

Quality Network for Forensic Mental Health Services



Summary: MSU Email Discussion Group Activity

June 2008 – June 2009

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Date posted	Topic	No. of posts	Response
18/06/08	<p>Food Supplements</p> <p>An issue was raised regarding the use of muscle promoting food supplements, due to concerns that they may be associated with increased assaults. Strategies and views from other MSUs were requested.</p>	6	<p>Overall, respondents championed cardiovascular exercise over weight lifting based exercise. The rationale for this is detailed below.</p> <p>One respondent raised the issue that if patients are becoming physically stronger restraints may become more difficult which will ultimately lead to great frequency and severity of injuries to staff and patients alike. As a result, it was argued that muscle promoting supplements should not be used by service users.</p> <p>Another respondent noted that there are different supplements available, for example those which are anabolically active (which are probably illegal) and those which are nutritional (for example, contain amino acids). Additionally, it was suggested that whilst muscle bulk makes assaults more problematic when they occur, it probably doesn't make them more likely.</p> <p>Lastly, one respondent noted that some people believe that creatine can have reactions with some psychiatric medication; however this has neither been confirmed nor disproven. Further to this, it was argued that the amount of training that service users are able to do does not really warrant the use of creatine.</p> <p>On the whole, respondents suggested promoting a variety of cardiovascular exercises, such as aerobics, running, treadmills etc.</p>

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25/06/08	<p>Staff well being</p> <p>A request for information was sent to the group regarding strategies they have in place for staff well being.</p>	7	<p>One service reported to run a three day course for forensic service senior staff which addressed post-incident support and defusing, this was noted to include significant experiential/practice components.</p> <p>Another service reported that their staff are able to access a part time counselling service. In addition it was noted that their Trust also has a staff well being committee which supports staff throughout the service.</p> <p>Alternatively, another service reported to be carrying out developments in this area, through the appointment of a trauma advisor. Additionally, it was reported that this service employs Care First to provide input to staff where necessary.</p> <p>Lastly, one service reported to have a three pronged approach to staff well being. It was reported that within the wards there are reflective practice groups provided by the psychotherapy department. In addition, there is a staff support system and an incident debrief procedure in place. Further to this, the Trust in which this MSU is situated, was reported to have an internal support system. This involves a senior psychologist from a different directorate which provides post incident support.</p>
0/06/08	<p>Bringing Food into MSUs</p> <p>One MSU noted that there is a risk involved with families bringing in pre-cooked food to the unit, as this could be a method for getting contraband into the unit. A request was made for policies which address this.</p>	3	<p>One respondent reported that they do not allow friends and family to bring food into the unit, for the reasons identified in the original post.</p> <p>However, another respondent noted that their service does allow relatives to bring in shop bought, factory sealed items. It was noted that whilst this is not a fool proof system, it has been operationally achievable and there is no evidence to suggest that there have been breaches occurring.</p>

Date posted	Topic	No. of posts	Response
02/07/08	<p>Family therapy</p> <p>Information was requested regarding family therapy sessions available in other MSUs. Specifically, information regarding the amount of sessions; the work undertaken; issues that have arisen and evaluative work that has been conducted.</p>	7	<p>The majority of respondents reported providing family therapy; however this was noted to be varied.</p> <p>One respondent noted that they provide family therapy once service users have reached the rehab stage of the care pathway.</p> <p>Another respondent reported that their family therapy service has been running for just over a year; the team is comprised of three clinical psychologists, who are all at different stages of family therapy training. The team operates three sessions per month, two of which are dedicated to appointments and the third is used for supervision and service development. The majority of patients who are referred to these sessions are suffering from psychosis and have a past history of violence.</p> <p>Lastly, one respondent noted that their family therapy team consists of psychologists, psychiatrists and nurses, who provide two sessions per week. In addition they employ a consultant family therapist. It was noted that the work undertaken by this team is varied, and upon receiving a referral the team will meet with the referring multidisciplinary team to discuss their hopes for outcomes from the work. The respondent provided examples of the type of work that they conduct:</p> <ul style="list-style-type: none"> • Exploring with family and service user their understandings of service user's illness and index offence (e.g. where MDT is concerned family does not understand or there is disagreement between family and professionals). • Working with relationships where risk issues are identified (e.g. partner/ family member was victim of offence). • S.U. has got 'stuck' and is not progressing - work with family can give a context for the difficulties and/ or S.U. talks and responds differently in presence of family so that family therapy becomes a setting where issues can be addressed that S.U. has not addressed in other settings. • Discussion with family of future plans/ hopes/ fears/ risks as S.U. is approaching discharge. • Involving S.U. in 'family talk' as a means of helping them cope with events that may have occurred in their absence (e.g. deaths, separations, ill-health among family members) and/ or as a means of supporting their wider identities and combating institutionalisation. <p>In terms of issues that this service has faced, it was noted that the work is slow and sometimes families and service users are difficult to engage. Additionally, access to a comprehensive interpreting service was noted to be essential.</p>

