staff agreed that the project had not placed great emphasis on changing practices of risk management or working with particularly challenging patients. Staff expressed a request for further training in dealing with patients diagnosed with Personality Disorder (PD), which are frequently seen as very difficult to work with on wards. It was pointed out that more and better training would help staff to feel more secure in dealing with this group of patients and for the team to take a common approach (avoiding 'splitting').

#### **Areas for service improvement**

On 28 February 2007 a one-day workshop was held between the project team and Charge Nurses from Downsvie, Villa Ward and Rose Ward, the Downsvie manager and the Nurse Consultant for acute mental health services. Findings from the individual interviews with staff were presented and the clinical educators presented their experiences with providing the training workshops and subsequent individual follow-up on 1:1 engagement in clinical practice.

At the meeting agreement was reached to work for service improvement in respect to the four key areas:

1. Introduction of new assessment paperwork
2. Risk assessment and risk management
3. Clinical supervision
4. Working with difficult patients

#### *Introduction of new assessment paperwork*

Minor design problems (lack of page numbering) in some versions of the paperwork would be addressed by forwarding the most recent version. (Action: TD)

The PDF (AS) would make appointments with wards as required and hold staff meetings to clarify any misunderstandings in using the paperwork, make suggestions to improve practices regarding how and when to use the paperwork and, if necessary, collate suggestions for improvements in the design of the paperwork. (Action: AS)

The discussion highlighted the importance of presenting the new paperwork to the doctors and ensuring its correct usage. It was recognised that some doctors may be unfamiliar with using assessment forms that are jointly filled in by the multi-professional team. This could in some cases represent a culture shift that would have to be handled with care and consideration for sensitivities involved. It was agreed that it is the responsibility of the Ward Manager to ensure that doctors use the correct paperwork. (Action: Ward Managers)

As the paperwork is being introduced and best practices emerge it was agreed to be useful for Charge Nurses and Ward Managers to share ideas for trouble-shooting and best practice across the wards. (Action: North Sussex Ward Manager and Charge Nurse Meeting)

#### *Risk assessment and risk management*

The project findings highlight problems regarding practice and documentation of risk assessment, particularly: 1) the timing of the risk assessment in relation to discharge, 2) the possibility of the risk assessment being carried out multi-professionally by a nurse and doctor and 3) the need for the risk assessment to take account of individual patients' changes in risk status over time (see also more full discussion above). However, the wards are tied to using the CPA process that is applied throughout the Trust. Furthermore, there is currently a national project looking at risk assessments (which is likely to identify similar problems). In support and recognition of these ongoing developments a decision was made at this stage merely to flag up these issues for them to be considered when the CPA risk assessment procedure and documentation are updated.

#### *Clinical supervision*

It was agreed that clinical supervision needs to be provided on a more regular – and perhaps mandatory – basis. In particular, it is of importance that supervision is considered to be a necessary and quality-improving measure that highlights patient care and recovery, and safety for patients and staff.

The discussion highlighted that clinical supervision contains two key components: 1) restorative supervision, that involves off-loading and dealing with staff concerns and experienced difficulties; and 2) formative supervision, where the emphasis is on developing and enhancing clinical skills by providing guidance and advice. These two aspects can be emphasised differently in individual supervision sessions, but it is important to recognise how they interrelate and to avoid that one type is given exclusive primacy at the expense of the other.

A culture of peer-support and continued learning through reflection on practice needs to replace a widespread feeling among nursing staff that clinical supervision is about critical assessment, control and reprimand. Through the discussion it was felt that the best way to work for this culture change is through doing it by example: setting up structures and resources that facilitate a positive and supportive approach to clinical supervision. The findings support the view that the project has contributed by directing constructive attention to put greater emphasis on the need for clinical supervision.

