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inside this edition:

user standards for ward rounds

views on a nursing philosophy

**developing skills in
medication management**

an introduction to research governance

and more.....



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Editorial Group: *Advancing Practice in Bedfordshire*

introducing the Editorial Group for this edition:

John Butler

Lecturer Practitioner in Mental Health, Bedfordshire & Luton Community NHS Trust
e-mail: John.Butler@blct.nhs.uk

Mark Doshier

Practice Educator, Bedfordshire & Luton Community NHS Trust / University of Luton

C Menna

Trainer Facilitator in Mental Health, Bedfordshire & Luton Community NHS Trust

Jay Nair

Lead CMH Nurse & Beacon House (CMHC) Manager, Bedfordshire & Luton Community NHS Trust
e-mail: Jay.Nair@blct.nhs.uk

Mandy Quarmby

Clinical Audit Manager, Bedfordshire & Luton Community NHS Trust
e-mail: Mandy.Quarmby@blct.nhs.uk

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

All articles for submission should be forwarded as e-mail attachments in MS Word (doc) format, to:
John.Butler@blct.nhs.uk.

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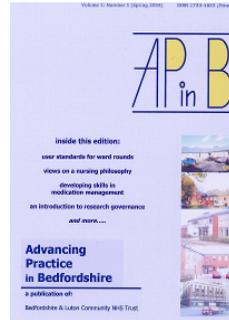
John Butler

Welcome to 'Advancing Practice in Bedfordshire'—the first edition of the re-launched Journal of Bedfordshire & Luton Community NHS Trust..

The journal has been re-launched as an important way of encouraging Trust practitioners and clinicians to share their work with others, both within and outside the Trust. Our aims in producing this quarterly journal are to:

- ◆ inform practitioners and clinicians about innovative practices taking place in Bedfordshire;
- ◆ promote learning and development and, in particular, explore its impact on clinical practice;
- ◆ share and advance examples of good clinical practice and evidence-based interventions;
- ◆ stimulate critical thinking, debate and discussion.

In our first issue, for late Spring 2004, we are pleased to feature initiatives taking place within the acute mental health care setting, which coincides with the recent establishment of an Acute Care Collaborative in the Eastern Region (*take a look at the NIMHE Eastern web-site for more information: <http://www.nimheeastern.org.uk>*) and the re-launch of the Bedfordshire Acute Care Forum (*for more information, e-mail: catherine.pearson@blct.nhs.uk*). The first article featured in this issue describes the development, application and audit of service-user standards for multi-disciplinary team meetings within Weller Wing, an acute mental health unit in North Bedfordshire, with the aim of enhancing the service-user experience.



To complement this, the second article highlights some encouraging findings from the piloting of a cultural sensitivity survey of service-user perceptions within the acute mental health service of South Bedfordshire.

A literature review, an outline of the Bedfordshire Research Governance Framework, perspectives on managing change, views on a nursing philosophy, and an action research study complete our first issue.

We would like to encourage you all to contribute to the success of this new initiative by sending in your ideas for future editions and submitting items for inclusion. We are particularly interested in featuring papers on the following: service-user and carer experiences; an innovative clinical practice; a recent or current audit, project or research study, especially if this has already influenced change; the development of a new clinical tool / resource; the impact of learning and development on practice; and, briefings on the latest research findings which impact on practice. Alternatively, if you would like to express your views on any of the topics covered, then we'd be very pleased to hear from you—see page 2 for our contact details.

Multi-disciplinary Team Ward Rounds: implementing user-focused standards within the acute in-patient setting

Sue Robson¹ & Maggie Nicholls²
Bedfordshire & Luton Community NHS Trust

¹ Service Manager, Occupational Therapy Service ² Clinical Effectiveness Unit

QUALITY IMPROVEMENT & AUDIT CYCLE

Introduction

In May 2000, a baseline audit was undertaken to further develop standards for multidisciplinary ward rounds that would '...minimise variation... and maximise quality of care, ...and create a framework which provides opportunity for the user to participate more fully in their care.' From this work, ten standards were developed and action plans were proposed, which included the completion of a client ward round preparation checklist and subsequent re-audit.

This re-audit was undertaken to compare compliance with standards against the baseline audit findings, and to assess whether the preparation checklist was being used. Service-users were asked to provide their perceptions of their ward round experiences through the completion of a questionnaire.

The aims of this re-audit were to evaluate whether the standards agreed in the baseline audit were being adhered to, and to evaluate the ongoing relevance of these standards to service-users needs. The objectives were: to compare current findings with the baseline audit; to examine whether the standards developed for ward rounds in 2000 still meet the needs of clients; and, to compare current service-user perceptions of their ward round experience with findings from the baseline audit.

Methodology

A multidisciplinary audit team was formed that included therapy, nursing, medical and audit personnel. The audit team agreed that tools from the 2000 audit would be used in the re-audit: this would include the use of a ward round client preparation checklist in gaining evidence of the service-user's preparation for ward rounds, rather than nurse interviews that had also been conducted. This checklist had been developed and implemented following the baseline audit.

Therefore, data was collected through:

- the completion of a questionnaire by an observer sitting in on ward rounds;
- a service-user questionnaire / interview, allowing service-users to give their perceptions of the same ward round that the observer had attended;
- an audit of the completion of the ward round preparation checklist.

It was agreed that the audit team-member from the Trust's Clinical Effectiveness Unit (CEU) would complete the observations and preparation checklist elements, with the audit team-member from Rethink conducting the service-user interviews. This approach was taken to reduce auditor / researcher bias.

As the purpose of this re-audit was to check the suitability and level of compliance with standards that were developed from the baseline audit, and levels of user satisfaction, the design of this re-audit differed significantly from the baseline audit, thus limiting opportunities for direct comparisons. However, direct comparisons between the perceptions of service-users in the baseline audit (2000) and re-audit (2003) are made.

Posters were prepared for each ward to advise service-users of the forthcoming audit. These were placed where service-users could read them and they were encouraged to ask ward staff any questions. Nursing staff discussed the purpose and process of the audit with service-users, ascertaining their willingness to participate within the audit. Those willing to take part were asked to sign a consent form. However, it was agreed that both auditors/researchers would speak with each

individual service-user prior to observing their ward round and interviewing them, to ensure that they were still willing to participate. Service-user and Consultant details were coded to ensure anonymity. Data collection tools were developed from those used for the baseline audit – as such, it was agreed that a pilot study was not required.

The intended sample size was a maximum of five service-users per Consultant, giving a total sample of 25 service-users. It was expected that only a limited number of service-users would be willing to take part, which would result in a self-selecting sample. However, if more than five clients per Consultant were willing to participate, then the CEU audit team-member would randomly select five service-users.

Upon seeking consent, a total of 13 service-users agreed to participate in all three elements of the audit – access to their preparation checklist; observation of ward round; interview / questionnaire following the ward round. Of these, one service-user left the service before the audit commenced and two others withdrew their consent prior to ward round observation taking place.

All data collection took place within a four-week period. Since there were so few participants involved, the Project Lead and CEU audit team-member agreed that analysis of results would be based on the entire sample, and not separated out by Consultant as had occurred in the baseline audit.

Summary of Findings

The audit findings are summarised in Tables 1 – 3: Table 1 shows compliance with the criteria on the ward round preparation checklist (n=10); Table 2 shows compliance for the ward round observation questionnaire (n=10, with

| Criteria | % compliance |
|---|--------------|
| client's full name entered | 70 |
| date of preparation entered | 70 |
| date of ward round entered | 70 |
| client told who will be present | 70 |
| client told what the Consultant is likely to discuss | 70 |
| client asked what they would like to discuss | 70 |
| client asked if they want family or friends present | 70 |
| client asked if they are willing to have trainees present | 70 |
| client given approximate appointment time | 70 |
| preparing nurse's initials present | 70 |
| client initialled checklist | 60 |

service-users from four Consultants in the sample); Table 3 shows compliance for the client interviews / questionnaires (n=10).

The one client who was not seen at their given appointment time was seen much earlier to suit their need to attend another appointment.

Comparison of Findings

Some direct comparisons can be made between the findings for the baseline audit and this re-audit, as shown in Table 4, although these are best considered as trends due to the difference in sample sizes between the two audits: 24 service-users participated in the 2000 audit; only 10 participated in the 2003 audit.

| Criteria | % compliance |
|---|--------------|
| client was given an appointment time | 100 |
| client was seen within 30 minutes of appointment time | 90 |
| Consultant checked if client knew everyone present | 100 |
| client was told everyone's name | 70 |
| client was told everyone's position | 50 |
| client was told the reason for the presence of unknown people | 60 |
| numbers of trained staff attending ward rounds | 4 – 9 staff |
| no trainees present at their ward round | 80 |
| client was given information about their treatment in their ward round | 90 |
| client was given information about services available in their ward round | 100 |
| client was given information about side-effects of medication in their ward round | 60 |
| client was given an explanation of any changes made to their medication | 90 |

Conclusions

User questionnaire responses for 2003 indicate improvements in all areas of preparation for ward rounds since the 2000 baseline audit. The greatest

| Table 3: Service-User Interviews / Questionnaires | |
|--|--|
| Criteria | % compliance |
| clients recalled being prepared for their ward round | 90 |
| clients said they had been told who would be present in their ward round | 80 |
| clients said they were told what the Consultant was likely to discuss with them | 40 |
| clients said they were asked what they would like to discuss in their ward round | 90 |
| clients said they were asked what they wanted to happen as a result of the ward round | 70 |
| clients said they were asked if they wanted family or friends present in their ward round | 60 |
| clients said they were asked if they were willing to have trainees present in their ward round | 90 |
| clients said the preparation they received for their ward round was 'about right' | 60 <i>30 (said it was 'too little')</i> |
| clients said they did not need an interpreter present in their ward round | 100 |
| clients said they were given an approximate appointment time for their ward round | 90 |
| clients said they were seen within 30 minutes of the appointment time they were given | 56 <i>33 (said they were not)</i> |
| clients said that they knew why everyone was present in their ward round | 56 <i>44 (said they did not)</i> |
| clients said the number of staff present in their ward round was 'about right' | 60 <i>40 (said there were too many)</i> |
| clients said everyone present in their ward round was, or could be, involved in their care | 56 <i>44 (said this was not the case)</i> |
| clients said the information given to them by their Consultant was 'about right' | 70 <i>10 (too much) 20 (too little)</i> |

improvements were for: the service-user being told who would be present at their ward round (80% vs 40%); being asked what they would like to discuss (90% vs 55%); and, being asked if they were willing to have trainees present (90% vs 44%). These findings suggest that the implementation of the preparation checklist has been useful in ensuring that all elements of preparation are covered with the service-user.