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09/07/08	<p>Patient Mail</p> <p>A request was made for policies and protocol regarding patient mail and circumstances when it may be withheld. For example, packages with suspected drugs enclosed.</p>	2	<p>The response to this post came from a MSU in Scotland, who cited the 2003 Scottish Mental Health Act, which states that a 'specified person' may have their mail stopped and opened; it was noted that there is a requirement to notify the mental welfare commission and the person in question when this has taken place.</p>
14/07/08	<p>Isolation/segregation</p> <p>A request was made for policies and protocols regarding isolation and segregation.</p>	5	<p>One respondent noted that this issue had been much debated in their service and on the whole they have found the below definition of seclusion the most useful. Additionally, the respondent noted that in their opinion any intervention that restricts liberty should be defined as seclusion.</p> <p><i>"The supervised confinement of a patient in a room, which <u>may</u> be locked to protect others from significant harm". (MHA Code of Practice, paragraph 19.16.)</i></p> <p>Another service also noted that they have debated the differences between seclusion and isolation and reported that the general agreement is that it is seclusion when a specific locked seclusion room is used. It was reported that this service has a seclusion area which comprises of 2 seclusion rooms, a lounge and courtyard area. It was noted that the policy allows for two patients to be secluded at once. In response to the first post the second respondent argued whether the form of isolation or time-out described can automatically be called seclusion. It was added that the MHA (1983) Code of Practice (Ch.18) identifies 'time-out' as being a form of psychological treatment and describes it as <i>'...a behaviour modification technique which denies a patient, for a period of no more than 15 minutes, opportunities to participate in an activity or to obtain positive behaviours immediately following an incident of unacceptable behaviour. The patient is then returned to his or her original environment. Time-out should never include the use of a locked room and should be clearly distinguished from seclusion.'</i></p>

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23/07/08	<p>Overarching models of care</p> <p>Information was requested regarding how MSUs approach overarching models of care and which models are in use in other services. Additionally, a request was made for information as to how sector teams (where there are several teams managing in patient services) manage themselves and whether they have a team manager.</p>	5	<p>One service reported to have based their model of care document on recovery principles. In response to their post, another service reported to have conducted work in a similar way. This service noted that they have made a significant number of changes to address this, for example: vocational service; broad service user involvement and recovery based groups all of which incorporate recovery principles.</p>
24/07/08	<p>Smoking ban and Violence</p> <p>Due to an impending smoking ban one service raised concerns regarding reports of violence by patients towards staff due to restrictions on nicotine intake. A request was made for any information/experiences in this area.</p>	9	<p>A number of services replied to this post. Consistently, it was reported that there have not been any violent incidents linked with smoking bans.</p> <p>It was noted that where bans have been put in place, smoking cessation programmes have been found to be very beneficial.</p> <p>The only reported problems have been that some service users have been found to secrete lighters and then smoke in their bedroom at night.</p>

