PB-PG-0808-17014 – NIHR Research for Patient Benefit Programme – Final report

Project title: A preliminary comparison of acute mental health inpatients wards which use Patient Engagement time with other wards delivering standard care alone

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Plain language summary
Despite various local and national initiatives, we do not yet have an evidence-based way of addressing the problem of patients reporting that acute wards are boring or intimidating places. Protected Engagement Time (PET) has emerged as a promising initiative for improving quantity and usefulness of staff-patient contact. During fixed periods of the day, staff are asked to focus solely on patient contact: visitors are not admitted and administrative duties and meetings not allowed. This approach is popular and inexpensive to implement. However, we do not have any evidence about whether it works or how it should be implemented to achieve the best results.

Our study aimed to address this, and had three components;

a) A national survey investigating how widespread PET is in England, and how it has been implemented.

b) Evaluation of the effects of PET on patients and staff by comparing 12 wards with PET and 12 wards without. We observed whether there was more contact between staff and patients with PET, and used questionnaires and interviews to compare patients' satisfaction with care and staff burnout on wards with and without PET. We also examined the frequency of conflict between staff and patients and staff and patient perceptions of the ward environment.

c) In-depth case studies on three wards with PET, using open-ended interviews with patients, staff, carers and service managers, exploring their experiences of the effects of PET and how best to implement it.

We identified 446 acute wards in all mental health trusts in England, of which 210 were found to have PET. 192 of these wards completed our telephone survey and over 90% reported positive effects of using PET on staff and patients, however the way it was implemented varied greatly.

We did not find any differences in patient satisfaction with treatment, levels of staff burnout or therapeutic engagement between staff and patients in the 12 wards with and 12 wards without PET. We did find some evidence staff may spend more time with patients on PET wards.

We completed 47 in-depth interviews on the 3 case study wards. Ward staff expressed mainly positive views about PET, but patients' views were more mixed.

The picture obtained was mixed: despite widespread uptake, we did not find any quantitative evidence of an impact of PET. Qualitative findings hint at some possible positive impacts but are not conclusive.

Keywords
Protected Engagement Time, Acute inpatient wards, therapeutic alliance, activities

Summary of research findings
Evidence suggests being a psychiatric in-patient is an unpleasant experience for many. Recent surveys suggest inpatients find the staff contact and activity available on wards too limited (Higgins et al 1999). "Protected Engagement Time" (PET) is an initiative aimed at enhancing the quantity and quality of patient-staff interactions, with wards closed to visitors and staff released from office duties. PET originates from clinical practice and had not been clearly manualised or thoroughly evaluated prior to this study. However, many acute inpatient services had introduced PET, some reporting that they felt PET may create a calmer ward atmosphere and reduce untoward incidents (CSIP, 2005). PET is a potentially attractive intervention, requiring no staff training with few or no cost implications.

Aims and objectives:

Our overall aim was to assess the impact of Protected Engagement Time (PET), an approach to delivering acute psychiatric ward care that is intended to improve the quantity and quality of contact between staff and patients, and thus the quality of patient and staff experiences on these wards. We compared wards on which this model was implemented with otherwise similar local wards where it was not. We chose a naturalistic methodology, as this was an innovative model that had already been widely adopted, so there was an urgent need for rapid availability of preliminary evidence as to how the model has been implemented and whether there is evidence of positive effects. This was most effectively achieved using a naturalistic method, though was also aimed to assess whether a subsequent cluster randomised trial of a more clearly operationalised version of PET was warranted.

The following were the main research questions:

1. How widespread was the implementation of PET nationally and how had it been implemented?

2. Did inpatients on wards with PET spend more time in contact with staff than on other wards?

3. Were there differences between patient experiences between wards with and without PET? Our primary hypothesis was that patient satisfaction would be greater where PET was in place.

4. Were there differences between staff experiences on wards with and without PET?

5. Were there differences between rates of adverse incidents on wards with and without PET?

6. How did service users, ward staff and staff who work closely with acute wards experience PET, and what suggestions did they have about how to implement it?