However, although all areas have improved since 2000, there remain areas for further improvement, for example: being told as part of their preparation what the Consultant is likely to discuss—although the preparation checklist showed 70% compliance, only 40% of service-users confirmed that this had happened.

Suggestions were made by service-users on how their ward round

| Table 4: Comparison of Compliance Rates | | |
|--|---|--|
| Criteria | 2000 audit % compliance | 2003 audit % compliance |
| client was told who would be present in their ward round | 40 | 80 |
| client was told what their Consultant was likely to discuss | 30 | 40 |
| client was asked what they would like to discuss | 55 | 90 |
| client was asked what they want to happen as a result of their ward round | 35 | 70 |
| client was given an appointment time | 87.5 | 90 |
| client was asked if they are willing to have trainees present at their ward round | 44 | 90 |
| client was asked if they want family or friends to attend their ward round | 41 | 60 |
| client was seen within 30 minutes of their appointment time | 81 (client ques) 56 (observation) | 56 90 |
| client was told the names of everyone present at their ward round | 75 (observation) | 70 |
| client was told the position of everyone present at their ward round | 54 (observation) | 50 |
| client was told the reason for the presence of unknown people at their ward round | 54 (observation) | 60 |
| everyone present in the ward round was / could be in the future involved in their care | 61 (client ques) | 56 |
| client's satisfaction with number of staff present in their ward round | 75 (about right) 25 (too many) | 60 (about right) 40 (too many) |
| client perceptions about the amount of information given to them in their ward round by their Consultant | 62.5 (about right) 5 (too much) 33 (too little) | 70 (about right) 10 (too much) 20 (too little) |

preparation could be improved, which included: '*Generally more discussion beforehand on issues likely to arise and encouragement to think about them and have an opinion on issues.*'; '*Would like to know what questions would be asked so could prepare, as mind goes blank once there.*'

User questionnaire responses generally showed that present service-users were less happy with their ward round experience than those who had been interviewed in 2000.

Fewer service-users said they were seen within 30-minutes of their

appointment time than in 2000 (81% vs 56%), although the observer recorded far greater compliance (90%). Comments from service-users about this standard included: '*Quite normal to be late. It was one hour 15 minutes late...*'; '*About 45 minutes late. This is completely normal.*'

These comments may relate to the service-user's general perception about their ward round experience and may not necessarily be associated with the specific ward round that was observed, as it was not possible to conduct the service-user interview immediately following the ward round.

Combining the standards that require the client to be told the names, positions and reasons for the presence of unknown people at their ward round, observed levels of compliance were slightly lower than in 2000 for two standards, *names and positions*, whereas there was slightly greater compliance for giving reasons for the presence of unknown people.

In the majority of cases, Consultants did introduce everyone present with their job titles, which is excellent practice and fully meets the requirements of the standard developed in 2000.

However, perhaps a simpler standard would be beneficial, such as: 'The Consultant will ask the service-user if they know the name and role of everyone present and the reason why they are present'. It would then be a simpler process for service-user and Consultant to have unknown people introduced, and their position and purpose in attending explained.

The use of a notice board displaying details of everyone likely to be involved in ward rounds, including their designation and reasons for attending might also prove a useful aid to service-users – a suggestion that was originally made after the baseline audit.

Service-user satisfaction with the number of staff attending the ward round markedly decreased since 2000, with some 40% of the 2003 sample stating that there were too many staff attending. One factor for this could be the range in the number of staff attending: 3 – 7 in 2000 & 4 – 9 in 2003.

Service-user comments confirmed that greater numbers of staff was interpreted as intimidating: *'Prefer to be less people as would feel freer to speak then.'*; *'The ward round can be intimidating as there are lots of people. Know that can say if*

too many people and ask some to leave, but wouldn't feel able to.'

Service-user perceptions about the amount of information that was given to them in their ward round improved, with 70% in 2003 saying it was 'about right'. Fewer clients than in 2000 felt they received 'too little' information (20% vs 33%).

Service-user comments about this standard included: *'Didn't seem to want to listen to what I was saying. Anticipated answers before they were given.'*; *'Didn't give any opportunities to ask questions.'*

From the observation questionnaire, it was noted that Consultants gave high levels of information to service-users. However, even though compliance was generally high for giving information about treatment, medication and side-effects, what was not recorded was whether changes were in fact made to treatment or medication. If no changes were made, then it would be unreasonable to expect to find compliance for these standards when observing the ward round.

When asked as a final question, 'Is there any way you feel that the ward round could be made more beneficial to you?', service-users provided the following suggestions: *'... be longer.'*; *'More time to answer questions.'*; *'Better debriefing after the ward round, preferably with someone who's been in the ward round. It would also be better if it happened the same day (sometimes it doesn't happen at all).'*

It seems possible that longer ward round appointments, perhaps with a less 'formal' atmosphere, for example offering the service-user refreshments, may help the service-user to feel more comfortable and part of a team discussion. This approach might result

in increased levels of service-user satisfaction with the information that is discussed and better compliance with suggestions that are made about their treatment.

The service-user's proposal of a 'de-briefing' shortly after the ward round seems an excellent one, as this could not only benefit them, but could ensure that any misunderstandings and other issues that were not raised within the ward round are addressed, and hopefully whilst the relevant staff members are still easily available.

Recommendations

It is recommended that ward round preparation checklists continue to be used. However, perhaps the staff member conducting the preparation could increase the information they give to cover in more detail what the Consultant is likely to discuss, and if possible give more details about who will be present at the ward round. Talking with the service-user about their concerns and hopes about the ward round at this time might help ensure that they feel better able to participate in their ward round.

It would seem useful for Consultants to ask directly at the beginning of the ward round whether the service-user knows everyone present and why they are there, focusing only on those the service-user indicates as being unknown. Whilst the practice of everyone giving their name and designation is an excellent one, it is possible that, given the stress indicated in service-user responses about the ward round, such a general approach does not result in the information being absorbed and also uses up valuable meeting time. The suggestion of staff details being shown where service-users have easy access

seems an excellent one and this should be implemented as soon as possible.

The numbers of staff attending ward rounds appear to need reducing if at all possible. Whilst most service-users understood why individuals were there, the numbers present inhibited their active participation.

It is recommended that staff de-brief the service-user following the ward round within the same day. This de-briefing should cover issues about the staff attending their ward round, and provide any additional information they need – a simple checklist could be developed to ensure relevant areas are covered. It would also be a good forum to check that the service-user has understood clearly what had been agreed in the ward round. From the staff attending the ward round, an appropriate staff-member should be nominated to conduct the de-brief and document the outcome of this in the service-user's records.

It is recommended that the service-users of the participating wards are given feedback about the audit, perhaps in the form of a poster, outlining the main findings of the audit and agreed actions / outcomes.

As part of the action-plan, the project lead is currently leading a review of the multi-disciplinary ward round process, for completion in summer 2004.

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| Standards for Multi-disciplinary Team Ward Rounds |
|---|
| Each client is given the opportunity, with their named nurse / agreed alternative, to prepare for the ward round. |
| An interpreter must be available, where possible, for clients not speaking English. |
| Each client should be given an appointment time and seen within 30-minutes of that time. |
| The client should be given the opportunity to discuss with their named nurse / agreed alternative, the presence or otherwise of family members. |
| The client should be introduced to everyone present – who he or she is, their designation and what their role is. |
| With the exception of trainees and staff acting in liaison roles in the absence of other team colleagues, only those people currently involved, or with the potential to be involved in the future care of the client, should be present at the ward round. |
| Each client should be asked before the ward round whether they are willing to have trainees or students present. |
| During the ward round, the client will be given sufficient information about treatments and services available, to enable them to participate in the decision making about their care. |
| Where clients are unwilling or unable to be involved in decisions about their care, the reasons for this will be documented in the notes relating to the ward round. |
| There is a written record of the meeting, clearly indicating the agreements made. Each client is given the opportunity, with their named nurse / agreed alternative, to discuss the ward round and/or have a copy of the ward round record. |

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For Further Information

Sue Robson, Project Lead, Bedford Heights, Manton Lane, Bedford MK41 7PA.

Cultural Sensitivity: a short survey of service-user perceptions within an acute in-patient mental health service

Mike Jackson¹, John Butler², Shannaz Wahid³ & Toni Sebastian⁴
Bedfordshire & Luton Community NHS Trust

¹ Unit Manager, ² Lecturer Practitioner in Mental Health, ³ & ⁴ Community Mental Health Nurses / Ethnic Community Liaison Speciality

QUALITY IMPROVEMENT & AUDIT CYCLE

Introduction

Luton is a town in South Bedfordshire with a rich and diverse ethnic profile. Some of the town's central electoral wards have high numbers of people from ethnic minority groups, and particularly from the Black African, Black Afro-Caribbean and Asian groups. These same electoral wards are areas of known high social deprivation. These ethnic minority groups, in particular, are over-represented within the town's mental health services and their needs are thought to be very different from that of the White population.

Within Luton, there are two small community-based mental health in-patient units and four acute community mental health teams for people aged 16-65, with mental health services being provided by multi-disciplinary teams of specialist mental health practitioners. Two of the community mental health nurses have dedicated specialities in working with people from the ethnic minorities. With the help of a unit manager, they formed a small ethnic minorities project group, developing a short audit tool based upon the Sainsbury Centre for Mental Health cultural sensitivity audit tool (SCMH 2001a) which has been used in hospital based psychiatric services in the UK (SCMH 2001b).

The project group agreed to complete a pilot audit of the service-user's experience of local acute in-patient mental health services during 2003, with the support of the local Service Improvement Group.

Project Aims

1. To test the use of a short cultural sensitivity survey tool.
2. To understand the experiences of service-users from ethnic minority groups who have used local acute in-patient mental health services.
3. To establish the needs of people from ethnic minority groups who use local acute in-patient mental health services.
4. To understand what services are required by people from ethnic minority groups.

5. To assess the strengths and weaknesses of local acute in-patient mental health services in meeting the needs of service-users from ethnic minority groups.