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08/09/08	<p>Video conferencing</p> <p>As a result of a service installing a video conferencing system they noted its potential benefits for forensic work, for example, prison clinical work; remote assessments and supervision. A request was made for information from services that already have such systems in place and any thoughts members could contribute to a business plan to justify rental.</p>	5	<p>Such a system was reported to be used extensively in a service in Australia. It was noted that this is mainly used for court liaison, meetings, case conferences and consultation liaison. This technology was noted to be extremely useful, particularly in linking the inpatient unit to remote communities for family meetings. Other uses were reported to include supervision, cognitive behavioural therapy and education.</p> <p>Another respondent reporting using video conferencing for: gate keeping assessments; medico-legal reports; CPA meetings; therapy; supervision and on occasions for follow up.</p> <p>Lastly, another respondent noted that these systems have tremendous potential for MSUs, especially in reducing dead travelling time.</p>
09/09/08	<p>Tobacco</p> <p>A request for information was made regarding arrangements services have in place for service users to purchase tobacco products, especially for those who do not have any leave.</p>	5	<p>One service reported to have an arrangement whereby patients order cigarettes weekly from the local newsagents. The order is faxed to the shop and then they deliver the cigarettes to the unit, and staff collect them for each individual ward. The welfare department has the responsibility of releasing individual patients' money to the newsagents for payment. This system was noted to work very well for this particular service.</p> <p>Another service reported to run a shop twice weekly in order to facilitate the purchasing of cigarettes for patients who do not have leave. It was reported that a member of staff will visit the local supermarket during their shift and purchase tobacco products, patients are able to request certain products. A similar system is operated at another unit. It was reported that their shop trolley is taken to the acute and admission wards once a day, after lunch, and sells a small range of tobacco products. It was noted that this service uses the trolley as an opportunity to work through budgeting and planning issues with service users and also provides an opportunity for the patients on the rehabilitation wards to work.</p> <p>Lastly, another service reported to have a user's shop, which is situated in the activity centre at the unit, from which patients are able to purchase tobacco products. It was noted that patients who are unable to leave the ward area are able to put in an order from the shop through the nursing staff.</p>

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10/09/08	<p>RiO</p> <p>Information was requested regarding experiences services have had of using RiO. Specifically, does RiO meet the needs of a forensic service as an electronic care record, especially recording risk information.</p>	6	<p>Overall, respondents gave very positive feedback regarding their experiences of using RiO. It was reported that the system has enabled services to record service user risk assessments; care plans; HoNOS; incident and accident reports and other risk assessments relating to restraint. It was noted that the system provides a lot of scope as to what forms can be used, and this can be tailored to each service. Lastly, it was noted that although the task of transferring paper records to RiO is large, it is worth the time required.</p>
12/09/08	<p>Delayed transfers of care</p> <p>Due to requirements for services to report on delayed transfers of care within services, a request was made for units to share how they already report on this.</p>	3	<p>One service noted that they have been reporting on delayed transfers of care for several years. It was reported that once a transfer has been agreed the expectation is that they will have been transferred within three months; if they have not been transferred then they become a 'delayed transfer of care' which will then trigger correspondence from the unit and their commissioners. This was noted to aid in streamlining transfers and to tighten up timescales of transfer.</p>

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16/09/08	<p>Patient telephone systems</p> <p>Advice and suggestions were requested with regards to telephone systems that units have had installed, and the benefits and drawbacks of such systems.</p>	6	<p>Overall, respondents favoured a coin operated system for telephones within MSUs. There were a number of different reasons for this. One respondent argued that as MSUs are in the business of re-integrating patients into the community services should be designed to mimic the community as closely as possible, therefore suggested that a coin operated system would be more desirable.</p> <p>Another service reported to use a card operated system, however noted that this is more costly to patients than coin operated telephones. Further to this, this respondent advocated the use of coin operated phones as patients know exactly how much they are spending and can monitor this.</p> <p>Alternatively, one respondent reported that their phone card system has worked well for their unit; however provision needs to be made for service users who are calling abroad as the rates are extremely high. In addition, this respondent noted that there are drawbacks with the coin operated systems as they are easy to abuse and patients are required to carry cash, which raises vulnerability and bullying issues, as well as untraced monies. Conversely, another respondent noted that staff have to monitor calling cards closely, as patients have discovered that if they dial the last 4 digits they are able to communicate between wards free of charge, this was noted to be a potential security risk.</p>
16/09/08	<p>Star Wards</p> <p>A request for information was made from services who are involved in Star Wards, especially around issues such as engaging with volunteers, patient protected time and ward based nurse-led activities.</p>	2	<p>The response to this post came from a member of staff who had been specifically employed to launch a Star Ward. The work undertaken so far was reported to be identifying two Star Ward 'champions' per ward, one member of staff and one patient who have formed part of the Star Wards steering group. In addition two activity co-ordinators are involved in the programme of work and will be responsible for facilitating activities on their wards. It was reported that the ideas for these activities will be generated from staff and community meetings. Overall, the respondent advised that when developing Star Wards units should ensure that staff and patients understand that success will come from ideas generated by them, rather than ideas imposed from above.</p>

