



napicu

national association of psychiatric intensive care & **low secure** units

NAPICU PICU
occupational therapy network

Welcome



Not for profit multi-disciplinary organisation - a charity.

Committed to developing and promoting the specialty of psychiatric intensive care and low secure services.

Dedicated to improving patient experience and outcome, and to promoting staff support and development.

Aims:

- to improve patient experience and outcomes
- to promote staff support and development
 - to improve the delivery of care
 - to audit the effectiveness of care
- to promote research, education and practice development
- to provide best practice guidance in association with national bodies



<https://napicu.org.uk/>



PICU
Occupational
Therapy
Network,
3 March 2020

Participants'
employers/
services

- The Priory Group (Kneesworth)
- Betsi Cadwaladr University Health Board (Tryweryn)
- Cygnet (Westminster, Wigan, West Yorkshire, South Yorkshire)
- Surrey and Borders Partnership (Rowan)
- St Andrew's Healthcare (Essex, Northampton)
- Dorset Healthcare (Haven)
- Barnet, Enfield and Haringey (Chase Farm)
- Greater Glasgow & Clyde
- Southern Health (Hampton)
- Leicestershire Partnership (Bradgate)
- Cumbria, Northumberland, Tyne and Wear NHS Foundation (Rowanwood)
- Sussexpartnership (waiting list)
- Huntercombe (waiting list)
- MPFT (Stafford)
- Birmingham and Solihull (Caffra Suite)
- NELFT (Titian)
- EPUT (The Christopher Unit)
- Nottinghamshire Healthcare (Hercules)
- Northamptonshire Healthcare (Shearwater)
- Belfast H&SC Trust (Clare)
- East London Foundation Trust (Westferry)
- Norfolk & Suffolk NHS (Rollesby)
- SLAM (ES1 ward)
- SWLSGT
- High secure – Ashworth?

PICU
Occupational
Therapy
Network,
3 March 2020

Outline of the
day

- How it is – the PICU context, staffing, role and responsibilities
- Is there a need for occupational therapists in the PICU team?
- Sharing assessment practices – what information and understanding does occupational therapy contribute to the PICU team?
- Outcome measures and client evaluation/feedback
- Sharing intervention
- Evidence-base
- Research ideas
- What is deemed important for this network to achieve

NAPICU PICU OT Network launch

Dr Wendy Sherwood & Becky Davies

Network starting point (what should the network achieve?):

- **Sharing good practice (*'what works'*) and service development initiatives (QI)**
- Developing knowledge of the role and contribution of occupational therapy in PICU and Low Secure services
- Exploring the **evidence-base** for occupational therapy intervention (*research ideas*)
- Promote staff support (*gain confidence*)

Plan for meeting discussion:

How it is - Roles and realities

Sharing:

OT assessment and outcome measurement

Intervention

Evidence-base & research board



Agree good practice?

OT role – description; other discussion

Way forward

Breaks, lunch

How it is - roles and realities



The context - MDT staffing, OT staffing, OT role and responsibilities.

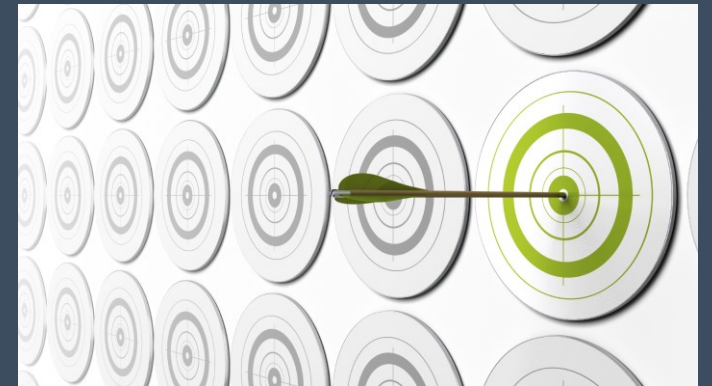
Prepare to feedback on:
Roles – what is similar, what is different and why.



Is there a need for an occupational therapist in PICU?