Method

A short cultural sensitivity survey tool was used as the basis for conducting semi-structured interviews with 11 service-users, all of whom had received in-patient care in the Luton-based acute mental health units during 2003. This survey only included service-users from the Black African, Black Afro-Caribbean and Asian ethnic minority groups. Each service-user was interviewed by one of two project group members, both of whom were working as experienced care coordinators (community mental health nurses), and each fulfilling a speciality role in engaging service-users from the ethnic minorities.

Findings

About the Respondents

Five female and six male service-users agreed to be interviewed for this audit study.

All respondents were aged 16-45, with 9/11 respondents being within the 26-35 age group.

The most represented ethnic minority groups were Black Afro-Caribbean (3 respondents), Bangladeshi (3) and Pakistani (2), with one further respondent for each of Black African, Black & Tamil groups.

7/9 service-users who responded stated that they had resided in the UK for 10-years or more, with 5/11 respondents having been born in the UK.

Some nine different languages were spoken by the respondents, eight of

whom reported speaking more than one language; 6/11 respondents stated their first language as English, with three others stating English as their second or third language; of the remaining two respondents, one stated simple English as their second language and only one did not speak English.

9/10 respondents reported that the first person they contacted when unwell was their family or partner, with 9/10 respondents reporting that they went on to see their General Practitioner about their problem.

Referral to mental health services was initiated by a variety of sources, which included the family / self in three cases, the Accident & Emergency Team in one case and the Police in one case.

Users' views on the cultural appropriateness of services provided

Spiritual & religious needs:

Of nine respondents who reported a religious affiliation, of whom five were Muslim and two were Pentecostal, only three respondents (Muslim, Christian & Pentecostal) stated that they usually visited a place of worship—all of whom confirmed there was a place on the unit to pray / worship. Five respondents did not think there was a place to pray / worship—none of these respondents reported usually visiting a place of worship, although four did state a religious affiliation.

Provision of Information:

6/10 respondents reported having received information about mental health services, three of whom received this in both verbal *and* written form, with the rest receiving only verbal information. All of those who received verbal information reported understanding some or all of the

information. Notably, four respondents reported that they did not receive any information and 1/3 respondents who received verbal and written information reported not understanding any of the information.

Access to interpreters:

Although 10/11 respondents spoke some English, 3/11 reported a need for an interpreter when speaking to people from mental health / social services. Of these: the only non-English speaking person reported gaining access to interpreters, both a family-member and a professional, although was not satisfied with the family interpreter; a Tamil service-user who spoke only simple English had access to a family interpreter and was satisfied with this; the third respondent requesting an interpreter was in fact born in England and spoke English—their needs were less clear.

Understanding:

All respondents reported that they understood some (4), most (2) or all (5) of what staff members said to them. 10/11 respondents reported that staff understood what they said to them some of the time (5), most of the time (2) or all of the time (3).

Food:

7/11 respondents reported having a special dietary requirement, with the most common being a halal diet which was requested and met in all four cases. 4/11 respondents reported that their dietary requirements were not met, one of whom was a vegetarian, one of whom had requested a normal diet, with the other two not stating any dietary preference. However, 10/11 respondents were satisfied with the available choice of food.

Preference for key-worker of same gender, same ethnic minority group & able to speak own language & standards of care:

6/11 respondents expressed a preference for staff-members who could understand their own language, although all of these reported being able to understand staff some or most of the time. 3/11 stated a preference for a named nurse or key-worker who was from a similar ethnic background (Pakistani, Tamil, Creole). Interestingly, only 2/5 female respondents stated a preference for a named nurse or key worker of the same gender, with the rest not stating any particular preference. 6/11 felt that their cultural needs were understood. 8/11 thought that their privacy was respected by staff. 9/11 thought that the service did encourage involvement from their family, and only one thought that they were treated differently as a result of their race, cultural and spiritual beliefs.

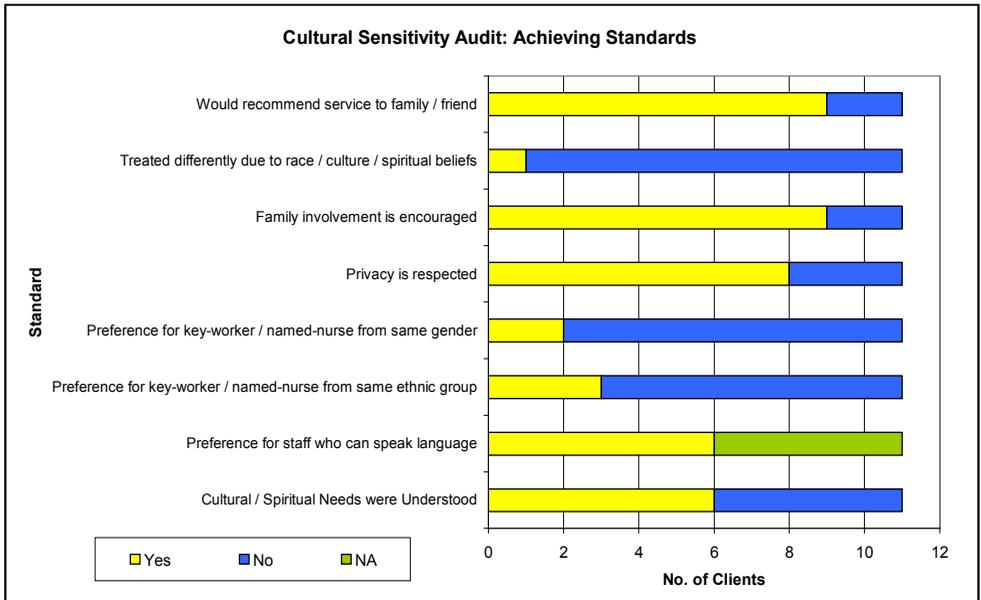
Users' views of the services provided

The best & worst things about in-patient services:

7/11 respondents made complimentary comments about the service, highlighting elements of the service that they liked / disliked. The positive comments included: 'staff taking time out to listen and not judge', 'meeting a staff-member from my own country', and 'staff being friendly'. The concerns included: 'food restrictions', 'nothing to do', and 'West Indian food not available'.

Recommendation of service:

9/11 respondents reported that they would recommend the service to a family-member or friend – a very encouraging finding.



Conclusion

The findings of this audit are clearly limited by the very small sample size and therefore it is difficult to make general recommendations.

Nevertheless, the findings are very encouraging, providing some evidence that the local acute in-patient mental health service is making considerable progress in meeting the cultural needs of people from ethnic minority groups.

There are some interesting findings, particularly with regard to the service-user’s preferences, highlighting the need for an open dialogue with all service-users, opportunities for them to state their individual preferences, rather than making any assumptions, and maximising efforts to meet those preferences, even if within the realistic constraints of available resources.

However, there is clearly a need to develop this audit project further: the audit tool requires some refinement by the project group as particular questions

did not yield any meaningful results, such as the questions relating to treatment provision. More could be made of the semi-structured interviewing approach—participants could be asked to clarify and elaborate on their views. Much larger numbers of service-users should be given the opportunity to contribute their views.

Recommendations

1. For the service improvement group to review the findings of this audit in developing and implementing an action plan aimed at fully meeting the needs of people from ethnic minority groups who access local services.
2. To further refine the local cultural sensitivity audit tool.
3. To conduct a further audit with a more representative sample size – conducting a semi-structured interview with 30–50 service-users, representative of the local

- ethnic minority groups.
4. To make better use of the semi-structured interviewing approach in further exploring the service-users' views and then engaging them in service improvement initiatives.
 5. To extend the audit to other areas of the local mental health service.

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Further Information

A copy of the full audit report and survey form can be obtained from:
Mike Jackson—Unit Manager
Townsend Court, Mayer Way, Houghton Regis, Dunstable, Bedfordshire.

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Male Adult Survivors of Childhood Sexual Abuse: a review of the literature

**Sue Stimson BA(Hons.), DipCouns, RMN
Lead Community Mental Health Nurse
Luton South East CMHT, Bedfordshire & Luton Community NHS Trust**

LITERATURE REVIEW

A Problem in Practice

I have worked with female survivors of childhood sexual abuse since 1996, when the Trust identified a need for this service. Over the past two years, I have seen an increase in referrals for male survivors and feel I have limited experience in this area.

Over the years, I have gathered experience and knowledge about female survivors and have realised that other professionals that I work with have difficulty hearing or believing the trauma that the survivors have experienced, especially with a male survivor. This leaves me working in isolation with a lack of support or adequate supervision.

Various researchers have stated that childhood sexual abuse in males is on the increase, so why do relatively few males seek professional help?

The purpose of this paper is to critically appraise some of the research literature on male survivors of childhood sexual abuse and the nursing professional's responses to disclosure in an attempt to ascertain whether nurses need further training in this area and to establish why so few male survivors seek professional help.

Definition

Health and mental health professionals frequently encounter adults who were sexually abused in childhood (Sgroi & Bunk 1988). They are referred to as adult survivors, people who

now, as adults, find that they have problems in functioning which they believe is caused by their childhood trauma. The implicit premise is that their early sexual experiences were emotionally damaging to the individual, and therefore the adult has survived a traumatic experience in childhood (Sgroi 1988). Sayce (1993) and Sheldon (1987) state that sexual abuse is not about intimacy or seduction but an abuse of power over a vulnerable child, who is never in a position to offer consent. There was no specific definition for male survivors in any of the articles reviewed.

Characteristics of the Studies

Of the six articles selected for this review, located through the Cinahl and Medline databases: two used hypothetical vignettes to ascertain reactions to disclosure, two were literature reviews, and there was one survey and one phenomenological study. All six concluded that further research is needed.

Although the literature on female survivors is still limited, the body of literature on male survivors is far less. Apart from a few isolated papers, it is only during recent years that any books have been published. There appears to be a relative silence about the abuse of young and adolescent boys, which has fostered a belief among health professionals and society that the problem is uncommon and the outcomes are not severe (Spencer & Tan 1999). Prevalence rates show otherwise: 16% males & 27% females in the USA (Finkelhor et al 1990). National surveys show that about 30% of all childhood sexual abuse victims are males, although only 9% of these males were referred for professional help as adults (Spencer & Dunklee 1986).

Holmes et al (1997) suggested four possible reasons for this:

- ◆ childhood abuse may have a lesser impact on males
- ◆ men with a history of childhood sexual abuse may have come into contact with other agencies e.g. probation
- ◆ men don't discuss their childhood experiences
- ◆ professionals don't inquire or suspect histories of childhood sexual abuse in adult men

In their review of the literature, Holmes & Slap (1998) concluded that sexual abuse is under-recognised and under-reported in boys.