Methods:

The study had three modules

Module 1 was a national survey of the implementation of PET. Specific objectives were:

a. To ascertain how many of a nationwide random sample of 100 wards had introduced PET.

b. To describe how it has been implemented, including hours of implementation and restrictions used to protect engagement time.

All acute mental health wards in England were identified and called by phone to ascertain whether they implemented PET. If they did, the ward manager or nominated staff member was requested to participate in a telephone survey using a questionnaire developed by the study team.

Module 2 was a quantitative investigation, comparing eight wards with PET with eight without in three Trusts. Specific objectives were:

a. To compare patient satisfaction between wards with and without PET, testing the hypothesis that satisfaction was greater with PET

b. To compare patient-reported ward atmosphere, therapeutic alliance and interventions received with and without PET

c. To compare staff burnout and staff-reported ward atmosphere with and without PET, testing the hypothesis that burnout was less with PET

d. To compare proportion of patients' time spent in direct contact with staff with and without PET, testing the hypothesis that there was more contact time with PET

e. To compare conflict behaviours and use of staff containment measures on wards with and without PET

The study researcher assisted patients to complete their questionnaires where needed. All staff working on the 24 wards in the study were asked to participate. The observational data was collected by the researcher over a 3 week period across 12 hours. The conflict behaviour questionnaire was completed by ward staff.

Module 3 was a qualitative investigation of 3 case study wards on which PET was implemented. Specific objectives were:

a. To explore patients' experiences of PET, whether, and in what ways they saw it as having an impact on the quantity and quality of their contacts with staff, whether they reported any negative experiences, and what suggestions they had for improvements in the model

b. To explore staff's experiences of PET, what impact they felt it had on their working lives and relationships with patients, and what suggestions they have for improvements

c. To explore the views about PET of others working closely with the ward, including community teams and managers.

d. To explore the view of carers on how the ward was organised and the quality of the relationship between their relative and staff.

Results:

National survey:

We changed our sampling strategy to include all acute wards in England, instead of the initial target of 100 randomly sampled. We identified 446 acute wards across all 61 mental health Trusts, of which 210 wards in 43 Trusts reported using PET (47%). 192 (91%) wards completed the telephone survey and of these 144 (75%) aimed to provide PET for min 5 hours over min 3 days per week. Most of the respondents perceived general advantages to PET in terms of facilitating more time with patients (75%), positive effect on patients (95%), and therapeutic relations (61%). Very few disadvantages were identified.

Module 2:

We recruited 346 patients and 424 staff (original target was 300 of each). 161 patients were from control (non-PET) wards and 185 from intervention (PET) wards, while 211 staff were from control wards and 213 intervention. The two groups did not differ significantly in any clinical, demographic or professional characteristic, except 2: The PET group had significantly more female patients (probably due to one of the 8 PET wards being all female) and the PET ward staff were older than the non-PET, with more over the age of 46 than in the non-PET wards. Average age for patients was 40, around half were white British, their average time on the wards when interviewed was 4-5 weeks, and 75% of them had been under a section of the mental health act at some point in their admission.

Most staff respondents were nurses or health care assistants (80%), 64% were female and 50% were white.

Our primary outcome measure was patient satisfaction. We did not find any difference between levels of satisfaction with treatment on PET and non-PET wards. Neither did we find any differences in ward atmosphere (using the Ward Atmosphere Scale and the Good Milieu Index), perceptions of recovery (using the Recovery Assessment Scale) therapeutic alliance (using the STAR measure), or interpersonal relationships (using the Interpersonal Relationships Inventory). Experiences of negative and positive events were similar in both groups. The CCCQ results indicated that some needs were net more effectively in PET wards.

We no differences in conflict and containment in Pet and non-Pet wards (measured by the PCC-SR), nor in positive, negative and neutral interactions (measured by the IOC). We did find that staff on PET wards spent significantly more time with patients than on non-PET wards (24.3 vs 17.8, p= 0.002, units in % if total time).