**What can you
share on the OT
assessment and
outcome
measurement?**



3.2.49. There should be provision for specialist functional assessments by a specialist occupational therapist using standardised tools; for example: Assessment of Motor and Process skills (AMPS); Assessment of Communication and Interaction skills (ACIS) Canadian Occupational Performance Measure (COPM); Model of Human Occupation Screening tool (MOHOST) (College of Occupational Therapists, 2012); and assessments to aid diagnosis (for example behavioural memory testing batteries, such as the Rivermead (Wilson et al. 2008).

3.2.50. Models of occupation should be used to ensure consideration of the occupational life history of patients and their past, present and future roles; for example, the Model of Human Occupation (MOHO) or the Canadian Model of Occupational Performance (CMOP)(College of Occupational Therapists, 2012).

NAPICU standards have extremely limited publications/evidence to draw on to support guidance – OTs need to start producing practice-based publications and research.

Occupational therapists'
use of occupation-focused
practice in secure hospitals

Practice guideline
Second Edition

Royal College of Occupational Therapists

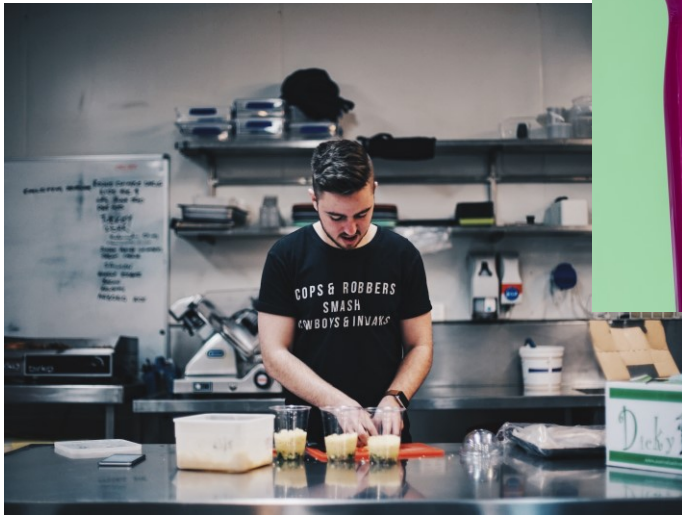
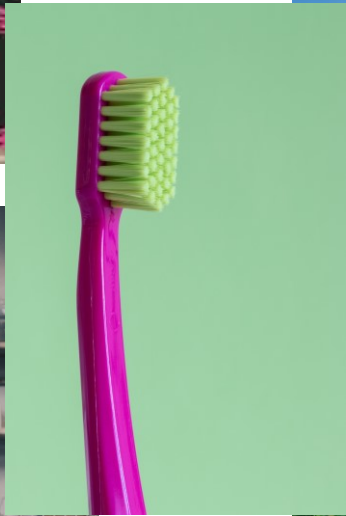
Group discussion points:

- Pathways, contribute to risk, CQC
- Use a broad range of assessment methods
- Standardised and non-standardised
- Should be evidence-based
- Need for contemporary research on use of assessments
- OT support workers provide valuable information, analysed by an OT
- The PICU team should support adequate occupational therapy assessment
- Outcome measures are essential



Reality to aim for:
What does the group
agree to be good
practice /
recommend?

What evidence is
needed? – on the
research board?



What can you share
on occupational
therapy intervention
/ treatment?

Standards for Psychiatric Intensive Care Units

Quality Network for Psychiatric Intensive Care Units

- A range of accessible recreational activities, including engaging in creative work, hobbies and special and social interests, are provided 7 days a week including evenings and bank holidays.
- Every patient has a personalised timetable of activities and interventions to promote social inclusion, which the team supports and enables them to engage with.
Guidance: This is co-produced with the patient and could include activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependents.
- Patients have access to a range of art/creative therapies.
- Life skills training is available for patients. This could include; psychoeducation on topics about activities of daily living, interpersonal communication, relationships, coping with stigma, stress management and anger management.
- The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to: Voluntary organisations; Community centres; Local religious/cultural groups; Peer support networks; Recovery colleges.

3.2.42. Health promotion activities should be available and encouraged, including: diet; exercise; substance misuse and smoking cessation.

3.2.43. Social-skills or life-skills training should be available, incorporating psycho-education, on topics relating to activities of daily living such as interpersonal communication, relationships, coping with stigma and stress management.

3.2.47. The PICU team should ensure that a defined activity programme is available to all patients, with individual and tailored activities where required. This should facilitate meaningful occupational choice and be available at weekends and evenings (College of Occupational Therapists, 2012).

