Bitesize Training and the Inpatient Staff Team

Broadland Clinic

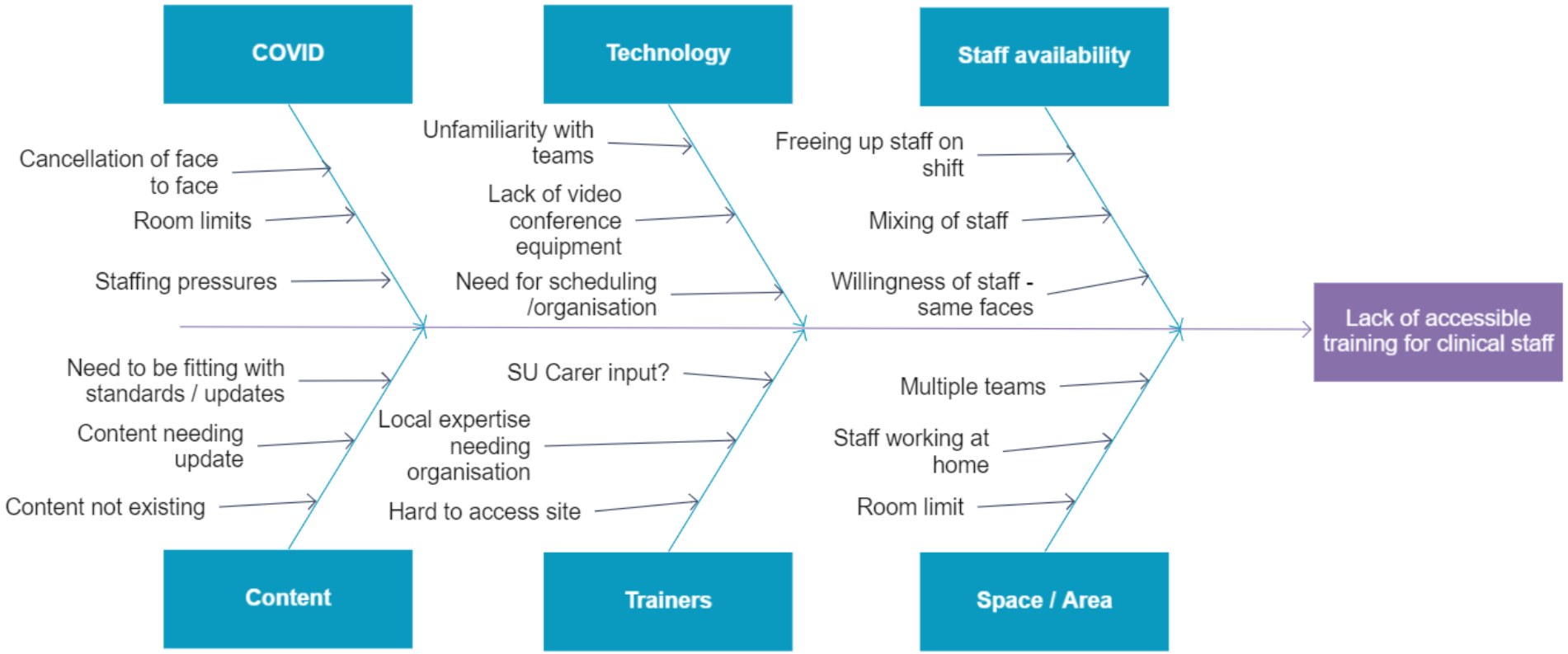
- MSU specialising in ID and Autism
- Bed capacity: 25 patients
- Wider site with an Assessment & Treatment Unit, Enhanced Community Outreach Team, Admin and Medical Staff