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18/09/08	<p>PMVA training</p> <p>Advice was requested regarding how many staff it is safe to have on a unit/ward who are not trained in PMVA (for physical reasons).</p>	3	<p>One respondent noted that within their service they have a tolerance for 5% of the clinical workforce who are exempt from PMVA training. It was reported that there is some flexibility in this number for short term exemptions, due to injury or pregnancy.</p> <p>Alternatively, another service posted a reply which stated that they do not have any staff deployed in the clinical area who cannot fulfil PMVA duties. If a member of staff were unable to fulfil these duties due to short term physical problems then the unit would undertake to explore temporary redeployment to reception, admin or support to the training and development department. However, if this is a long-term issue arose the individual would be subject to redeployment in accordance with the trust sickness and absenteeism policy.</p>
19/09/08	<p>Smoking agenda</p> <p>Advice was requested regarding systems that services have in place regarding implementing non smoking within NHS buildings.</p>	3	<p>It was reported that services have created guidelines that state that service users are not permitted to smoke within the buildings of the unit. One service reported to have a specific garden in which patients can smoke and there are designated times at which they can do so. It was reported that this service requires service users to sign contracts which state that they will only smoke in the designated areas. Further to this, both respondents noted that lighters are managed as security items and are signed in and out to patients. Both services reported to have strict consequences in place for abuse of smoking policies, such as reviews of risk assessments and management plans.</p>
22/09/08	<p>Prohibited items - Aerosols</p> <p>One service asked the discussion group if other units consider aerosols as prohibited items.</p>	5	<p>The majority of services reported that aerosols are security items within their service. One service noted that after appropriate risk assessment service users have access to aerosols, under supervision. This practice was noted to be in place at another service, where all access to aerosols is supervised and monitored by nursing staff. Another unit reported that no aerosols of any sort are permitted within the unit, and non aerosol versions of all products are required to be used by patients</p>

Date posted	Topic	No. of posts	Response
29/09/08	<p>Patient photos</p> <p>An issue was raised by one unit regarding patients refusing to have their photograph taken for the unit's records. Advice was sought as to whether the service can take photographs of patients without consent.</p>	5	<p>One respondent reported that they have come across a similar situation in a High Secure facility, and were legally advised that they are on safe ground in enforcing service users to have their photograph taken. This was due to the duty the service has to ensure the safety of the public through maintaining security. In order to maintain security the service needs an up to date photographic record of the patient, without such a record the escape/absconding/AWOL procedures of both the Police and the Service are rendered all but useless. It was noted that this advice was given some time ago, and therefore the service should check whether this is still current.</p> <p>Another service posted that they have a policy which requires all patients to have their photograph taken. It was reported that this service uses a passport size photographs on patients' leave cards, which creates an incentive for the patients to cooperate.</p> <p>An additional service noted that the MHAC 12th Biennial report is helpful in addressing this issue and provided a section which is particularly useful (see below).</p> <p><i>In some parts of the secure sector, detained patients are photographed upon admission, primarily to provide a likeness of the patient to be used if that patient goes AWOL (staff also may take a note of patients' clothing when they go out on leave for the same purpose). In this period we have been asked for a view on the extension of such practices to open wards, and whether detained patients should be considered to have a right to decline to be photographed. In practical terms, we suggest that notwithstanding the arguments that may be made for or against deriving powers to photograph patients from the fact of their detention, no detained patient who declines to be photographed should ever be forced into posing for the camera in the manner of old asylum casebooks. However, where a risk assessment suggests that it would be prudent to possess an image of a patient, we can see no reason why the taking of such a photograph should not be stated to be a condition of that patient being granted leave of absence. If a patient continues to refuse to be photographed in such circumstances, the responsible medical officer should consider very carefully what meaning to attach to such refusal if he or she decides to reconsider the position.</i></p> <p>Lastly, one service noted that the safe administration of medication, due to the possible new staff on a ward, requires a photograph on the drug chart. It was noted that on this basis patients agree to be photographed.</p>
02/10/08	<p>Clinical supervision</p> <p>Up to date information and advice regarding the response of clinical supervision was requested.</p>	2	<p>The respondent noted that the BSMFT has a clinical supervision policy, which would be relevant to this post. It was reported that ward managers are expected to return monthly figures on the uptake of clinical supervision, which is overseen by the lead nurse/service manager under a performance management system.</p>