The findings from the staff were also non-significant. No differences were found in perceptions of ward environment (WAS), therapeutic alliance (Using the STAR) or burnout (using the Maslach Burnout Inventory). Experience of negative and positive events was also similar in both groups.

Module 3:

We conducted 47 semi-structured interviews with stakeholders in 3 case study wards where PET was implemented (one ward per site). Of these, 19 were with patients, 14 with ward staff, 8 with linked staff and 6 with carers.

Initial analysis of the qualitative data has identified largely positive views among the staff participants around their involvement with and expectations of the impact of PET. Patients and carers were generally unaware of the intervention as a concept but could comment on ward activities, routine, and relationships with others. Their views on these activities were mixed in that patients sometimes enjoyed them but felt they could be improved. Patients and staff felt that relationships were improved through one-to-one time and through interactions, which patients felt should occur more often.

Conclusions:

The findings from this study are important on two counts:

a) They highlight that interventions advocated by local and national policy should be evidenced prior to implementation. The Chief Nursing Officer (CNO) review of mental health nursing in 2006, Acute Care Collaboration 2005, and reports by the Sainsbury Centre 2006 2006 advised implementation of PET, but without evidence to substantiate the proposals. The findings of this study have been equivocal but have indicated that PET has been implemented across the country in at least half of our acute inpatient wards.

b) The positive regard for the concept of protected time in the national survey and qualitative interviews did not translate into positive impact on outcomes in our sample of 24 wards. Further research is needed using a PET intervention that is standardised, and draws on the components that have been highlighted as important in our national survey and our case study interviews (e.g. frequent and regular times, patient involvement in determining how the time is used, structured interventions and activities that occur during these times). We believe that developing a manualised version of PET then testing this in a trial is the next step in this programme of research. Without this evidence, wards may continue to implement this intervention with little effect.

Patient and public involvement

One of the study applicants (HG) is a mental health service user researcher with experience of conducting researcher in acute settings. and has personal experience of using mental health services. She was involved in the original design of the research and has provided on-ongoing input throughout the duration of the study, including conducting the qualitative analysis.

We established a steering committee to monitor the conduct of the study, which met 5 times between June 2010 and March 2013. The committee was chaired by an independent academic, and membership comprised mental health professionals, service users and carers. Feedback from the service user and carer members helped shape how we disseminated the study findings. A service user and carer from this committee presented the study outline at the national Mental Health Research Network (MHRN) conference in Birmingham in May 2012.

The study proposal was shaped through consultation with the Service User Research Forum (SURF) at UCL prior to submission for funding. The Service User and Carer Group Advising on Research (SUGAR) in East London provided valuable feedback on the study questionnaires, particularly the negative and positive events scales. The positive events scale was constructed largely from SUGAR comments. One of the study applicants (AS) has a strong track record of service user engagement and was responsible for establishing SUGAR in 2010.

Two working groups were set up by the study lead with a view to commenting on and assisting to develop the patient and staff questionnaires for module 2 as well as the semi-structured interview schedules for module 3. The service user group comprised of 4 members and the staff group of 5 inpatient ward nurses from Camden and Islington.

These groups met several times in the initial stages of the study. The interview schedules for module 3 were greatly modified following their comments.

Data sharing statement
See link [https://www.nihr.ac.uk/documents/nihr-position-on-the-sharing-of-research-data/12253] for the NIHR position of the sharing of research data. The NIHR strongly supports the sharing of data in the most appropriate way, to help deliver research that maximises benefits to patients and the wider public, the health and care system and which contributes to economic growth in the UK. All requests for data should be directed to the award holder and managed by the award holder.

Disclaimer
This project is funded by the National Institute for Health Research (NIHR) under its Research for Patient Benefit (RfPB) Programme (Grant Reference Number PG-PB-0808-17014). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

This project was carried out between April 2010 and September 2012. This final report has not been peer-reviewed. The report was examined by the Programme Director at the time of submission to assess completeness against the stated aims.