- Team development days identified a lack of accessible and responsive training

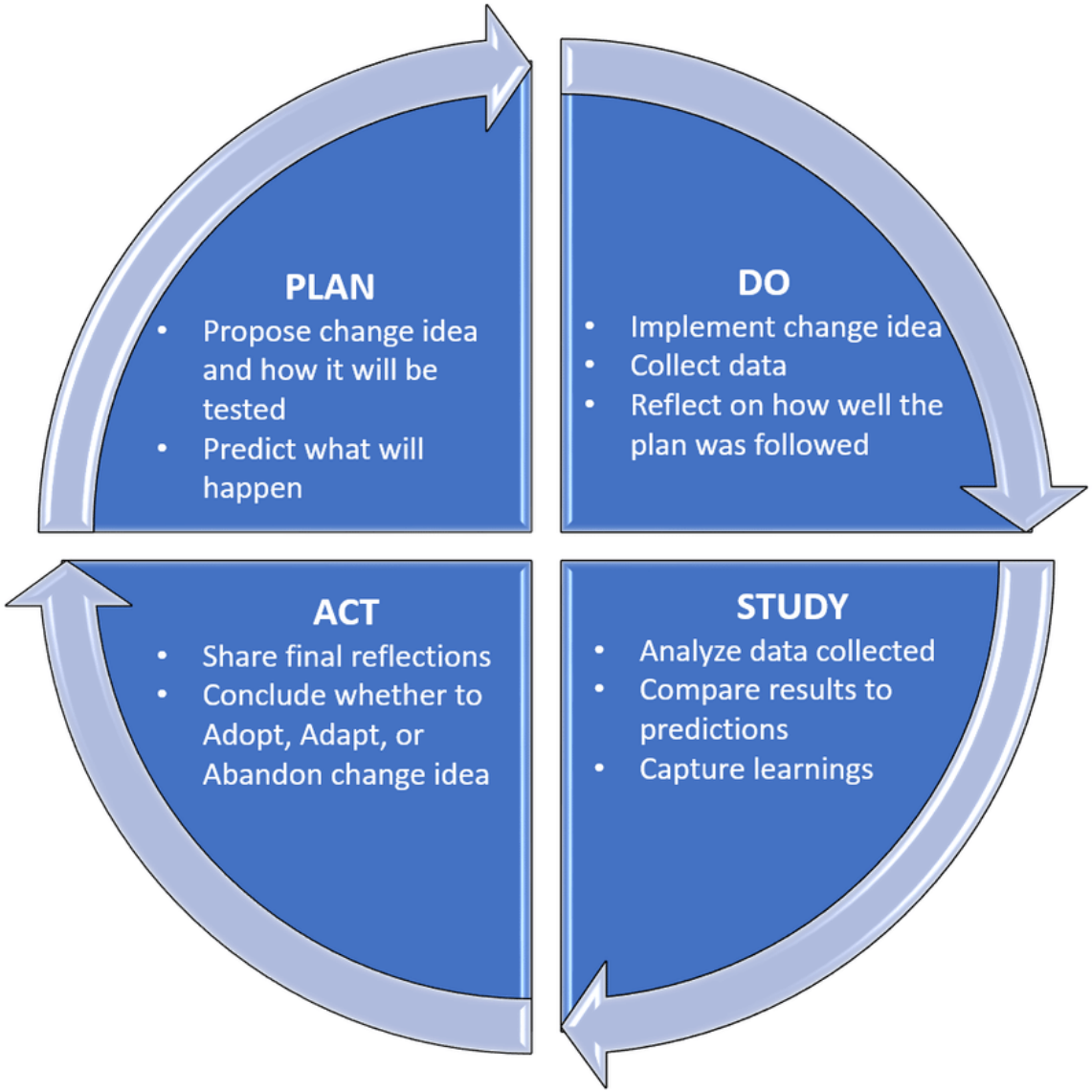
CQI methodology

- Engage stakeholders
- Fully understand problem before solutions
- Develop, test and implement changes scientifically
- Small scale implementation, PDSA
- Collect data
- SU / carer involvement
- Systematic

What limits the efficacy of your in house training programme?


COVID
Technology
Staff availability
Cancellation of face to face
Room limits
Staffing pressures
Unfamiliarity with teams
Lack of video conference equipment
Need for scheduling /organisation
Freeing up staff on shift
Mixing of staff
Willingness of staff - same faces
Lack of accessible training for clinical staff
Need to be fitting with standards / updates
Content needing update
Content not existing
SU Carer input?
Local expertise needing organisation
Hard to access site
Multiple teams
Staff working at home
Room limit
Content
Trainers
Space / Area

PDSA Cycle


PLAN
Propose change idea and how it will be tested
Predict what will happen
DO
Implement change idea
Collect data
Reflect on how well the plan was followed
STUDY
Analyze data collected
Compare results to predictions
Capture learnings
ACT
Share final reflections
Conclude whether to Adopt, Adapt, or Abandon change idea

Aim

Defined Aim: “To increase accessibility of high quality training to inpatient staff of all disciplines at Little Plumstead” within six months