3.2.51. PICU professional staff should ensure the delivery of psycho-education to deconstruct complex tasks, with the objective of promoting recovery and improved functioning.

3.2.52. Arrangements should be in place for appropriately qualified and trained staff to deliver group-work, individual skills sessions and activities of daily living (ADL).

3.2.53. The PICU MDT should ensure provision of a tailored and bespoke treatment, engagement and activity programme utilising the skills of all members of the MDT. This should have PICU specific consideration including functional, diversional, psycho-educational therapy focusing on the holistic care of acutely disturbed patients.

3.2.54. Patients should be assisted in the development of coping strategies and trigger-recognition, leading to an overall Wellness Recovery Action Plan (WRAP).

3.2.55. A range of art therapy and creative media should be available.



What evidence is in the literature? Firstly, there's very little literature written by OTs in this field.

Meaningful activity benefits

In PICUs and HDUs:

- improving the consumer experience
- promoting more supportive relationships between staff and clients
- providing daily structure
- minimising aggression related to boredom
- assisting services to become more recovery oriented, shifting from a culture of 'control' to a culture of care

(Ash et al.; Gwinner & Ward; Pereira & Woollaston; Salzmann-Erikson et al.; Sullivan et al. Cited by Evatt et al, 2016)



Occupational therapy & PICU

Best (1996)	The Developing Role of Occupational Therapy in Psychiatric Intensive Care
Davies et al (2019)	Sensory room in a psychiatric intensive care unit
Evatt et al (2016)	Exploring consumer functioning in High Dependency Units and Psychiatric Intensive Care Units: Implications for mental health occupational therapy
Harrison (2002)	Activities and multiprofessional teamwork on a psychiatric unit (not a good paper)
Hickey (2016)	An exploration into occupational therapists' use of creativity within psychiatric intensive care units.

	Intervention	For:	Benefits:
Best (1996) Anecdotal	Informal groups – OT dept.	Assessment: role, behaviours, dynamics; capacity to cope with being transferred to a less intensively supportive environment.	Maintain contact with life outside the PICU. Prepares for return to acute ward
	Community visits		Maintain contact with and awareness of the external environment; promotes orientation to reality; use and development of skills.
	Activities (graded, flexible)	Poor concentration, thought disorder and poor problem-solving skills	Experience the concrete realities of established boundaries. Experimentation of skills and behaviours in a safe, constructive way.
	Activities (meaningful, immediate & clearly apparent rewards)	Participation, autonomy	Participation, autonomy. Success & achievement.
	Activities as a focus for interaction; concrete steps; demonstration, written instructions, verbal prompts	Difficulty expressing self verbally; verbal interaction = an unreliable and stressful method of communication	Facilitates a relaxed and potentially therapeutic atmosphere. Reduce anxiety and lower potential of aggression. Success & achievement.

	Intervention		
Davies et al (2019)	Sensory room (OT MDT trainer; mainly nurse facilitators)	Calmer, more relaxed Enjoyed access to different sensations, Valued being able to get away from other areas of the PICU and relax	
Evatt et al	Groups focused on simple and enjoyable activities.	Very focused on internal phenomena; difficulty noticing and engaging with external people and events. Very distractible; short attention spans. Struggle with verbal information or complex activities.	

Lack of specific intervention guidelines for treatment approaches in PICUs Crowhurst and Bowers (2002).

Evatt et al (2016)

Stage 6: Full engagement

- Encourage appropriate therapeutic leave
- Engage in discharge planning
- Support individual activities to avoid boredom

Stage 5: Supported engagement

- Provide less instruction, encourage problem solving
- Encourage cooperation with other people and tolerance of disturbed behaviour from others
- Provide psychoeducation and examine the causes of hospitalisation

Stage 4: Active attempts to engage

- Try to engage the person in conversation
- Use activities that require social interaction
- Discuss recent events/interesting topics to stimulate conversation

Stage 3: Initial engagement

- Set up activities for the person
- Provide simple activities with step by step instructions
- Provide modelling one step at a time to allow copying
- Limit opportunities for unsafe errors
- Provide prompts to sustain actions