Holmes et al (1997) did not state how many studies they reviewed but used North American studies that included telephone surveys, postal surveys and face to face contact. They report that consideration needs to be given to methodological and sampling issues, limiting the generalisability of some of their conclusions. Both literature reviews state that childhood sexual abuse has a similar impact upon male and female adults, indicating that one cannot conclude that men are referred less often for psychological help because the experience has only a minor impact. Holmes et al (1997) did show that males disclose their abuse less often and that clinicians are less likely to believe in the disclosure or to treat it as an issue for therapy. Although raising issues for clinical practice, their review was mainly based upon studies that were over ten years old.

Holmes & Slap (1998) presented a statistical analysis in their review, highlighting some interesting conclusions: boys at highest risk were under 13-years old, non-white, of low socio-economic status and were not

living with their fathers. Bear (1998) reports that survivors come from varied backgrounds, and are not just from low socio-economic groups. My own clinical experiences support this: encountering male survivors of mixed backgrounds, upbringing and culture, and only from a white background.

Exploring the Issue of Blame

Back & Lips (1998) investigated the effects of victim age, victim gender and observer gender on the tendency to attribute responsibility for extra-familial child sexual abuse to the victim and non-offending parents. 145 undergraduate students were asked to read a vignette describing a sexually abusive interaction, varying the child's gender and age (6 & 13 years old). Students used a likert scale to indicate the degree of responsibility.

Spencer & Tan (1999) carried out a similar study to explore the reactions of undergraduate students to analogue male disclosure of sexual abuse, occurring at ages 5, 15 & 25 years old, with a male or female offender.

Both studies used a good sample size, although Back & Lips (1998) included more female students, who were found to be less judgemental than male students. The mean age of students was very similar in both studies.

Both studies found that the older the victim age, the less responsibility was placed on the offender, and that male students assigned less responsibility to the offender. Back & Lips (1998) found that some of their hypotheses were unfounded e.g. that the non-offending mother would be assigned more blame.

In summary, the findings were that older children who may be at greater risk and more likely to disclose, are also at greater risk of being held responsible,

especially if disclosure is made to a male. Spencer & Tan (1999) found similar results, that males were more negative than females in their reactions to survivors, although they stated that both men and women indicated general support for the survivor and a disapproving attitude to the offender. They also found that the age of abuse had an impact on reactions. Both studies recognised the need to undertake research within the general population, realising the limitations of using undergraduate students in a classroom setting.

Exploring Training Needs

Gallop et al (1998) used surveys to research comfort, attitudes, competencies and educational needs of psychiatric nurses who work with clients with a history of childhood sexual abuse. They posted 3,532 surveys to nurses in four Canadian states, receiving a 48% response rate. Of the 1,701 responses returned, they established that 4% had not cared for clients with a history of childhood sexual abuse, and that 19% of nurses had their own history of childhood sexual abuse.

Gallop et al (1998) used three sets of scales: a sexual abuse comfort scale (Gallop et al 1994); a sexual attitude scale (Hudson et al 1983), to ascertain nurses sexual attitudes and their comfort in intervening in situations involving sexual abuse; a questionnaire on educational needs.

Gallop et al (1998) claim that their findings can be generalised to psychiatric nurses in the English speaking part of Canada, concluding that nurses have liberal sexual attitudes and feel that inquiry should be made about the likelihood of childhood sexual abuse in their clients, although it was not established when inquiry should take

place. They found male participants were less comfortable about these issues and met their hypothesis that nurses are in need or request further training in this area, especially when survivors disclose. Most participants assumed that the offender was male and the victim was female. They stated that 'educators owe it to nurses and clients to provide education', although they did not identify what type or delivery of education is needed. Nurses recognised the importance of listening and believing, although they made little references to self awareness.

Fater & Mullaney (2000) researched adult male survivors abused by clergy, to aid nurses in identifying risk factors, designing prevention strategies and enhancing empathy for a healing relationship. They used a small sample of seven adult men who had been sexually abused by clergy, using a phenomenological study. These subjects were aged 28 – 48 years old, with the age of abuse ranging from 9 – 19 years old. The frequency of abuse varied: one to many experiences over 4 years.

They asked open ended questions to commence an interview, with both researchers audio-taping interviews. Interviews continued until no new themes emerged and they used a nurse expert in phenomenological study to listen to the audio-tapes. The data was independently analysed and all survivors were involved in reviewing ten themes as a validation check.

The themes and survivor quotations were not dissimilar to how all adult male survivors feel, not just those abused by clergy (Ethrington 2000). Unfortunately, the study did not suggest ways in which nurses could help survivors and did not identify any educational needs, nor how to deal with disclosure.

Conclusions

All six articles have recognised the need for further research and dismissed myths that males are not affected by childhood sexual abuse. Some of the findings have serious implications regarding the prevention of sexual abuse and its treatment. If society views an older child victim as responsible, then these children are less likely to disclose and less likely to receive treatment. Because age plays a strong role in determining others' responses to disclosure, there are fears among male survivors that they may be seen as unmasculine should they disclose, although men who survive childhood sexual abuse may not necessarily receive the negative reactions they anticipate.

It is important for professionals to understand interpersonal reactions to male sexual abuse and the factors that affect those reactions are important in facilitating abuse identification and recovery.

Some of the findings suggest a need for professionals to recognise, feel comfortable and deal with disclosure from male survivors. The findings imply that male professionals were less comfortable working with survivors, although this may be a response to the reality that most abusers are male and many survivors are female, and male victims may feel uncomfortable working with a male professional.

Most of the findings suggest that further education is needed, not just of professionals but of society as a whole. Holmes et al (1997) argue for an improved awareness of male victims of childhood sexual abuse in enabling more males to access help. In South Bedfordshire, male survivors are accessing help yet rarely complete the counselling process. Holmes et al (1997) went on to state that the myths

about female survivors have existed in the past e.g. girls are not abused. The same myths apply to male survivors presently and we need to challenge our own assumptions regarding all children who are abused. Holmes & Slap (1998) stated that sexual abuse in boys is under-reported and under-recognised for the same reasons and that, as professionals, we are more accepting of female abuse.

They suggested that if we work with male survivors in the same way as female survivors, this will be a start in enabling males to disclose comfortably.

At the most basic level, nurses need to understand the prevalence and impact of childhood sexual abuse, and how and when to inquire and respond to disclosure (Gallop et al 1995). I have realised the importance of educating / helping health care professionals deal with disclosure and have been asked to present a number of sessions on dealing with disclosure to learning disability and mental health nurses. I hope this will facilitate health professionals to feel comfortable and competent in dealing with these issues.

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Research Governance Framework for Bedfordshire & Luton Community NHS Trust

Anna Hames

**Psychology / Research Assistant to Dr GA Kupshik
Bedfordshire & Luton Community NHS Trust**

RESEARCH & DEVELOPMENT

Introduction

The purpose of this article is to set out a framework for Research Governance, explain its importance and emphasise why all staff need to be aware of it. The Research Governance Approvals pathway will be explained in some detail and the responsibilities of the various individuals involved in research emphasised. Furthermore, a pathway for individuals to progress from their initial idea through to beginning their research is outlined.

Research Framework

Research is essential to advance our knowledge and understanding and to ensure our health services are as effective as is currently possible. However, there have been several publicly reported incidents of when badly managed research has caused harm or distress to others. Research Governance aims to prevent any such harmful events from occurring. By closely monitoring and guiding research activity, Research Governance aims to ensure research is of a high quality, that the findings would actually be of use and that all ethical considerations are fully taken account of. The interests of the participants must always come first. With such controls in place, the public can be confident about and benefit from research.

It is essential for every individual who works in a service or academic context to be aware of what constitutes good quality research and to understand how such research should be properly conducted. In 2001 the government published 'The Research Governance Framework for Health and Social Care'. This document sets out guidelines for the proper governance of research and describes the manner in which this should be assessed and monitored so as to ensure standards are met. Local Research Governance Approvals Groups aim to implement these guidelines. It is only with Research Governance Approval (which precedes Ethics approval) that any research can be conducted within the Trust.

Each Trust has their own Research Governance Approvals Group. Bedfordshire and Luton Community Trust's Group

meets once a month. The committee consists of six members, each with varied backgrounds and different areas of expertise. Potential researchers must prepare and submit a research study proposal to this group. The group considers whether they believe the proposed research would be beneficial to the Trust, whether ethical considerations have been taken into account and whether suitable controls are in place for its safe and successful implementation.

If approved, the proposed research study is guided towards the local ethics committee. Once this has been granted, the research can begin. If, however, the group feel unable to give full approval to the proposal then the researcher is advised about the group's concerns and offered assistance in modifying their proposal to an acceptable standard. It is not the purpose of the group to act as a barrier preventing people from conducting research, but to encourage and assist people in conducting research of a good quality, which is ethically sound. All such individuals are offered either direct assistance or given further contacts and are invited to resubmit once specific changes have been made.

The purpose of asking potential researchers to submit a study proposal is to ensure that they have considered whether their research idea can be implemented safely and effectively. It is also important that the findings of the research would be of benefit to the Trust and that no participants would come to any harm.

Research Process Checklist

A checklist to follow from starting with an initial research idea through to submitting a proposal is suggested below:

1. Decide on a general area of interest
 - Develop a preliminary research question – what do you hope to investigate?
 - Develop a hypothesis – what do you expect to find? Or what questions do you hope to raise?
 - Why would this research be important? How might it benefit NHS patients or service-users?
2. Review the literature
 - Use internet and library search engines to make a systematic review of the current literature. Online databases such as PsycInfo and Medline are a useful starting point. Consult your librarian for advice about various searching methods.
 - Read extensively around your proposed research question.
 - Is your idea novel? Will it contribute something new to the area of research? It is unethical to needlessly duplicate previous work.
 - Refine your research question to incorporate your new knowledge, ensuring that your study is novel and the findings would be of use.
3. Design your study
 - Decide what method would be most appropriate to use.
 - Discuss with your supervisor and line manager as to the practicalities and suitability of

your method.

- Decide how many participants you will need and how you will recruit them. Think about whether and how consent will be gained.
- How you will analyse the data – what statistical methods will you employ? This may impact your method of data collection.

4. Consider ethical implications

- Are the participants likely to come to any harm or distress? How will you minimise this risk and what procedures are in place for dealing with any distress?
- How can you guarantee that consent is informed? This is particularly important when dealing with children or vulnerable adults.
- How will participants' data be protected and confidentiality be assured?
- Participants must be free to withdraw at any time, without this impacting on their continued care in any way.
- Participants should be involved wherever possible in the design, conduct and analysis of the study.

5. Ensure you have the backing of your sponsor and line manager

- Your sponsor is usually your employing organisation, who takes overall responsibility for the research.
- Enquire about any honorary contracts that are needed for non-NHS staff.
- Discuss ideas with your line

manager / head of department. Any research requires their support prior to consideration of your study by the Research Governance Approvals Group. See below for line manager responsibilities.

6. Write your research proposal

- Follow the guidelines on how to write your proposal for the Research Governance Group you are submitting to. This can be found through the 'Research Governance' link of the 'Bedfordshire Web' (see later).

7. Submit your proposal

- Find the date of the next Research Governance Approvals Group meeting. Submit your proposal and wait for feedback!

Responsibilities

To reduce the risk of any adverse events and to ensure that research is being well managed from the idea conception through to carrying out the research, analysing the data and disseminating the findings, it is important for each individual involved to have a clear set of responsibilities and accountability. A summary of the main roles involved with a research study are listed below, with their key responsibilities outlined.

Principal Investigator

The principal investigator takes overall responsibility for the research, from its design and conduct through to its dissemination. This individual is responsible for ensuring their research has gained Research Governance and Ethics approval and that the agreed protocol is adhered to. They have a

responsibility to ensure participants' welfare at all times.

Line Manager

This is either the Head of Department, Service, Associate or Clinical Director. Line manager approval must be sought prior to a proposal being submitted to the Research Governance Approvals Group. Approving a research project implies a responsibility to ensure that the research is carried out in accordance with the Trusts Research Governance framework. They must ensure that the researchers are competent in carrying out the research and that the participants' dignity, rights, safety and well-being is paramount. This individual has overall accountability for all data and documentation arising from the study and in ensuring the data collected is accurate and of high quality. Further responsibilities include archiving the data after project completion and disseminating the findings to participants.

Sponsor

This is the organisation that takes overall responsibility for ensuring the research can begin. This includes making arrangements for the initiation, management and funding of the study. They are responsible for ensuring the study has Research Governance and Ethics approval before research begins and making arrangements for monitoring the study, including reporting any serious incidents that may arise. They must have an agreement in place to provide compensation in the event of non-negligent harm and have made financial arrangements made for this.

Conclusion

In conclusion, the aim of Research Governance is to promote well-governed research. We are eager for everyone to understand how to conduct research safely and efficiently, so as to safeguard our participants and to produce work that will be of benefit to our services. Badly managed research wastes the time and resources of both staff and participants and risks causing harm and distress. It is not the aim of Research Governance to deter people from conducting research, but to ensure that research that does take place is of good quality and is beneficial for all involved.

References & Useful Links

The Bedfordshire Web

<http://nww.eastern.nhs.uk/>

(soon to be launched)

Click on the 'Bedfordshire' link, 'Research Information', 'Research Management and Governance Steering Group'.

This includes details of the various Research Governance Groups in Bedfordshire, including guidelines on how to prepare a study proposal, an outline of the responsibilities of the various individuals involved in the research, a description of the approvals process and useful dates of any upcoming events and meetings.

RDDirect

<http://www.rddirect.org.uk>

A useful website for potential researchers working in health and social care settings.

Department of Health (2001) *Research Governance Framework for Health and Social Care*. Department of Health, London
<http://www.dh.gov.uk>

Click on 'Research and Development', 'Research Governance'.

Challenging Assumptions: a perspective on the process of generating and managing change

Claire Day RMN, BA (Healthcare Management)
Community Mental Health Nurse,
Pathfinder Team,
Older Peoples Services, Bedfordshire & Luton Community NHS Trust

MANAGING CHANGE

Introduction

Nursing, and healthcare generally, are constantly re-building to provide better, quicker, more dependable services and care and, as a result, change is an inevitable part of our professional lives. It is also a complex process that can generate unpredictable results. Publication of the National Service Frameworks (NSF) for mental health (DOH 1999), Modernising Mental Health Services—Safe, Sound and Supportive (DOH 1998), and the Care Programme Approach (CPA) (DOH 1990) have all been intended to develop services, and CPNs have often been at the forefront of these changes. It is recognised that the management of change requires high levels of skills and knowledge in relation to the change process. Lindenfield (1992) corroborates this. He also contends that the individuals involved in the change process need to understand themselves, perhaps via their own reflection and learning from previous changes, in order to understand others while undergoing or implementing change.

The Change Agent

Rafferty (1991) and Turner-Shaw & Bosanquet (1991) identify how those in clinical leadership positions, such as sisters and charge nurses, frequently act as change agents, promoting and changing standards of care. Lancaster & Lancaster (1982) describe a change agent as someone who generates ideas, introduces innovation, attempts to develop an appropriate climate for change, and then implements and evaluates that change. They point out, however, that change will not always be successful without the full co-operation of those most affected by them.

Maulsh & Miller (1981) claim that the status of the person suggesting or promoting a particular change has a considerable influence on the manner in which new ideas are accepted, and although Ottoway (1980) claimed that all nurses could act as change agents, almost two decades later, Wright (1998) suggested that many nurses still lack the knowledge and skills to undertake this role. This may be because nurse education has only recently begun to encourage nurses to challenge events and practices. Furthermore, nurses who

were trained in a traditional and ritualistic manner may find it difficult to question practice: a position supported by Menzies (1960), who suggested that nurses often perceive change as a threatening event, and that ritualistic practices survive in order to avoid anxiety.

Ottoway (1982) describes three types of change agents: Adopters, who hear about a change, implement it, accept it and incorporate it into their practice; Generators, who recognise the need for change and provide enthusiasm for it; and Implementers, who take responsibility for bringing about change once its need has been recognised. Implementers seek to develop good working relationships and a collaborative, mutually supportive approach. Each is interdependent upon the others, and each must be involved in any successful change process. Generators, according to Ottoway (1982), although enthusiastic are not in themselves sufficient to bring about change, as their commitment is not consistent at all stages of the change process.

Wright (1998) criticised this construct, particularly the idea of Adaptors, saying that they were not clinically credible because of a lack of research ability. This made them ineffective in implementing evidence-based practice and risked using unreliable and invalid findings in their attempt to improve patient care—it could, however, be argued that adopters comprise the majority of people responsible for enforcing change.

A significant aspect of the change agent's role is to distinguish between necessary and un-necessary change (Cahill 1995). This involves assessment of the benefits of change. However, Wright (1998) argues that many nurses

lack the knowledge and skills necessary to undertake this role and alleges that they are incapable of resisting negative changes when they are imposed upon them.

Preparing for Change

Prior to instituting any kind of change, it is essential to accurately assess the current situation and define the desired state (Richardson 1999). It is necessary to establish all the relevant facts in order to gain a global view of the possible effects of the planned change (Haynes 1992), and central to the implementation of change is the selection of strategies that are likely to achieve the desired outcome (Bennis et al 1976). Choosing a strategy for change helps to: clarify thoughts on the nature of the change; and, develop plans of action in a logical and orderly manner (Callaghan 1998). Haffer (1986) argues that two important issues need to be considered when selecting an appropriate strategy to facilitate change: that the strategy should focus on the appropriate change target; and, should consider the willingness and ability of the group to change.

Strategies for Change

Sugden (1984) and Keyzer (1985), amongst others, identify three change strategies each with its own advantages and disadvantages. Each strategy is based on different assumptions about what makes people change or alter their behaviour. These strategies are Power-Coercive, Rational-Empirical and Normative-Re-educative. The Power-Coercive strategy is based on the use of political and economic sanctions to achieve the desired outcome and, when necessary, the use of moral power. The assumption underpinning the Power-Coercive strategy is that persons with less power will always comply with the

plans, directives and leadership of those with greater power. Whilst being told what to do can be a comfortable way of functioning for many people, Wright (1998) maintains that the effectiveness of any particular task is increased when the individual concerned knows why it should be done in a given way. The Power-Coercive strategy is frequently viewed as a top down approach which fails to acknowledge that people require many things when going through change, including recognition, advancement, interest and overall security (Wilson & Rosenfield 1996). If change threatens any or all of these, then it can become difficult, if not impossible, to achieve with the individual or team involved. When coercion or threats are used to implement change, as in the Power-Coercive strategy, it may seem as though change has taken place initially, but this is often superficial and underlying changes in attitude or behaviour have probably not taken place at all.

The Rational-Empirical approach assumes people are going to view change in a positive manner and work constructively towards it if they are given the basic facts, and so long as there is some evidence that they will derive a degree of benefit from the change. The Normative-Re-educative approach takes this further by arguing that people need to be involved in all aspect of the change process. This approach is viewed as a 'bottom-up' type of strategy, and its success depends on the individual's or group's perceptions of the need for change and its relationship to daily practices.

Model of Change

Lewin's (1951) model of organisational change provides a framework for understanding how organisations change, and is based on the idea that in

any change there are two opposing forces: driving and restraining. Lewin identifies three steps in his theory of change. Stage one is identified as unfreezing which involves motivating people towards change and the unfreezing of old attitudes or ideas. Lewin suggests that force field analysis is employed in order to achieve a balance between two opposing forces. In order to progress, any restraining forces must be reduced and driving forces increased. The change agent using the Rational-Empirical and Normative-Re-educative strategies begins to unfreeze established beliefs by working from the bottom up. These strategies help the change agent to negotiate with the group in decision-making and provide supportive education programs where a theory practice gap can be identified. The change agent also employs elements of the Rational-Empirical strategy, as it is assumed nurses will adopt change if it can be rationally justified and demonstrate a positive gain. It should, however, be acknowledged that people do not always act rationally with respect to implementing research findings, and the Rational-Empirical strategy should not be used in isolation (Smyth, 1995). Lewin identifies the second step in his theory of change as the moving stage. It is during this stage that the need for the change becomes recognised, and directions and solutions are sought. Sullivan et al (1992) describe how, during the moving stage, information about the change is collected and discussed and plans are made to implement it. Potential problems are discussed and solutions sought and the transition to a new level of working can begin. Prochaska & DiClemente (1983) term this the 'contemplation' phase: an interactive period where information is required about what the change might

mean for those involved. Wright (1998) advises that an appropriate time scale should be set in which to implement the proposed change. He maintains that this must be of sufficient length to enable everyone involved in the change process to accept it and prepare for it.