Change idea

- 30 minute training slot 13.30-14.00
- Main principle - accessibility
- All disciplines invited to attend and contribute
- Utilising all resources to cover the ward

Change idea

- Microsoft teams
- Promoted and available site wide
- Recorded to share with wider team
- Improved COVID safety
- RADiANT involvement

A NEW TRAINING SLOT AT BROADLAND CLINIC

BITESIZE TRAINING

A weekly training session led by MDT and Nursing staff. A different topic each week

Training, PBS reviews, careplan reviews, assessments, new patients, carer awareness, My Shared Pathway, communication skills

Do you want to use this slot to share ideas, train staff or discuss a patient related issue? Contact vicki.malcolm@nhs.net

TUESDAY 13.30 - 14.00

Supported by RADiANT

NHS Hertfordshire Partnership University NHS Foundation Trust

continuously improving quality

as one

Our values
Welcoming Kind Positive Respectful Professional

Study - Data collection

Launched October 6th

17/27 possible sessions went ahead in first 6m – process measure

5 cancelled - ban on face to face training during outbreak

Total participants 126 (excluding trainers)

Total teaching hours 63 – outcome measure

Content and topics

- Autism training
- Patient history
- Carer awareness training (coproduced)
- Assessment of sexual risk
- Remotivation process
- Talking mats
- PBS
- Dysphagia awareness
- Intellectual disability
- PBS review
- ADL Assessment

A sense of the sessions…

- An Overview of Static and Dynamic Risk Assessment
- Key care plans and formulation of a patient transferring to a rehab ward
- Dynamic Appraisal of Situational Aggression (DASA)
- Pre-Admission Planning
- Carer Awareness Training

Static & Dynamic Risk Assessments in patients with LD & offending behaviour

Dr Phil Temple

Aims

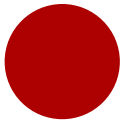
- To define static and dynamic risk factors.
- To set out the actuarial and structured clinical judgment (SCJ) approaches to risk assessment and management.
- To describe the key risk assessment instruments, their characteristics and where to access them or get specialist help.

Assessing Risk

- Professionals and carers will need not only to accurately assess the risk of future offending, but also identify those factors and contexts in which such offending may occur.
- While there is an extensive body of knowledge available in this field regarding general offender populations and those in contact with mainstream mental health services, it is relatively less well developed for people with learning disability and 'offending behaviours'

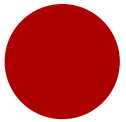
Static Risk Factors

- Static risk factors are those that are historical or unchanging.
- These risk factors are used in actuarial risk assessment instruments that are described in the next section.
- Though not as robust as that in general offender and mental health groups, there is evidence that some static risk factors are predictive of recidivism in this group. Of particular relevance are:
  - (1) being younger and male,
  - (2) having a history of substance misuse,
  - (3) a diagnosis of personality disorder
  - (4) a history of violence and offending.
- These factors do not significantly differ from those for mentally disordered offences and hence those risk assessment instruments developed for that group should be valid for use here too



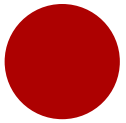
Dynamic Risk Factors

- Dynamic factors reflect changeable environmental variables and internal states that are temporary such as attitudes, cognitions or
- Research shows there are nine issues commonly associated with offending behaviour:
  - unstable accommodation
  - a lack of employment
  - no positive recreation activities
  - poor personal relationships
  - alcohol misuse
  - drug misuse
  - impulsivity and poor emotional control
  - anti-social peers
  - attitudes that support crime.
- These dynamic risk factors are also sometimes called criminogenic needs.



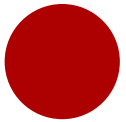
Dynamic Risk Factors

- In line with the risk-needs-responsivity model of understanding risk…
  - static risk factors may be seen as determining 'who' should be treated (i.e. by identifying the higher risk offender),
  - dynamic measures as determining 'what' should be treated (i.e. by identifying the criminogenic needs to be targeted)
  - and the responsivity principle as determining 'how' to deliver that treatment (i.e. by targeting the individual's unique characteristics).