### *Working with difficult patients*

The project had taken a general approach to staff-patient engagement and it was agreed that there had not been special attention to how to work therapeutically with difficult patients, in particular patients diagnosed with Personality Disorder. It would be necessary in the future to seek to set up training and support with this focus in mind, possibly by drawing on teaching provided by Universities (Brighton and/or Surrey). (Action: TD through the module development team at University of Brighton and /or the Mental Health PDU at University of Surrey.)

### **Project outcomes and discussion**

The project provided training workshops on clinical engagement and risk assessment for all nursing staff and initiated a structure for providing improved clinical support and supervision for staff. The quality and sustainability of the provision of clinical supervision is dependent on the provision of ongoing support from existing structures, both Trust-internal (like the Ward Manager and Charge Nurse meetings) and external, as Universities (Surrey and Brighton) may be able to provide courses or tailor-made practice development interventions. These have been extensively outlined and discussed in the previous sections.

However, the practice development project has also been supporting concrete improvements in clinical work and organisational practice (level four in Kirkpatrick's model of educational outcomes, see Table 1):

1. Formalising and improving 1:1 nurse-patient sessions
2. Freeing nursing staff to focus on patient contact
3. Nurses involved in the Therapeutic Programme

#### *Formalising and improving 1:1 nurse-patient sessions (Rose Ward and Downsview)*

As the project started 1:1 sessions on Rose Ward were generally informal, adhoc and short (about five minutes) and often instigated by the patient. The team has now agreed a benchmark of a minimum of twice a week formal 1:1 sessions per patient, in addition to more informal conversations with patients. This will be audited, partly through the use of a rubber stamp that will indicate on the notes when these sessions have taken place. The introduction of protected time and the change in shift pattern has helped to ensure that time spent individually with patients is consistently offered. The Charge Nurses are continuing to offer support in practice. This has highlighted the need for training in supervision skills and the need for continued support for the supervisors to build skills and confidence. On Downsview the new Ward Manager has been setting up structures and arranging shift patterns to free up nursing staff to further engage in 1:1 sessions with patients. These improvements have been supported by a move towards increased formalisation of clinical supervision support for nursing staff.

#### *Freeing nursing staff to focus on patient contact (Villa Ward)*

Supported by the practice development project the team has taken the decision to remove the member of nursing staff who sat by the entrance to the ward to monitor who was coming and going. This is an important change that has enabled a more effective use of staff time.

#### *Nurses involved in the Therapeutic Programme (Rose Ward and Villa Ward)*

As the project started the nurses were not involved in the implementation of the therapeutic programme. On Rose Ward it was run exclusively by the Occupational Therapists and a Psychology Assistant. The programme is now facilitated by the

nursing, Occupational Therapy and Art Therapy staff. The nurses report greater satisfaction with their working day through the addition of being involved in the group programme. Villa Ward has also begun to establish a therapeutic programme involving the nursing and Occupational Therapy staff. Both these disciplines are now working towards being able to offer a more consistent programme.

#### *The collaborative context of change*

It is important to point out that the above-mentioned improvements in practice are just the most concrete to be mentioned to date, and that other, subtler and yet not realised changes are linked to the success of the intervention (see the section 'Areas for service improvement'). Equally important, the project did not achieve these outcomes in isolation, but only by linking with and supporting activities that were already in process in the local practice environments. Also, it was significant for this project that it coincided with the employment of a PDF (AS) who could offer more intensive support working directly with the wards.<sup>2</sup>

As set out in the project objectives, the intervention was focused on supporting existing skills and resources and, through the inquiry-mindedness in the action research approach, benefit from the local knowledge and clinical insights to identify opportunities and barriers to move forward. Crucially, the outcome of the intervention depended on the active support and engagement from ward managers and staff. In terms of the staff embracing the process of change it seemed that two significant factors enabled the process. The ward manager was a key figure in working alongside the PDF and having an expectation of being able to deliver a quality service. It is perhaps significant that Rose Ward has had PDFs involved with them over the last few years (Bob Birtwell and Alex Jones). There was therefore a familiarity with practice development and a positive questioning of the current practice to bring about change. By working clinically alongside the staff, the PDF created an opportunity to both offer training and to role model good practice. This presence on the ward has been key to the process of change and essential in being able to develop a constructive relationship with the staff.