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03/10/08	<p>Dress code</p> <p>Advice was sought regarding whether services allow staff to wear open toe sandals; whether staff are permitted to wear shorts; how units deal with body piercings and direction units give staff regarding tattoos (especially in obvious areas).</p>	8	<p>One respondent noted that the issues surrounding open toed shoes/sandals, shorts and body piercing should be covered from a health and safety point of view. With regard to tattoos, it was noted that this would be dependent on whether the content was offensive or not.</p> <p>One service reported that in the past they had had a member of staff who had a prominent cannabis leaf tattooed on their leg. They were encouraged to cover this with appropriate clothing and the issue was addressed through the 'professional image and health promotion' line. This service reported to have found that service users are keen for their carers to appear professional.</p> <p>Another respondent noted that the wearing of open toed shoes could be quite a risk with in an MSU and therefore no staff should be allowed in a clinical area with such footwear. In addition, it was noted that people who are trained in PMVA and will be called upon to perform a restraint should be particularly aware of the risks of wearing open toed shoes. It was noted that the same applies to piercings. With regards to tattoos, this respondent noted that if they are on the face, neck or hands they should be covered up, whilst taking cultural issues into account. Lastly, it was reported that staff should be permitted to wear shorts, as long as they are knee length, made of cotton or similar material and not worn on a professional visit.</p> <p>Alternatively, another unit reported that staff are not allowed to wear shorts, they are expected to take out any body piercing that is exposed, for infection control purposes (e.g. lip or eyebrow piercings) and they are required to cover up all tattoos.</p>
07/10/08	<p>24 hour senior cover</p> <p>Information was requested as to the systems services have in place to ensure that there is 24 hour senior cover on site.</p>	2	<p>One service reported that they have band 7 nursing staff (site senior nurses) covering out of hours, which includes all day at the weekend and nights. However, it was noted that this service does not have onsite medical cover out of hours. The ward managers (band 7) cover 9 until 5, at times they may be required to work shifts in the absence of the site senior nurse.</p>

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08/10/08	<p>Staffing levels and Shift Patterns</p> <p>Information regarding staffing levels and shift patterns utilised at units was requested.</p>	2	<p>One service responded to this post. It was reported that this service has 86 WTE nursing and healthcare staff in total, with a skill mix of 49 RMNs, including 3 ward managers (Band 7), 7 lead clinical nurses (Band 6) and 37 healthcare assistants (Band 3). Additionally, it was reported that the admission/assessment ward (with 12 beds) has 36 staff, and a ratio of 3:1 over a 24hr period. For the intermediate care ward, with 12 dedicated female beds, it was reported that there are 30 staff, with a 2:5 ratio over a 24hr period. The 10 bedded rehabilitation ward has 20 staff, and a 2:1 ratio over a 24hr period. This unit was reported to have a varied shift pattern which consists of 3 long days or 5 shorter early or late days; this has to reflect the needs of the services. Lastly, it was reported that staff rotate onto night duty for 1 month at a time, but there is flexibility for some staff to work longer periods on night duty. The shift patterns are as follows: Long Day 7.30am – 9pm Early Shift 7.30am to 2pm Late Shift 1pm to 9pm Night Duty 7.45pm 8.45am</p>
20/10/08	<p>Mobile phones</p> <p>Advice regarding patient use of mobile phones whilst on section 17 leave was requested, in order to support a service in developing a policy in this area.</p>	4	<p>One service reported that mobile phones are listed as contraband at their unit, and therefore are collected and returned on departure and return from leave of absence.</p> <p>Another unit reported that they do have some patients who have the use of a mobile phone whilst out on leave, and they are currently developing a more comprehensive policy in this area. This service reported to have integrated 'lifelong learning' schemes into the occupational therapy process. As part of this, education and training for patients (risk assessment permitting) is provided in using the technology that people use in the community.</p>