Stage 2: Observation

- Create opportunities for the person to watch activities
- Tell the person it is okay to come and go from activities as they feel comfortable
- Explain the purpose of the activity (to engage with activity to assist with recovery)
- Build rapport through helpful interactions (get a towel; open bedroom door; facilitate access to nicotine replacement therapy)

Stage 1: Unable to engage

- Focus on basic interactions such as saying hello to the person
- Ensure the person sees that things are happening around them so they can join in if they so desire
- Create a pleasant environment which may attract the person (e.g., sit in the sun; sit in garden; use pictures; have newspapers and magazines available)

Other discipline-led research and publications

Smith et al	Use of a sensory room on an intensive care unit.	
Taube et al (2016)	The development of a modification of behavioural activation as a solution to reduce patient boredom in a PICU: overcoming patient and staff challenges	Star Wards initiatives: activities contribute to a general sense of wellbeing; enhancing environment by art therapist with a 'Wall of Creations' following the suggestion of a nurse who wanted patients to have a place to admire their creativity – has enhanced the physical space, contributing to the changing milieu.
Thomas et al (2006)	P.r.n. medication use in a psychiatric high-dependency unit following the introduction of a nurse-led activity programme.	Purposeful activity programme for severely disturbed psychiatric clients in a HDU setting can be effective in reducing disturbed behaviour and therefore the need for p.r.n. medication.
Tully et al (2016)	Innovation and pragmatism required to reduce seclusion practices	An approach incl MDT working, senior administrative involvement, dynamic risk assessment, and bespoke occupational therapy may lead to a more effective model of reducing seclusion in high secure hospitals and other psychiatric settings.
Wood & Alsawy (2016)	Patient experiences of psychiatric inpatient care: a systematic review of qualitative evidence	Need for sense of community on ward, reduce detachment from social life; maintain daily activities for identity and independence; need to go out/home/community visits. Needs to be a continued effort to develop occupational interventions.

Evaluation

Patient feedback processes

8.2.14. In order to promote a positive, transparent culture that supports learning by engaging patients in processes which offer feedback mechanisms, the following areas should be considered, all to be guided by an agreed model of confidentiality:

8.2.14.1. Clinical aspects:

- Individual patient participation, contribution and involvement in their care and treatment;
- Patient feedback on their experience of safety and security within the unit;
- Patient engagement with and feedback on the design of a relevant social and therapeutic activities programme;
- Patient feedback on their experience of the unit's approach to managing high levels of acuity or disturbance or violent incidents;
- Patient feedback on their experience of developing their unique treatment or care plan and advanced statement or directive.

Needs to be a
rationale for why an
occupational
therapist
(experienced)
should be in the
PICU MDT
(Hickey, 2016)



“The national minimum standards for psychiatric intensive care (NAPICU, 2014) state that PICUs should have a core team including experienced occupational therapy staff. No further elaboration is given on the reasoning for this post other than it is important to have a specialist occupational therapist in psychiatric intensive care. These guidelines suggest that all disciplines should have mental health experience (except for nursing staff who can work with support from more experienced nursing staff; NAPICU, 2014).

There is clearly a lack of information available on the reasoning behind the need for an experienced occupational therapist. This fails to support the role and the drive for occupational therapists to be working in this area” (Hickey, 2016, p90).

4.2.1. All PICUs should have input from professionals in the following disciplines within the context of core team skills:

- Medical (a consultant psychiatrist and a trainee psychiatric doctor)
- Nursing (a team of specialist inpatient nurses, both qualified nurses, healthcare support workers and assistant practitioners)
- Management (a manager and deputy with relevant clinical expertise)
- Occupational therapy (a specialist in psychiatric inpatient care)
- Psychology (a specialist clinical psychologist)
- Pharmacy (a specialist pharmacist with experience in acute psychiatric inpatient settings)
- Social work (access to a social worker to address holistic care needs)
- Activity, physical health and engagement (e.g. physiotherapist, sports therapist, dietician).

See Chapter 21 for further details.

21.2.3. PICUs require staff with the capacity and capability to engage effectively with highly disturbed patients with complex needs, to provide a range of multidisciplinary therapeutic interventions and clinical treatments.