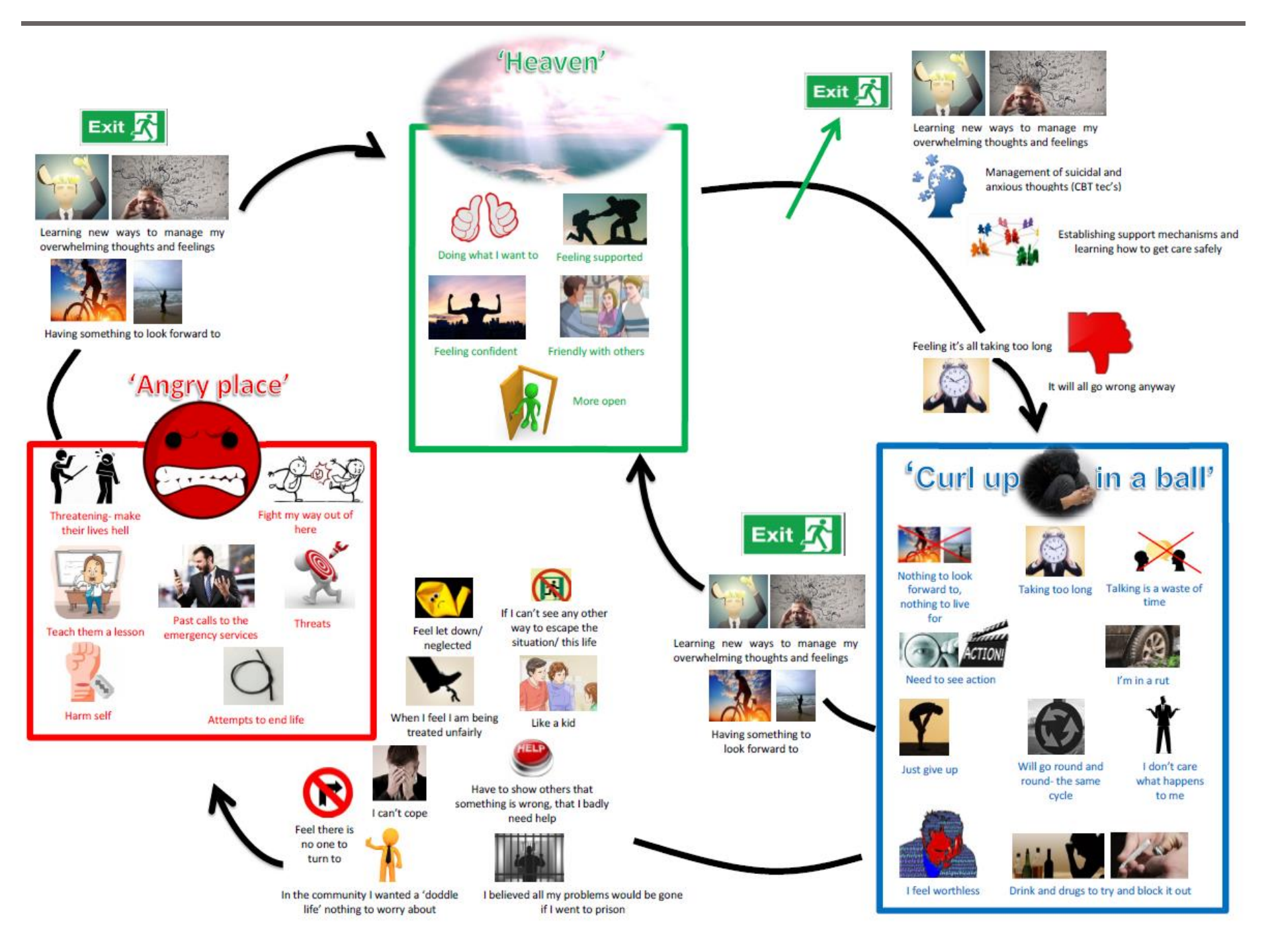


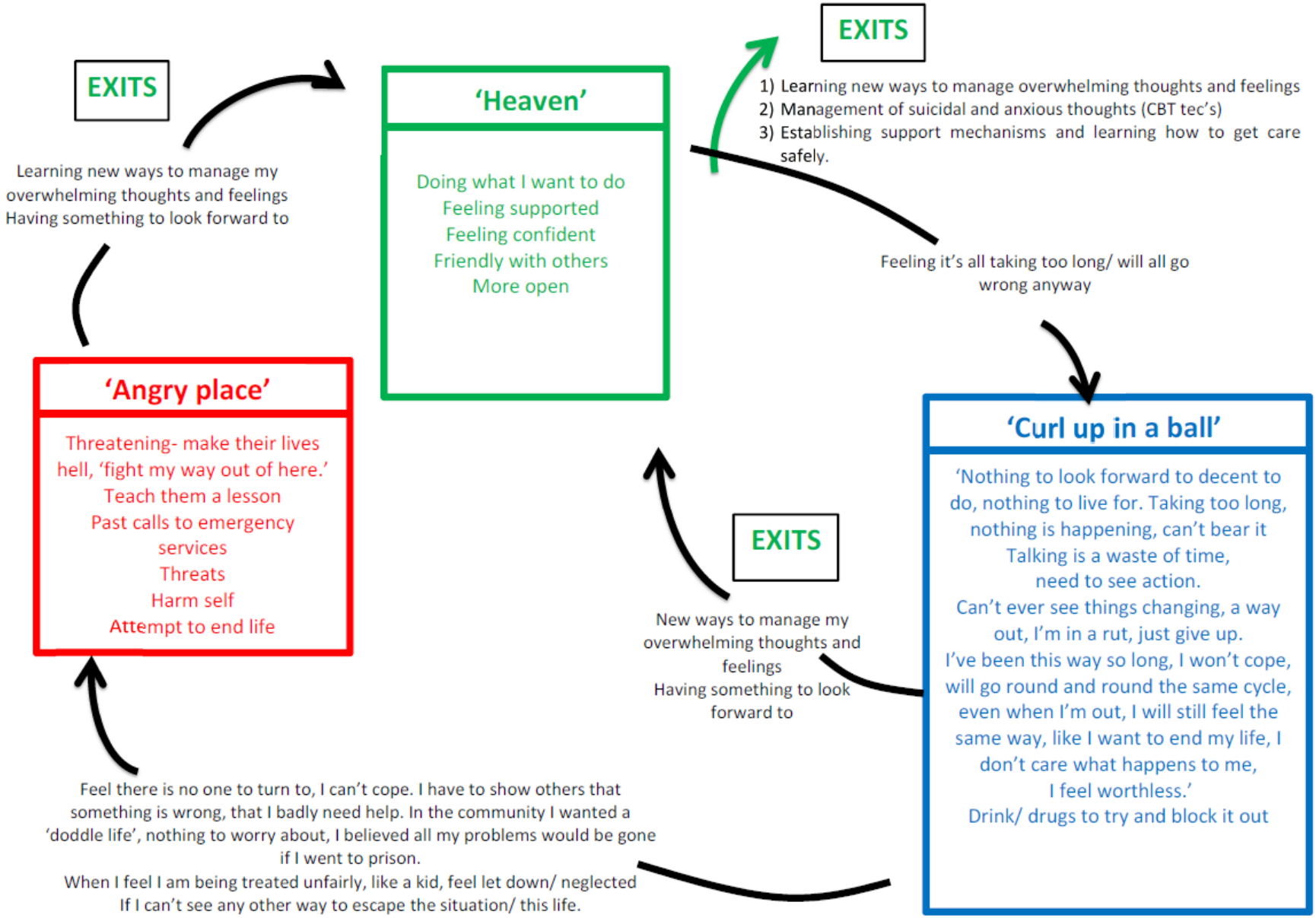
Structured Professional (Clinical) Judgement Instruments

- The structured professional judgement approach covers both static and dynamic factors, and attempts to bridge the gap between unstructured clinical judgement and actuarial approach
- Widely used in general offender populations and in the field of offenders with mental health problems, they are also relevant in people with learning disability and offending behaviours.



Key care plans, including Visual PBS for a patient transferring to a rehab ward


'Heaven'
Exit
Learning new ways to manage my overwhelming thoughts and feelings
Having something to look forward to
Doing what I want to
Feeling supported
Feeling confident
Friendly with others
More open
Exit
Learning new ways to manage my overwhelming thoughts and feelings
Management of suicidal and anxious thoughts (CBT tec's)
Establishing support mechanisms and learning how to get care safely
Feeling it's all taking too long
It will all go wrong anyway
'Curl up in a ball'
Nothing to look forward to, nothing to live for
Taking too long
Talking is a waste of time
Need to see action
I'm in a rut
Just give up
Will go round and round- the same cycle
I don't care what happens to me
I feel worthless
Drink and drugs to try and block it out
Exit
Learning new ways to manage my overwhelming thoughts and feelings
Having something to look forward to
If I can't see any other way to escape the situation/ this life
Like a kid
Have to show others that something is wrong, that I badly need help
I believed all my problems would be gone if I went to prison
Feel let down/ neglected
When I feel I am being treated unfairly
I can't cope
Feel there is no one to turn to
In the community I wanted a 'doddle life' nothing to worry about
'Angry place'
Threatening- make their lives hell
Fight my way out of here
Teach them a lesson
Past calls to the emergency services
Threats
Harm self
Attempts to end life