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12/11/08	<p>Deep fat fryers</p> <p>Due to risks and health issues surrounding the use of deep fat fryers, advice was sought from units as to how they address such issues.</p>	7	<p>Four services reported that they do not allow patients to use a chip pan/deep fat fryer, for the reasons highlighted in the original post. One service reported that chefs in the kitchen are the only personnel allowed to use such appliances, and this is well away from patient areas.</p> <p>Another service reported that the risk of hot oil being thrown was also another factor in not allowing chip pans or deep fat fryers in patient areas.</p> <p>However, another service reported that within the O.T. department they do have a deep fat fryer in the kitchen. It was reported that this is an electric fryer and has a temperature controlled switch to stop the oil over heating and to set the temperature for this items that are being cooked. It was reported that olive oil is used in the pan in order to aid a healthier diet. It was noted that the fryer is not used that often.</p>

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19/11/08	<p>Internet for service users</p> <p>Information was requested regarding information units could share on their experiences of internet access for service users. For example, the technology systems in place, the types of access for service users and the levels of supervision provided.</p>	5	<p>This post received a number of posts. One service reported to work with their Local Authority in providing a "Cyberbus" service, which is external to the service and patients need community leave to access it. In addition to this, a policy has been developed and agreed for patients to have access to the internet within their unit through a separate internet USB connection. This was reported to be problematic in terms of getting a signal. With regards to monitoring the sites being used the unit reported to use a Netnanny programme and 1:1 supervision by staff (who are IT literate).</p> <p>Another service reported that they have allocated computers within their service on which service users are able to access internet sites. The internet is provided via the Trust network with a robust firewall in place. It was reported that whenever service users use a PC, whether they're on the internet or not, they are closely supervised at all times by a member of staff. The units' protocol in this area notes that the supervising member of staff has the authority to stop a PC session if they have concerns about what a service user is doing. Service users are required to sign a contract agreeing to the conditions of using the PC and internet.</p> <p>A further service reported to have successfully introduced internet access into their unit. Patient access to the internet is approved through the CPA process. It was reported that once the service user has been approved for internet use any internet supervisor can take them on, but they must agree before the session what they wish to use the internet for. This service reported to have Guardware on the computers to prevent access to inappropriate sites and Spector Pro which monitors the sites that have been accessed. Print outs from Spector Pro are kept with patient notes.</p> <p>One respondent reported that within their service patients undergo a risk assessment which involves MDT clearance, a pre-online internet training course (through learn direct), close observation and an induction with signed agreement from the patient. It was reported that the history is checked after use and there are parental controls in place. This service reported to have an interactive whiteboard connected to the internet, which allows greater observation and therefore does not require one to one supervision.</p>

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01/12/08	<p>Key tally system</p> <p>A request was made for people to share their experiences of tally systems for signing in and out keys.</p>	3	<p>One service reported to use an ID card exchange system, whereby a community photo ID is exchanged for an ID pass which staff wear once inside the unit. This system was noted to work well, and ensures that whilst in the community staff will always have a photo ID available to confirm their position.</p> <p>Another service, which is currently in the process of building a new 97 bed MSU, has proposed using a Traka key exchange system. Staff will be issued with an access control card which will gain them access to the staff-only airlock, they will then obtain their clinical pass key from the Traka key cabinet, using a personal digital code. This cabinet is linked to a PC which is able to monitor who is in the unit and who is not at any one time. The clinical pass key is re-deposited in the cabinet when the staff member leaves the facility; if they fail to do this a buzzer will sound as they try to leave main reception. Additionally, if an access control card is reported lost it is automatically deleted from the system. It was reported that the loss of a card is not a problem in itself, as in order to leave the unit, entry to the staff airlock is controlled by both access card and staff's personalised pin code.</p>