#### *Addressing policy objectives*

Taken together the concrete improvements in clinical practices on the wards and the move towards providing innovative Trust-University collaboration around support for clinical supervision address a number of key recommendations presented in the 2006 report from the Chief Nursing Officer: *From values to action* (DoH 2006):

- The need to implement the principles of the Recovery Approach in every aspect of mental health nursing practice.
- The need for mental health nursing staff to be developing and sustaining positive therapeutic relationships with service users.
- The need for mental health nursing staff to increase the time (and the quality of this time) they spend in direct clinical contact.
- The need for mental health nursing staff to be trained in risk assessment and management and work closely with service users to develop realistic care plans.
- The need to develop structural and professional aspects of care provision and improvement, reviewing career structures according to local needs.
- The need to strengthen relationships between higher education institutions and service providers.

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<sup>2</sup> See Larsen et al. (2005a, b) for a fuller description of the Practice Development Facilitator (PDF) role.

## **Action points and recommendations**

The workshop discussion on 28 February 2007 identified existing structures that can take forward the learning points from this practice development project to ensure their sustainability and impact to deliver service improvement. These are:

1. The Practice Development Facilitator (AS) who, through special funding for the Acute Care Partnership project, is currently available for specialised support for practice development.
2. The 6-weekly Ward Manager and Charge Nurse Meeting which has recently been set up for acute psychiatric wards in North Sussex.
3. The Brighton/Sussex Partnership Module Development grouping aiming for the University of Brighton to develop and offer modules specifically targeted for mental health nursing staff in Sussex.

The Practice Development Facilitator (AS) will continue to provide individualised support for clinical supervision as agreed with the wards. She will also, as described above, be available for wards to provide further assistance regarding the use of the new paperwork. However, it is recognised that this is a temporary post (secured till spring 2008), and unless additional funding is identified by the Trust or SHA to continue the post, it does not provide a long-term sustainable resource.

The following two resource structures have been established and exist independently of the project, and the project has no authority to define their focus or terms of reference. However, it was felt that these provide ideal forums for developing and monitoring sustainable service improvement regarding the project focus. We therefore agreed a list of recommendations for each to consider as part of their terms of reference.

### *Ward Manager and Charge Nurse Meeting*

- a. To share best practice on arranging shift patterns and identifying shift leaders (not necessarily the Charge Nurse) on each shift, allowing nurses protected time for 1:1 sessions.
- b. To discuss and develop a model for ensuring that the Charge Nurse role includes taking part in staff development (i.e. supervision of colleagues).
- c. To share best practice on setting up regular clinical supervision for all staff.
- d. To discuss and share best practice regarding risk assessment and risk management – especially regarding multi-professional assessment preceding decision on discharge and ensuring documentation of changes in risk for individual patients.
- e. To ensure the sharing of best practice regarding the implementation and usage of new and existing paperwork.
- f. To consider including representatives from the Crisis Team in the forum, to ensure care continuity for patients and sharing of best practice.

### *Brighton/Sussex Partnership Module Development*

- a. The module should be designed to address issues specifically relevant to acute care.
- b. The module should address problem-clarification skills – developing a structure for 1:1 engagement.
- c. Some learning to take place in practice with patients.
- d. The module should be helping learners to become supervisors themselves (perhaps need for an independent module on supervision which could ideally involve 1-2 days on course and follow-up in practice for up to 6 months).

### *Towards structural sustainability of service improvement and learning*

On 23 March 2007 a meeting was held in the project group to discuss how to take forward experiences from the project.

It was agreed that the project had been a success in actively contributing to drive service improvement through staff learning and organisational change in a situation where the involved clinical areas were facing significant re-structuring and there was a growing pressure for a 'need to change'. External facilitation and the expert educational and clinical skills provided by the University educators had supported the wards in the change process.