Conclusion

It is acknowledged that the implementation of change is a complex process requiring high levels of skills and knowledge and anyone entering the process of change needs to have a clear understanding of their professional boundaries and accountability.

It should be accepted that not all change improves things. It should also be acknowledged that resistance to change is not always a negative process as it can challenge the proponents of change to justify and clarify the reasons for their proposals. Nurses must be able to understand the process of change in order that they are better able to determine its course and so that they can protect themselves and their patients. Knowledge is power, and knowledge of change helps to give nurses a degree of control over the change process. Thus empowered, they are not left merely to react but can become proactive in determining the course that nursing takes.

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Towards a Philosophical Construct of Nursing

Mark Doshier, Kim Maskell & David Roberts—Practice Educators,
Bedfordshire and Luton NHS Community Trust / University of Luton

A NURSING PHILOSOPHY

Introduction

Within the context created by the broad principles of the Practice Educators' (PE) function, a significant aspect of the role must include the exploration of theoretical and philosophical perspectives that help develop a fully informed context upon which nursing can position itself. A sound philosophical base is necessary as a framework through which specific theoretical ideas can be linked to practice. For instance, if we have the philosophical perspective that the only relevant issue in practice is the correct administration of procedure, then it will prove impossible to adopt a style of work that emphasises the interpersonal—there being no reason for it. Thus any philosophy that seeks to guide action must possess moral and ethical aspects that connect with the personal beliefs of individual practitioners and students. One of the PE's roles is to make that connection.

Firstly, no matter the degree of clinical expertise or specialist knowledge applied, nursing is a humanistic activity—that is, it is concerned with the patient as a human being experiencing the clinical procedures practiced upon it. We do not doubt that Medicine as a discipline would argue the same for itself, but it is a fact that the medical model conceptualises the individual as a collection of systems each requiring its own specialist approach terms of medical or surgical interventions. Indeed, the old distinction (*familiar to nurses of a certain generation*) that doctors 'treat' patients whilst nurses 'care' for them is convenient shorthand for defining these two distinct clinical perspectives, although it is also true to say that, in some areas of nursing, this distinction is becoming progressively less defined. However, this humanistic foundation is the true core of the philosophy that underpins nursing.

Secondly, nursing has long debated the merits of seeking an underlying theory based on a construct of nursing as an activity that can be supported scientifically (Melling & Hewitt-Taylor 2003). Although the arguments tend either to question or support the idea that nursing *of itself* can be defined in scientific terms, it is certainly true that many nursing activities *can* be evaluated scientifically, although there are those who question the assertion that scientific methods *per se* lead to a true understanding of reality.

A Philosophical Approach: Three Principles

The philosophical approach that we as Practice Educators seek to promote and develop is based upon a view of people that leads to three principles that we believe can guide the work that nurses do. These are:

Human beings are driven principally by their emotions and not by a process of Socratic reasoning.

This applies, of course, to nurses and other health professionals as much as to any other person, and those who give care need acknowledgement of their emotional needs and experiences as much as anyone else. Too often we pay even less attention to the experience of giving care than we give to the experience of receiving it, and it is a truism to say that those who are not cared for and nurtured by their support systems tend to pass on the neglect they experience to the people for whom they care. Only through a clear understanding of our joint humanity can nurses and patients achieve a truly collaborative process.

The experience of care received, and particularly the emotional response to that care, is as important as, if not more than, the outcome of any clinical procedure.

This may be somewhat controversial, but springs directly from an extension of the principles of person-centred care. In this extension, people undergoing clinical procedures construe those procedures within the context of the emotional experience they anticipate, and this anticipation arises from either a previous real-life experience or one that is conjured from the imagination. Furthermore, individuals attribute value

to a given procedure on the basis of what they are prepared to tolerate. Clinicians, on the other hand, may have a strong tendency to construe clinical procedures *only in terms of the clinical value they present to the disorder to which they are applied*. This incongruence, coupled with a perception on the part of the patient that their experience of care is unrecognised, can lie at the heart of non-compliance and, particularly in socially-constructed disorders for which the treatment is primarily an interpersonal process, failure to benefit.

The nurse is as much responsible for the emotional well-being of those receiving care as any other aspect of that person's state,

This seeks to articulate a principle that some still find confusing—the holistic approach to care. In adopting a holistic approach, the nurse is encouraged to consider every aspect of the patient's circumstances, but this is, inevitably, an enormous task and can lead to a practice that pays only lip-service to the principle. We believe not that every aspect should be considered, but only every aspect *that our knowledge of, and relationship with, the patient tells us is important to them*.

Emotional well-being is not an accidental result of treatment or care. Rather, it is a direct product of the way in which care is experienced on all levels. What is true, though, is that people tend to describe their experience in terms of how they felt rather than the skill needed to perform a particular procedure.

In this construct of care-giving, the interpersonal aspects of the nurse's activity can determine the success or failure of any given procedure, the compliance that patients show in their

treatment, and the likelihood of them taking responsibility for their experience and condition once treatment is completed.

For us as Practice Educators the challenge is to incorporate into this humanistic philosophy the technical skills and knowledge that we teach and support. It requires not only a focus on the student, but also on the staff working in clinical areas and in particular the principles that inform their approach, and the expectations they have of the experience of those receiving care.

From our perspective, nursing is not simply a collection of clinical skills of varying complexity. Rather, it is both an idea and an ideal: as an idea, it is concerned with the fact that people who are ill require more than just a solution to their problems.

As an ideal, nursing is the synergy of emotional engagement, a particular understanding and knowledge of the care process, and the purpose for which that process is applied to the person receiving care. A nurse, therefore, is

someone engaged in a humanistic interpersonal activity, underpinned and informed by knowledge, but who also recognises that technical skill is only an adjunct to their interpersonal role. Caring and nurturing both reflect an appreciation of the emotional aspect of nursing without which nursing becomes a robotic repetition of pre-rehearsed activities that relegate the patient to the role of passive recipient or experimental subject.

We acknowledge that a philosophy is simply an articulated belief of how the world operates, and that this particular perspective may fail to resonate with some. This in itself is not a problem; the problem only arises when entrenched, or perhaps irrational, views fail to give accord to the essentially interpersonal nature of human relationships and nursing in particular.

Reference

Melling S & Hewitt-Taylor J (2003) New flexible healthcare roles and the purpose of nursing. *British Journal of Nursing* 12 (21): 1264

Are You Looking for Web-based Resources? Try these.....

C Menna—Trainer Facilitator in Mental Health

About the Care Programme Approach

CPA Research, Durham University: <http://www.dur.ac.uk/CASS/Research/cpa3.htm>

A Survey of the Care Programme Approach was carried out by Durham University and reflects the Operation and Organisation of Services for People with Severe Mental Illness in the UK. These results may be useful for service development purposes.

HoNOS: <http://www.rcpsych.ac.uk/cru/honoscales/honrefs/honrefs.htm>

This site gives the names of all the references to HoNOS from the Royal College of Psychiatrists for those who are interested in researching further into the subject.

Carers Assessment and employment: <http://www.carersonline.org.uk/?CLASS=Document&DBID=15e219243c667d1e20c5abecce06555a&REV=3>

This site is useful to all professionals who are involved in carers' assessment in remaining aware of the abilities of carers and how best to meet their needs.

Other web-sites of interest:

Media Interests: <http://news.bbc.co.uk/1/hi/health/>

This site is useful for people who are researching into health issues and want to know the views of the public. This includes interesting negative and positive views and access can be gained to historical information. There is also an archive of video clips of different BBC interviews which can be viewed on-line.

CHI Ratings for Mental Health Trusts:

http://www.chi.nhs.uk/eng/ratings/2003/mh_list.shtml

It is useful to browse this site as you can access NHS ratings of other Trusts for variance analysis compared to local performance. There are links which may be of assistance for specific area of interests.

NHS Complaints / Professional / Negligence and Accountability

http://www.davidevans-law.co.uk/clinical_negligence.htm

On this web site, explanations are given about how a court decides whether a doctor, midwife, nurse or other hospital employee has been negligent, clarifying the principles of law that have been applied in such cases.

Council for the Regulation of Healthcare Professionals

<http://www.crhpc.org.uk/about.html>

CRHP is a statutory overarching body, covering all of the United Kingdom and separate from Government, that was established from April 2003. It promotes best practice and consistency in the regulation of healthcare professionals through nine regulatory bodies. This may be of interest to those working within multi disciplinary teams in raising awareness of professional expectations.

Health Care Ombudsman

<http://www.ombudsman.org.uk/hsc/document/hicas03/hicas03.pdf>

This site gives the results and recommendations of recent investigations into complaints carried out by the Ombudsman.

Alternative Dispute Resolution and Management

<http://www.clinical-disputes-forum.org.uk/links.htm>

Action against Medical Accidents (AvMA): www.avma.org.uk

Council for the Regulation of Healthcare Professionals: www.crhpc.org.uk

The Medical & Dental Defense Union of Scotland: www.mddus.com

The National Health Service Litigation Authority: www.nhsla.com

General Dental Council: www.gdc-uk.org

These sites are useful for professionals who are seeking solutions, protection, safeguards and defence against litigation.

Facilitating Practitioners to apply newly-acquired skills in Medication Management: evaluation at the follow-up stage

John Butler MSc, PGDip HE, BSc(Jt. Hons.), RMN
Lecturer Practitioner in Mental Health
Bedfordshire & Luton Community NHS Trust

ACTION RESEARCH

Introduction:

There is a considerable and growing body of research available providing evidence of the effectiveness of psychosocial interventions for the severely mentally ill, which include: case management; cognitive-behavioural intervention; family work; and medication management. However, these approaches have still not been well recognised or accepted into routine clinical practice by practitioners (Slade & Haddock 1996).

With this in mind, together with a co-facilitator colleague, I have been offering a short skills-based course for qualified mental health practitioners on medication management within Bedfordshire since April 2002. Also known as compliance, concordance or adherence therapy (Kemp et al 1997, Gray et al 2002, Harris 2002), medication management training requires the active participation of course members and uses more novel and innovative teaching and learning methods (Bradshaw 2002), in helping participants to develop the knowledge, skills and attitudes to support their practical application of this evidence-based intervention within the clinical workplace (Gray et al 2002).