EXITS
Learning new ways to manage my overwhelming thoughts and feelings
Having something to look forward to
'Heaven'
Doing what I want to do
Feeling supported
Feeling confident
Friendly with others
More open
EXITS
1) Learning new ways to manage overwhelming thoughts and feelings
2) Management of suicidal and anxious thoughts (CBT tec's)
3) Establishing support mechanisms and learning how to get care safely.
Feeling it's all taking too long/ will all go wrong anyway
'Curl up in a ball'
'Nothing to look forward to decent to do, nothing to live for. Taking too long, nothing is happening, can't bear it
Talking is a waste of time, need to see action.
Can't ever see things changing, a way out, I'm in a rut, just give up.
I've been this way so long, I won't cope, will go round and round the same cycle, even when I'm out, I will still feel the same way, like I want to end my life, I don't care what happens to me, I feel worthless.'
Drink/ drugs to try and block it out
EXITS
New ways to manage my overwhelming thoughts and feelings
Having something to look forward to
'Angry place'
Threatening- make their lives hell, 'fight my way out of here.'
Teach them a lesson
Past calls to emergency services
Threats
Harm self
Attempt to end life
Feel there is no one to turn to, I can't cope. I have to show others that something is wrong, that I badly need help. In the community I wanted a 'doddle life', nothing to worry about, I believed all my problems would be gone if I went to prison.
When I feel I am being treated unfairly, like a kid, feel let down/ neglected
If I can't see any other way to escape the situation/ this life.

The Dynamic Appraisal of Situational Aggression (DASA)

1. The Dynamic Appraisal of Situational Aggression (DASA) is a tool developed by Ogloff & Daffern (2006) to assess the likelihood that A Service User will become aggressive within a psychiatric inpatient environment. The DASA is based on the Norwegian Brøset-Violence-Checklist (BVC):

DASA Items

- Irritability
- Impulsivity
- Unwillingness to follow instructions
- Sensitive to perceived provocation
- Easily angered when requests are denied
- Negative attitudes
- Verbal threats

Scoring

- Each of the items are scored 0 if absent or 1 if is present now or has been present in the last 24 hours. This means that if someone is not currently displaying easy anger upon denied requests, but was earlier, that item should be scored 1

- There is no typical cut-off score for the DASA, although Barry-Walsh et. al. (2009) note in their research that "for each increase in DASA total score, there was a 1.77 times increased likelihood that the patient would behave aggressively in the following 24 hours"

- In Ogloff & Daffern's original 2006 study:

  18% of aggressive patients scored 1 to 3
  15% of aggressive patients scored 4 or 5
  55% of aggressive patients scored 6 or 7

  Kaunomäki (2013) used a cut-off score of 4 to identify high-risk individuals

A - Irritability (Taken from the BVC with permission)

- **The patient is scored 1 if they have been considered easily annoyed or angered and unable to tolerate the presence of others within the previous 24 hours**

- **Scoring key:**
  - **0 – the patient has been calm, patient and relaxed during the previous 24 hours. They are comfortable and relaxed in the company of other patients and staff**
  - **1 – the patient is considered easily annoyed or angered and unable to tolerate the presence of others**
  - **Or – a score of 0 is assigned if the patient has been irritable over seven days with no incidents of aggression**
  - **Thereafter, a score of 1 will be assigned again if there is an appreciable increase in irritability**

Pre-Admission Planning:

- Summarise history
- Review key care plans
- Discuss notable risks
- Ensure coherent approach to early stages of admission

Carer Awareness at the Broadland Clinic

Vicki Malcolm and Rose McCloskey
Vicki.malcolm@nhs.net

Today's aims

- Build on your existing knowledge
- Understand the forensic carer perspective
- How we work with carers
- Triangle of care
- Our Carer's charter
- Explaining restrictions and rules to carers
- Common sense confidentiality
- Carers days and carer involvement

Our Values
Welcoming Kind Positive Respectful Professional

Carers in Hertfordshire
charity registration number 1085491

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust definition

"When we talk about carers, we mean people who provide support to someone who is using one of our services who may not be able to manage without that support. You may not think of yourself as a carer so it is important we make you aware of the support that is available to you. You might be a partner, husband, wife, sibling, parent, friend or neighbour"

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Secure Carer's Toolkit

This toolkit aims to provide clear information for carers, service users, service providers and commissioners about how carers of people who use secure mental health services should be engaged with, supported, involved and empowered.