21.2.4. The strength of the PICU team in delivering high quality patient care is in its full multidisciplinary nature. The MDT should include a broad range of professionals, over and above the core nursing and medical professionals. If staff of other disciplines are not directly provided for within the PICU team, there should be local contractual arrangements in place to provide these in a sustained fashion e.g. service level agreements with the local acute medical hospital for pharmacy services, contracts for psychologist input, occupational therapy input and sessional therapy staff.

21.2.18. In addition to the core established nursing and medical staff, the PICU team must also include the following:

- Occupational therapist with specialist skills in acute psychiatric inpatient care, and support staff (e.g. activities co-ordinator). This includes working on the PICU in the evenings and weekends in order to ensure that there is a defined activity programme available to all patients available at weekends and evenings (College of Occupational Therapists 2012),
- Qualified specialist clinical psychologist for a minimum of one day per week per PICU to deliver face-to-face patient care.
- Specialist mental health pharmacist who visits the PICU on a daily basis and takes part in the weekly multidisciplinary reviews; and support staff (e.g. pharmacy technicians/assistants).
- A PICU manager and a deputy, both with relevant clinical expertise in PICU.

3.3.5. PICU professional staff should be in the position to provide credible expert advice, underpinned by research evidence, to other clinical teams regarding the management of patients with acutely disturbed, challenging and aggressive behaviour.

Standard 79

The MDT consists of or has access to:

Medical (e.g. a dedicated consultant psychiatrist and a trainee psychiatric doctor);

Nursing (e.g. a team of specialist inpatient nurses, both qualified nurses, healthcare support workers and assistant practitioners);

Management (e.g. a manager and deputy with relevant clinical expertise);


Occupational therapy (a specialist in psychiatric inpatient care);

Psychology (a specialist clinical psychologist);

Pharmacy (a specialist pharmacist with experience in acute psychiatric inpatient settings);

Social care (e.g. access to a social worker or equivalent to address holistic care needs).

**Standards for Psychiatric
Intensive Care Units**
*Quality Network for
Psychiatric Intensive Care
Units*

A low-angle, close-up shot of a person's legs and feet as they walk on a dark asphalt path. The path is marked with a large, white, hand-painted arrow pointing forward. The person is wearing a teal dress and dark teal shoes with light-colored soles. The ground is scattered with dry, brown pine needles. The lighting is soft, suggesting an outdoor setting during the day.

Where do we go from here? What do you think NAPICU should aim for this network to achieve for PICU services and OT nationally?

Share

Good practice (for individual benefit & improve services); influence local policies

Provide

A platform for skill sharing and discussing current issues
Support for challenging role

Encourage

Occupational Therapists to work collaboratively to consider the essential and desirable OT provision within all PICUs throughout the UK.

Develop

Research and evidence-based correspondence

Evidence-base
Explore research

Demonstrate

How varied and applicable occupational therapy can be, even for people in acute illness, where typically people believe that a patient is "too unwell for therapy".

Deliver

Clear overview of roles, approaches and resources available to support occupational therapy practice.

What you want NAPICU network to achieve for PICU services and OT profession nationally

Ensure

Quality and parity across services regarding PICU occupational therapy provision; streamline assessment, intervention and outcome measurement tools to enhance service and professional development.

Enhance

The profession's and wider MDT awareness of an Occupational Therapist's role within a specialist service.

Diana Best 1996:

A network of PICU occupational therapists is evolving, with the aim of sharing ideas and consolidating an effective approach. It is hoped that this network will develop and promote the profession as a valuable contributor to PICU services. Input in this innovative and traditionally uncharted area of clinical practice gives credence to the profession as well as benefiting clients.

Requests/ideas for further network events

- Occupational Therapy staffing – the band, supervision; ratio to caseload (therapists and support workers) – adult and CAMHS
- Critical discussion of evidence-base / interventions
- Explore research opportunities, especially on effectiveness
- Explore publication ideas & opportunities
- Develop resources for occupational therapists
- Workshops on standardised occupational therapy assessments and outcome measures for PICU
- Case studies and case formulations
- Articulating the complexity of occupational therapy

- Local / regional meetings
- Peer reviews / 'critical friend' visits to services

Common feedback

- Very well organised and facilitated day
- A very exciting opportunity to be part of and see where it leads
- Happy to be involved in research
- I'm feeling inspired to write-up something as a report for the journal
- Research projects sound very interesting
- Would be great to have the network meet regularly
- Happy to host a networking day



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