Offered as a five day course over five weeks, with one follow-up day held 10 – 15 weeks after course completion, this course has proved to be in considerable demand by mental health practitioners with the support of their clinical managers, with three courses having been completed in the first year, and a fourth course being offered as a component of a local degree-level module in psychosocial interventions. Whilst each course has proved to be evaluated very positively by participants through a short post-course evaluation questionnaire, formal follow-up evaluation had not been undertaken. In the absence of any robust follow-up evaluation, the need to establish the extent to which participants actually apply newly-acquired skills within practice has increasingly become an important issue (Bailey et al 2002).

Conducted for the purpose of my own professional development, and in the context of the national drive to implement psychosocial interventions (DoH 1999, DoH 2001), I have planned and undertaken a local small scale study using

the action research approach, with the following broad aim: to investigate the extent to which newly-acquired knowledge and practical skills in medication management are being acquired and applied by mental health practitioners following their completion of a short skills-based course.

From this, a series of more specific study questions were formed:

Following a short five-day practical course in medication management, do participants: gain knowledge and new skills?; and, apply newly-acquired skills within the workplace / practice setting?

What are the obstacles to the effective application of medication management skills within the workplace?

How can facilitators best help participants to apply newly acquired medication management skills within the workplace?

Educational Issue: supporting the application of new skills

Although there are now a number of course programmes offering training in psychosocial interventions (Gournay 2000), some of the literature on evaluating this training has included criticisms of the failure of completing students to apply newly acquired skills within clinical practice, with a number of reasons being cited (Brooker & Butterworth 1991, Brennan & Gamble 1997, Gamble 1997, Kavanagh et al 1993, Leff 2000, Bailey et al 2002):

- ◆ an unwillingness or lack of confidence in applying newly-acquired skills;
- ◆ the unrealistic expectations of employers and completing students;
- ◆ a lack of support from service managers;
- ◆ difficulties in integrating new skills with current caseloads or

other work responsibilities;

- ◆ a perception that psychosocial methods and interventions cannot be applied with particular clients or within working roles
- ◆ limited access to required support, supervision and consultation to enable the consolidation of learning;
- ◆ a lack of access to co-facilitators and co-workers, especially important if offering family interventions; and,
- ◆ the isolation of completing students within teams, especially where other team-members are closed to the application of these interventions.

To highlight the scope of the problem, it is worth considering Fadden's (1997) survey of 86 therapists trained in family intervention: only 70% were applying the approach within their work, with the mean number of families seen per therapist being only 1.7, and with 40% of families being seen by only 8% of the therapists.

Whereas a variety of evaluation methods and strategies have been used to determine the achievement of the aims of university-based course programmes in psychosocial interventions, invariably leading to favourable outcomes for the care of the client and clearly enhancing the skills of students (Gamble 1997), the evaluation of short course programmes has been far less robust and much more variable. Furthermore, there is little evidence of training being evaluated beyond the level of the trainee's reactions, with an assumption that monitoring the transfer of learning to practice would occur through subsequent workplace supervision (Bailey et al 2002).

Methodology: the action research approach

As practice orientated practitioner research, involving structured self-reflection (Denscombe 1998), conducted to help improve my own practice and lead to my personal development and improved professional practice, I considered the action research approach to be appropriate and potentially valuable in investigating, understanding and influencing the impact of education and training on the practical application of skills.

Medication Management: an action research spiral

To illustrate the continuous and progressive process of action research, incorporating a self-reflective spiral, I have represented the main focus of my study, that of developing a follow-up evaluation method and process, in *Fig.1*. Most useful for disciplining and organising the action research process, McNiff et al (1996: 22-23) also suggest that action research cycles be transformed into dynamic spirals of action, which allow other issues to be investigated as side spirals, an example of which concerned my use of demonstrations within the workshop setting, one of which proved rather difficult during course 3. The outcome of this investigation formed part of a related study of my teaching methods, to be reported in a separate paper.

Methods of Data Collection

Webb (1991: 160-161) and Winter (1996: 15-16) highlight the value of using a variety of methods of data collection in enhancing the validity of research findings – in fact a fundamental aspect of the action research approach. This process of triangulation helps to achieve the aim of building a complete and detailed picture of the research

issue. Linked with this process is the need for methodological eclecticism, freely choosing from a range of different data-collection methods, off-setting the limitations of selecting only quantitative or qualitative methods. With this in mind, I planned to use several methods in attempting to gain insights into my research questions, being conscious of what would be possible in practice.

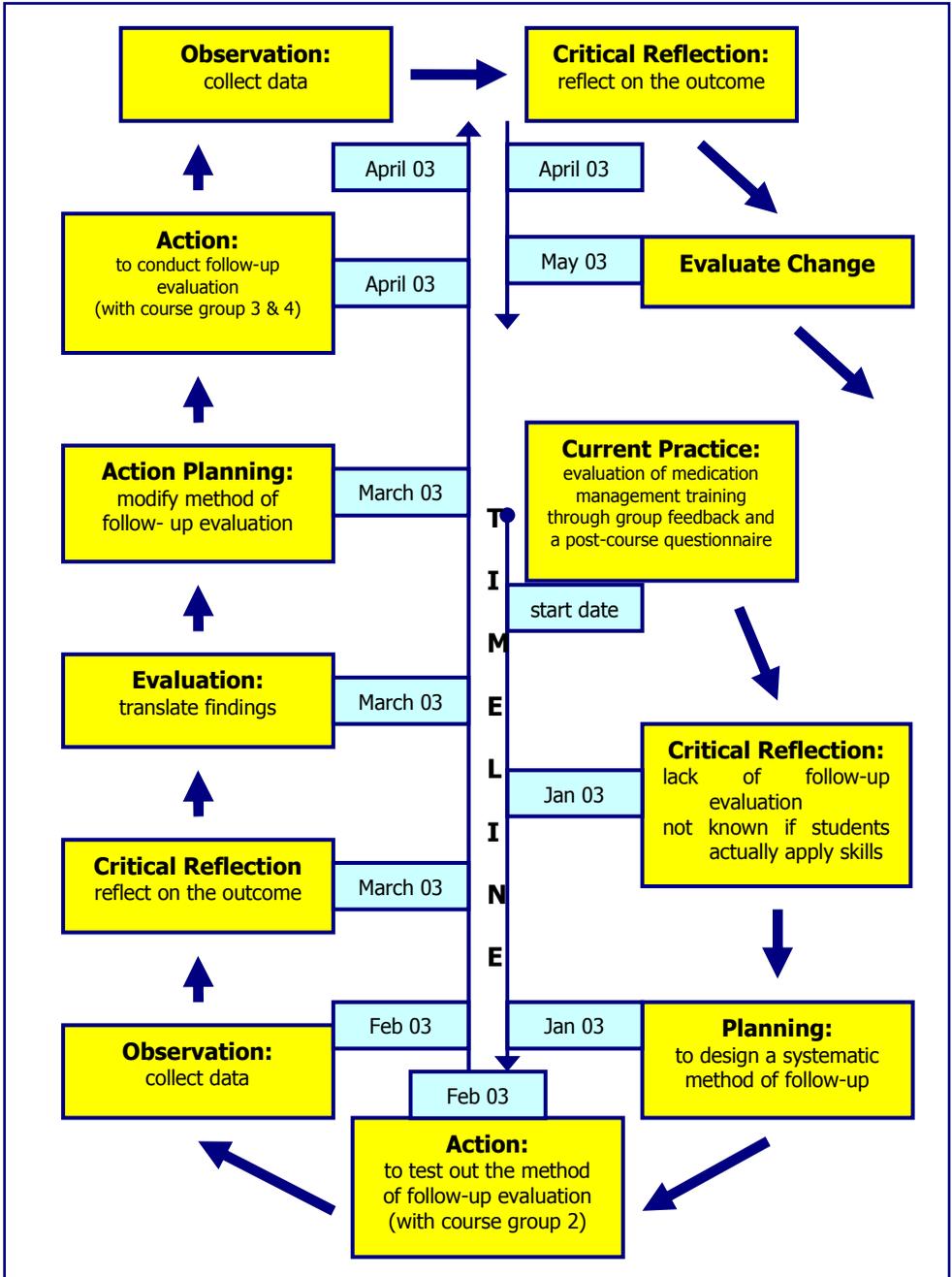
- ◆ Short multiple choice questionnaire on medication management (*quantitative*)

Adapted from the Knowledge about Medication Management Questionnaire, a tool with good content validity and good test-retest reliability (Gray 2001: 292-295), participants were asked to complete a 15-item multiple choice questionnaire related to short client vignettes, on Day 1 and Day 5 of the course, as a method of assessing change in their level of knowledge at the end of the core 5-day course. Participants were not permitted to keep copies of the questionnaire in an effort to minimise any influence on the outcome of training by enhancing the participants' motivation to study for the test (Gray 2001: 82).

- ◆ Post Course Evaluation Questionnaire (*quantitative & qualitative*)

In addition to a short post-course evaluation questionnaire consisting of fixed response and open comment items, which has been used routinely for all courses on Day 5, a short fixed response skills checklist was developed, based upon Gray's (2001) medication management training evaluation questionnaire, as a method of capturing each participant's actual or intended practice of medication management skills.

Fig. 1: action research spiral – evaluation of skills application



- ◆ Skills Application Checklist – follow-up version (*quantitative*)

Based upon the afore-mentioned tool, I designed, tested out and modified a short fixed response follow-up skills checklist, for completion by participants at the planned course follow-up day.

- ◆ Case Presentations (*qualitative*)

A scheduled component in the follow-up day of the course provides the opportunity for participants to present some aspect of their clinical work involving their initial application of the medication management approach with a client(s). I decided to take notes of these short 10-15 minute informal presentations by group-members, in gathering evidence of the successful application of skills and any reported obstacles / problems to practicing newly acquired skills, to be complemented with more formal course evaluation.

- ◆ Semi-structured Group Interview with participants (*qualitative*)

A short semi-structured interview was developed to gain feedback from participants on their perceptions of the helpful and unhelpful methods of teaching and learning, style of teaching delivery, the obstacles / problems that they face in applying medication management within clinical practice and their views about what would help their application of skills within the workplace. As a respondent interview (Powney & Watts 1987), a set of open questions was developed and used flexibly as the basis for a short group interview (Robson 1996: 231), as an efficient, non-threatening way of gathering data with the potential for discussions to develop (Watts & Ebbutt 1987).