It was pointed out by the Acute Mental Health Services Manager that there is a need for more active collaboration with expertise from the Universities in support of clinical service improvement. Currently, the dominant model for Continued Professional Development (CPD) is not very collaborative, as it merely consists in clinical teams sending off staff for particular training modules at the University – an activity which has proven not always to have much direct impact on improving patient care. If some of the CPD resources could be spent on teaching and learning activities tailor-made for specific service improvement initiatives it would have greater impact on developing staff skills and improving patient care. Although the Trust-University collaboration over project design and evaluation would involve resources, the intervention would in many cases be more cost-effective by achieving real and sustainable service improvement.

University educators (BB and KA) expressed the view that it could be possible to set up a structure that would allow a more flexible approach for Trust-University collaboration over the delivery of training and evaluation supporting specific service improvement initiatives. It would, however, require agreement at a strategic level within both organisations. It was therefore suggested to set up a meeting with senior managers to take forward the learning points and recommendations from this project. Also, the project findings have wider applications for the development of teaching and learning strategies in respect to mental health provisions in Higher Education, for example:

- Design of provisions specifically relevant to acute care settings.
- Development of teaching and learning strategies to build capacity for clinical supervision.
- Strengthening the development of student nurses' clinical engagement skills.

As this report is being finalised (early May 2007) there are plans to set up such strategic meetings between the University of Surrey and the mental health Trusts in both Sussex and Surrey, taking forward the learning points from the project.

### *Recommendations*

- Wards to continue developing and strengthening support for regular clinical support and supervision to staff on acute mental health wards, including suitable managerial and working structures (e.g. shift patterns and procedures/agreements to drive and document clinical supervision).
- Mental Health Trusts, wards and Universities to continue collaboration over developing teaching and learning opportunities and interventions that support staff's professional development and contribute to service improvement needs.
- Conversations to be had involving the SHA, Trusts and Universities over the practical procedures and financial and staff resources needed to support a more flexible and needs-adaptive approach to learning and practice development.

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## **Appendices**

Two-day workshop certificate  
Feedback and evaluation form



This is to certify that

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completed the

## **Two-day Workshop on Engagement, Risk and Assessment**

Autumn 2006

### **Topics covered**

- ◆ Therapeutic 1:1 Engagement
- ◆ Acute Mental Health Assessment: Introduction to New Documentation
- ◆ Risk Assessment: Enhancing Safety and Collaborative Engagement
- ◆ Risk Management and Recovery Processes

#### **University of Surrey and Sussex Partnership Trainers**

Anne Steele (Sussex Partnership)  
Bob Birtwell (University of Surrey)  
Kevin Acott (University of Surrey)  
Theresa Dorey (Sussex Partnership)

**1) Rapport building and engagement**

1 ----- 2 ----- 3 ----- 4 ----- 5

**Not quite there yet**

Talks to patient mainly from clinician's perspective, asking questions of interest to the clinician, but not the patient

**OK**

Gains and expresses to patient an understanding of their surface feelings

**Excellent**

Gains and expresses understanding of patient's deeper feelings and concerns

Comments:

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**2) Information sharing**

1 ----- 2 ----- 3 ----- 4 ----- 5

**Not quite there yet**

Talks to patient mainly from clinician's perspective, asking questions of interest to the clinician, but not the patient

**OK**

Gains and expresses to patient an understanding of their surface feelings

**Excellent**

Gains and expresses understanding of patient's deeper feelings and concerns

Comments:

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**3) Action planning**

1 ----- 2 ----- 3 ----- 4 ----- 5

**Not quite there yet**

Talks to patient mainly from clinician's perspective, asking questions of interest to the clinician, but not the patient

**OK**

Gains and expresses to patient an understanding of their surface feelings

**Excellent**

Gains and expresses understanding of patient's deeper feelings and concerns

Comments:

