napicu
national association of psychiatric intensive care & low secure units

Recorded responses to the day's group discussions:

How it is - roles and responsibilities

Most OTs are full time, but a lot are part-time. Full timers – less than 50% of their time is direct clinical work.

Bed numbers vary from 8-12 (usual number), to 17. One OT reported having two wards of 11, plus an HDU = 24 total clients. Caseloads range from 6-25. All blanket referral.

There was discussion about whether OTs are best placed on the ward or in the dept. At the event, about 80% were ward-based.

Discussion about supervision – whether OTs should supervise various support workers, and how often should PICU OTs get supervision, and from who – and should s/he have PICU experience?

Most OTs had support workers.

There are various support staff in wards: activity co-ordinator, mental health worker, TAN – therapeutic activity nurses, engagement co-ordinators, life skill recovery worker, social therapists.

Unqualifeid staff may be being used to fill in the gaps that OT can't fill due to time constraints, but is this dangerous and/or good quality service provision?

Discussion about OTs being included in ward safety numbers, and being used for other work e.g. escorts.

Should newly qualified band 5 OTs be working alone in PICU? Some discussion about the need to have developed resilience in order to manage the job.

MDT make-up differs – some teams have a dietician, or SaL, physio, social worker.

Some OTs now no longer included in restraint team – is this a good thing or not?

Broad range of age and quality of service contexts – newer PICUs can have very good resources; design input from OT. A lot of OTs consider wards as lacking adequate therapy space / are inadequate.

Varied roles. Some OTs do assessments and run/co-ordinate the group programme.

All OTs attend ward round.

Some discussion about the challenges and responsibilities for some OTs, especially those trying to rebuild an OT service in PICU after absence of OT for some time, or inputting OT into a service for the first time – could do with a set of resources to use.

Staff turnover/changes impacts on service delivery.

A difference in the way OT is provided and differences in how closely OTs and nurses work and understand clients, is whether OTs are using MOHO or the VdTMoCA.

Assessment – what information and understanding does occupational therapy contribute to the team?

Holistic

Gives a voice to the client: views, values, interests, future vision/wishes.

OTs find solutions to client's problems/needs.
Activity – not merely activity for its inherent value, but in doing activity a client has the opportunity to apply or learn new skills: OTs use their activity analysis and grading skills to make this possible.
OTs have knowledge of what can be achieved and how to achieve it; knowledge of enabling engagement - we break down activities.
OTs contextualise care; client-centred; we have ability to get client's on board with therapeutic intervention.
Knowledge of barriers to occupational performance and engagement – whether the issues are to do with skills, learning problems, etc.
Knowledge in relation to risk and activity; the impact positive or negative, of an activity.
Knowledge of the importance of roles, routine, and activities of daily living.
Knowledge of the sensory aspects of performance, and relation between person-environment.
Understand how to utilise the environment space, and how the environment affects motivation.
Understanding of potential for clients to become de-skilled – the importance of doing with, rather than for, which is more of a nurse's approach; maintain function asap.
Predicting function on discharge.
Identify whether the client is ready to move to a higher stimulus ward, or have section 17 leave.
Skills assessment e.g. mobility and skills for community living.
Perceived level of functioning informs MDT within 48 hours.
Activity analysis – are the problems to do with volition or skills?
Understanding habituation.

Seeing past the surface presentation of a client – may be seen by other ward staff as 'managing leave well' for example, but we know that this does not necessarily mean the client has the skills for managing outside the ward/in the community.

Assessments in use

1. OT Model tools:

MOHO tools - MOHOST – single obs and full screen for ADL assessment. Fits well with the setting but lacks sensitivity for picking up change; doesn't measure very low functioning. AMPS, VQ, OSA (level of insight), ACIS – depends on client's length of stay, needs, and whether it's a group or individual assessment. Child Occupational Self Assessment (COSA) - adapted to be adolescent-based. MOHO EXPLORE – being considered for use, unsure if useful. OPI II. Interviews informed by MOHO concept. Role checklist. OCAIRS – as initial.

Some discussion about the limits of MOHOST in terms of difficulty using it to predict performance outside of PICU. Rationale for using MOHOST – most OTs engaged in that discussion said they used MOHOST because they have to use MOHO in their Trust and the MOHOST findings fit into the report template. OTs do the score, write the reports, but don't necessarily find the scoring results useful for goal-setting – the findings don't necessarily help with formulating a clear intervention plan.
There was some discussion about the point of reporting on MOHOST scores - who reads them or are they useful to?
The changeable nature of clients' performance makes capturing a clear picture problematic.
Interest checklists can inform activity provision, but there are problems with clients saying they do certain activities, but they don't.

Vona du Toit Model of Creative Ability tools - Creative Participation Assessment (also a measure), Activity Participation Outcome Measure. Task assessment.