Carer's Toolkit

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Your experience

- Think of a time you have been in a caring role, or had to communicate with health professionals
- What did you appreciate from the health professionals? What was most important?
- What was unhelpful? What could be unhelpful?

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Forensic Carer experience

- Fragmented and piecemeal support
- Defensive practice and problems with confidentiality
- Family placed out of area - distance
- High stress from both situation and system
- Untapped resource
- Info is great, time spent is better
- Designated workers are appreciated
- Therapeutic support is rare
- Visits, rules, are tricky. Phone to follow up
- Fears about discharge or patient being moved

Explaining rules and restrictions

In pairs, try this discussion. A patients mum has brought in a surprise cake for their son's birthday

The staff member has to explain that it isn't allowed

The mum wants staff to make an exception

Have you ever had to have a difficult conversation with a carer?

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Carers Days

- The Format
- The feedback
- The cake

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So who attended?

- 37 Asst OT
- 22 Student AHP
- 16 HCA
- 13 OT
- 8 Nurse
- 8 Nurse student
- 7 Psychology
- 6 Social worker
- 5 Education
- 4 SLT
- 1 Medic

And who ran the sessions?

OT 9 sessions

Research associate 3 sessions

SLT 3 sessions

Medic 1 session

Psychology 2 sessions

Further data to collect

Further data to collect

- Reasons for cancellations?
- Spread of sessions – topics covered over time
- Reactive vs responsive topics
- Qualitative data on missing people

MISSING

ADDITIONAL DETAIL

NAME :

HEIGHT :

WEIGHT :

AGE :

EYES :

HAIR :

UNIQUE SIGN :

[PUT OTHER IMPORTANT INFORMATION HERE]

LAST SEEN :

TEXT 1

TEXT 2

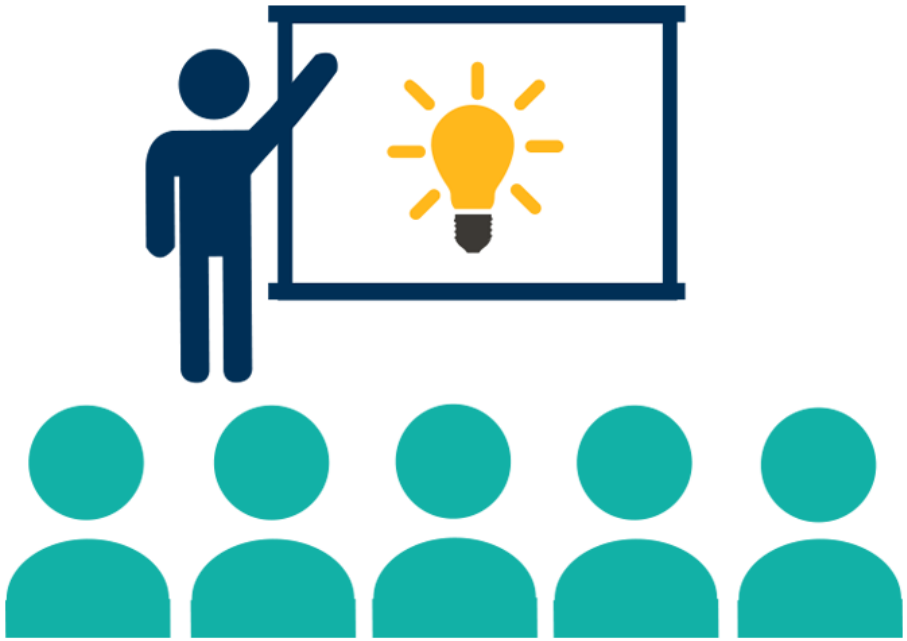
TEXT 3

IF YOU HAVE INFORMATION PLEASE CONTACT (Phone Number)

Act - conclusions

- Continue and improve!
- Gather data on cancellation reasons
- Further advance planning on topics
- More promotion across the site to drive up attendance
- Further discussion on why some staff are not attending
- Creation of further resources for short notice sessions

Your experiences




Thank you!