Viewed as reflective practice 'akin to Schon's (1983) reflection in action' (Bryant 1996: 115), the action research process clearly requires critical

self-reflection: a theme throughout my research activity.

Implementation: data collection and analysis

For this report, I have summarised and highlighted some of the key findings.

Change in the mean total scores on the medication management questionnaire at pre & post training is shown in Table 1 (maximum score on questionnaire = 15), highlighting significant improvements in the knowledge of participants in all course groups.

Each group evaluated the course very positively and all participants provided some evidence of applying one or more of the key medication management interventions at the post-course stage. In summary, participants thought that the course was well presented, following a logical sequence at a good pace, was supported by helpful written resources, and some highlighted the value of group work / role play. A number of claims concerning the application of skills were made by participants at this post-course stage:

- ◆ 80% reported that they were now systematically monitoring the side-effects of medication;
- ◆ 70% reported that they were managing side-effects;
- ◆ 45% & 25%, respectively, reported that they were now using problem-solving strategies and testing clients' beliefs towards treatment, with as many reporting an intention to begin using these collaborative techniques.

Of course, none of these claims were verified at post-course evaluation. Furthermore, many participants requested supervision and training updates in supporting their application of knowledge and skills.

Table 1: Change in Knowledge following Training

| | Pre-Training Mean Score / 15 (sd) | Post-Training Mean Score / 15 (sd) | p value (2-tailed paired t-test) |
|-----------------|--|---|---|
| Group 1 (N= 14) | <i>Ques. not used</i> | <i>Ques. not used</i> | <i>Ques. not used</i> |
| Group 2 (N=13) | 5.46 (2.3) | 10 (1.6) | p=0.0002 |
| Group 3 (N=15) | 6.53 (2.17) | 10.13 (2.1) | p=0.0001 |
| Group 4 (N=9) | 6 (2.87) | 9.78 (2.2) | p=0.0009 |

Version 1 of the follow-up skills checklist was tested with three participants at the follow-up day for course group 2. This highlighted some weaknesses of the tool, in that participants would tick more than one column thus giving confusing and unclear responses. Version 2 of this skills checklist was completed by 14 participants at the follow-up day for course group 3. Whilst a number of participants claim to have been practicing some of the skills before commencing the course, between 7 (50%) & 10 (71%) participants confirmed their practice of 11 of the 14 key skills since commencing the course. However, whilst encouraging, again this finding is limited to self-report.

Participants presented short case presentations at the respective planned follow-up day for each of the first three courses, with 25 / 40 participants attending these follow-up days. There is considerable and encouraging evidence from these presentations of participants returning to their workplace and practicing one or more medication management interventions.

It is noteworthy that whilst only 8 / 14 participants from course group 1 and 3 / 11 participants from course group 2 attended the respective follow-up days, 14 / 15 participants from course group 3 attended. Course group 3 was sent a reminder memo for the follow-up day,

unlike for the previous two groups, even though the dates for follow-up days had been set on each final course day (Day 5) with the whole group present.

Whilst participants chose what to present, the popularity of particular skills reflected participant self-report on the skills checklist. As shown in Table 2, these presentations highlighted evidence of the use of a wide range of skills.

Of particular interest were the reported obstacles and problems encountered in applying skills in the workplace, particularly for those working within in-patient areas:

- ◆ the problems of shift-work, client leave periods and the early discharge of clients, impacting on the practitioner's ability to complete an intervention;
- ◆ the problems of particular mental health symptoms such as low motivation or impaired insight;
- ◆ the attitude of the family towards treatment;
- ◆ the inability of some clients to make informed choices.

My ensuing discussions with the group and my co-facilitator proved very illuminating, in considering some of the potential solutions for effective implementation:

- ◆ the need to adapt medication

Table 2: Summary of Key Skills covered in Case Presentations (follow-up)

| Key Skills Presented | N / 25 | Key Skills Presented | N / 25 |
|---------------------------------------|--------|--|--------|
| Using assessment tools | 9 | Collaborative working | 16 |
| Psycho-education | 4 | Behavioural tailoring | 1 |
| Stress vulnerability model | 2 | Reviewing the illness timeline | 11 |
| Explaining psycho-pharmacology | 9 | Exploring ambivalence | 3 |
| Reviewing medication | 10 | Problem-solving | 2 |
| Challenging prescribing practices | 7 | Planning for the future | 1 |
| Monitoring side-effects of medication | 8 | Goal setting | 1 |
| Managing side-effects | 1 | Relapse prevention | 2 |
| Positive risk taking | 1 | Planning / reviewing / adapting strategies | 4 |

management strategies for use in in-patient settings;

- ◆ the need to integrate the approach into routine clinical practice;
- ◆ the need to carefully select and apply the right strategy at the right time;
- ◆ the need for realistic expectations, both for practitioners and clients, irrespective of the care setting;
- ◆ the need for continuity of approach between in-patient and community teams, requiring close liaison or, preferably, joint working.

Group Interviews

Prior to conducting any group interviews, a briefing sheet and consent for participation was developed (McNiff et al 1996) and a short interview guide was written, which was tested out with three participants from course 2 and my co-facilitator. The interview guide was later modified to include more specific questions on the obstacles / problems in

applying medication management interventions. An audio-recorded group interview was subsequently held with six participants, as an optimal group size, for about 40-minutes, as an acceptable length (Robson 1996: 229). A full transcription of this recording was made.

Participants highlighted a number of key learning points and areas of further need, as shown by their comments – *selected comments are shown:*

Increasing knowledge

'I can now safely think along the lines of proper drug administration... when I'm giving drugs, there's some effects and side-effects that I'm now observant of which I didn't quite understand before'

The value of reflective practice & self-feedback

'a good thing to take back into practice (is) to stand back and to say to yourself: 'OK, well I did OK in that situation and, you know, next time I could do differently, but what I did was OK''
'Being aware of the pros and cons of using medication management

strategies, highlighting the need for the selective and careful use of strategies, and where necessary, the need to offer further support and care to the client'

'I talked... about someone who did a timeline exercise... who found it very useful in terms of practical application, but also found it very distressing because it highlights just how serious their symptoms are and how many times they've been admitted to hospital, and how difficult their life has become as a result, and what a profound effect it's had on their ability to have anything in their life... and also how useless this particular person felt in being able to do anything about it'

Obstacles to Practice

'I think the length of time you have contact with the patient on an acute ward... it's difficult to fit this in around the other things that are going on for them at the time as well... it's quite difficult to have individual time for people when you've got (X) people in all'

'The treatment plan can be an obstacle as well, as far as acute in-patient structure is concerned... leave is considered as therapeutic... so where a patient is going on this leave... you're not able to engage with them...'

'there are several issues to do with the service such as (the need to) reducing caseloads'

'It's more about caseload... having appropriate clients... and what you can fit in'

The value of follow-up days

'This day (follow up day) would help... I've got to try some of this out because I've got to come back and talk about it... helps to focus the mind'

'Having a follow up day helps us to realise that... how much we're actually using it'

Some of the solutions in promoting application

'(It's) a matter of experience and trial and error... learning and gaining confidence from experience and practice... and gaining some successes'

'Having more members of staff going through this type of course'

'to provide supervision on medication management issues'

'It could be quite helpful for clinical supervisors to go through this type of course'

'Make consultants aware of what is being learned...'

'to consider doing a roadshow (on medication management) to teams'

'(Having) something like a network'

'The website'

(www.medicationmanagement.org)

'The CD-ROM' (this was created and given to participants)

'A kind of auditing system'

'We audit all the time... it's just a way of supporting... yes, what you're doing is right'

Confirming the evidence from the case presentations, interviewed participants thus further confirmed and added to the list of obstacles and problems encountered in applying medication management interventions within clinical practice:

- ◆ high caseloads;
- ◆ limited time available;
- ◆ whilst some clients find practical strategies useful, they can also find them distressing.

However, interviewed participants also proved able to generate a number of potentially helpful methods of encouraging the application of newly-acquired skills, reinforcing and further illuminating those ideas identified in the case presentations.

- ◆ to be flexible in applying the

- approach;
- ◆ to make ongoing supervision available;
- ◆ to make up-to-date information available through CD-ROM and website media;
- ◆ through further planned follow-up days;
- ◆ by developing an audit system.

Conclusion & Discussion:

Through quantitative and qualitative methods of data collection, there is considerable evidence to support my claim that many participants are returning to the workplace and applying medication management skills within clinical practice following their completion of a short 5-day course.

I have become aware of a number of client-related and service-related obstacles and problems faced by the practitioner in attempting to transfer newly-acquired skills to practice, learning much from the case presentations and participant interviews. It is worth noting that much of this sounds familiar, confirming the findings reported in the wider literature (Bailey 2002). However, the methodology adopted has proved helpful in involving participants in generating some practical solutions to these perceived or actual obstacles and problems, and in identifying a number of areas for further action in supporting the application of skills by practitioners:

- ◆ planning events for supervisors and managers;
- ◆ creative ways of making up-to-date information available, using multimedia resources;
- ◆ establishing audit activity for quality improvement, as suggested and viewed positively by interviewed participants;
- ◆ emphasising the flexible and

- individualised nature of planning interventions with clients, with future course groups;
- ◆ the need to provide participants with guidance on the practice of skills within different care settings;
- ◆ and, the value of follow-up days.

However, as I cannot make any claims about the quality of skills application by participants within clinical practice, there is a need to consider ways of involving and preparing workplace clinical supervisors in supporting and consolidating skilled intervention by participants.

Of course, the action research process also appears to have a number of drawbacks: my close involvement in the process may have limited the scope and scale of my research; having a vested interest in the findings for resolving problems, I cannot claim to have been completely impartial; the localised nature of my research clearly limits the generalisation of my findings; and whilst I have clearly found the process beneficial, this has certainly required considerable time and effort (Denscombe 1998: 65)

However, on balance, I believe that I was able to adopt a reflexive approach (Webb 1991: 161-162, Winter 1996: 13-14) in presenting my data, being conscious of the effects of my personal involvement as practitioner-researcher, and supporting and questioning my judgements with examples from my direct experience and through discussion with my mentor.

Conducting this study has been illuminating, stimulating (Webb 1996: 156) and motivating, in terms of integrating research activity with teaching and practice, with the aims of enhancing participant learning and my own insights and understanding.

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Bedfordshire & Luton Community NHS Trust
Charter House
Alma Street
Luton
Bedfordshire

www.blct.nhs.uk

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