KAWA – OT students in particular are bringing this model.

2. Other assessments:

Screening before groups, creativity.
Sensory Profile
Self-reporting Spiral
Formulaic work (Forsyth 2017).
Addenbrookes
Process Assessment of the Learner
Tinetti falls assessment
Allen Cognitive assessment
GAS
TOMS (outcome measure)
SI training assessment
MAPPA
Shower assessment
ADOS
Life stories, person-centred plans, sensory profiles.
Mental capacity assessment.
BART
M-ABC
Meyers initial interview.

3. Problems – client is discharged or transferred before OT input.

One group stated that the main use of intervention is for assessment: identifying underlying cause for block in occupation and engagement at following levels: motor & process skills, sensory, volition, social interaction. Need for ADL equipment/adaptations to environment.
Observation of client in absence of activity – can they occupy themselves? Can they develop a routine?

Outcome measures: Creative Participation Assessment & Activity Participation Outcome Measure (from VdTMoCA), VQ, MOHOST, OCAIRS, AMPS, MOHO-EXPLORE

Intervention

Groups: Food-based, arts & crafts, self-care, music, sensory, gardening, physical activity
Cooking/meal prep & baking: for functional skills, choices, empowerment, independence & confidence.
Coffee morning: for wake-up, routine, engagement.
Beauty & self-care: for maintaining personal care, sense of identity, routine + able to assess safe use of tools.
Rap music group / rap as an intervention: chance to convey narrative, showcase a skill, index a point in time; identity.
Men's group – discuss stigma re: mental ill-health.
Football – rapport, relationships, social, physical.
Smoothies: executive functioning, skills building, confidence.
Creative activities – problem-solving, concentration, fun, engagement, relaxation, self-expression..
Breakfast group – planning, encourage to get up.
Daily planning meeting – routine, structure.
Weekly planning tool.
Managing and understanding emotions.

Other:
Sensory room
SI7
Novel tasks
Sensory circuits
Graded exposure to community; community leave – for skills.
Breakfast club, newspaper topics, quizzes – for social..
Sleep clinic – sleep hygiene Parenting as an occupation (CAMHS) – looks at parenting roles; involving parents with their children
Lego-based therapy – achievement, different roles as 2/3 people work together and have to communicate; distraction.
Animal therapy / PAT dog – engagement, conversation topic.
Convo-pong.
Physical activity; Segregation Zumba.
Music – social, reduces distress, improves mood.
Bio-care (creative, horticulture, life story, letter writing, card writing).
Sensory ladders, self-soothe; desensitisation.
Koesler Art competition.
Service User awards.
Anxiety management.

Other reasons for intervention: social norms, coping mechanisms, developing roles and responsibilities, education, establishing community links.
Food-based activities – therapeutic relationship, mood, confidence, sensory benefits, social, process and product driven, cultural.

Other disciplines/agencies:
Outside agencies: In-reach programmes; charity/community
Art & music therapy.
Health promotion – dietician, smoking cessation, physio.
Discussion group with a psychologist e.g. anxiety, psychosis, drugs & alcohol.
Fitnes instructor

Evaluation / client feedback
Feedback Friday – forms
You said, we did board
Community meeting record.
Questionnaires
Head Space.
Some mention of difficulty with getting accurate feedback when clients are unwell.

Research questions/ideas:
Intervention type and effectiveness e.g. groups, 1:1 work, indirect, signposting.
What is the impact of PICU service delivery (e.g. staffing, therapy space) on an OT's ability to provide a quality service?
What OT assessments are used in PICU – what assessment have good utility?
Is MOHO EXPLORE a relevant and useful assessment in PICU?
OT role in seclusion & long-term segregation.
How is the physical environment impacting restrictive practice?

NAPICU National PICU Occupational Therapy Network launch, 3 March 2020

How are OTs managing dysregulation on the ward?
What methods are PICUs employing to reduce restraint and restriction.
Standardised assessment in CAMHS PICU & how this formulates intervention and outcome measurement.
OT-specific outcome measures focused on occupational identity and patients' insight into functional needs/goals (is this a research question? Could it be a topic for a literature review?).
Difference between outcomes from MOHOST, MOHO-EXPLORE and the VdTMoCA (I don't think this is a research topic, as reading these models and assessments will answer that question, but this could be a workshop topic for another networking event).
OT outcomes in relation to length of stay.
What treatment modalities are used on PICU by OTs?
Sensory-based activities on PICU – how effective?

Research/ experience-based reports to publish
Sensory based strategies in PICU to improve emotional regulation.
The VdTMoCA tools as a ward/patient outcome measure.
Implementing a co-production (peer and professional led) group with PICU.
Using sensory rooms in a PICU.