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04/12/08	<p>CPA information for commissioners</p> <p>An issue was raised by one service regarding confidentiality and providing commissioners with patient CPA information, after commissioners had requested the information for care planning monitoring purposes.</p>	9	<p>One service reported that they send CPA 'packs' to commissioners or to the case managers. It was reported that most documentation is sent via a secure email address or if by post by recorded delivery. In addition to this, services must adhere to the Data Protection Act therefore only patient initials are used to ensure confidentiality.</p> <p>Another service reported that they too provide commissioners with CPA information. However, it was reported that they experienced problems as patients refused to allow the RMO to forward CPA reports to commissioners. To manage this the unit send the CPA report to the external RC and also send a letter to the commissioners to inform them that the report has been sent out and who they need to contact in order to access the information.</p> <p>Alternatively, another service reported that they do not routinely provide such documentation to commissioners. This was reported to be due to the fact that personally identifiable information can only be disclosed with the informed consent of the patient. However, it was reported that they do send copies to all attendees of CPA reviews, which may include case managers, as a proxy for commissioners. This is only done however with the agreement of the patient. This respondent argued that it is appropriate for commissioners to have aggregated data such as activity levels, waiting times etc but added that CPA information should not be provided as routine. This view was supported by another respondent who argued that the proper route for confidential CPA information is via case managers and not directly to commissioners.</p>
10/12/08	<p>Secure transport</p> <p>Advice was sought regarding the use of private security companies in providing secure transport and drivers for high risk patients.</p>	4	<p>One service reported to have purchased a Peugeot Eurobus SRX, which has everything this service needs to transport high risk service users. The driver is protected by a high-impact protection screen, security locking system controlled by the driver, safety windows, six seats that can fold in the back, intercom system from passenger to driver and a built in ramp for wheelchairs.</p> <p>Alternatively, another service reported to have used Reliance Security to transport high risk patients. It was reported that they were able to provide a service at very short notice and the cost was reasonable. Their website is www.reliancesecurity.co.uk.</p> <p>Lastly, another service reported using 'Rapid and Secure' transport services, who are based in Bristol. They provide a 6 seater people carrier with escorts, one of whom is an RMN. This company was noted to be reliable, however somewhat expensive.</p>

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16/12/08	<p>Learning methods</p> <p>One service asked to hear from the discussion group about experiences that they may have had with various methods of teaching/learning. For example, DVDs, workbooks and computer based resources such as podcasts, videos, etc.</p>	3	<p>One service reported to have incorporated different learning styles in all their classroom based learning, which has been found to support increased engagement from learners. It was reported that the service uses work books extensively as they have been found to reinforce learning beyond the classroom. However, they reported to deliver very little via DVD and PowerPoint as it was felt that these delivery styles do not engage people sufficiently for good learning. Lastly, it was reported that when appropriate this service does use IT training delivery, however this was noted to focus on IT skills and clinical processes.</p> <p>Another service noted that they favour face to face training methods, which is often directly linked to workbooks that are completed prior to the training session in staffs' own time. With regards to e-learning this service noted that staff can gain skilled knowledge in isolation from peers, which is retained, usable and achieves its aim. In addition, staff can complete the tasks at their own pace and in their own environment. However, it has been noted that this approach to learning is mostly about 'completion' and ticking the boxes rather than learning something new, therefore falls short of delivering competency skills to staff. Overall, this service reported to consider that traditional teaching should be highly interactive and allow time for debate, which serves to inform and aid a deeper understanding. Lastly, with regards to teaching via DVD it was noted that people struggle to stay engaged and therefore face to face training is favoured.</p>
06/01/09	<p>Material on DVD/CD</p> <p>Established guidance was requested as to how services deal with recorded CDs and DVDs, and the possibility that the material on them could be illegal or legal.</p>	4	<p>One respondent reported that pre-recorded commercial CD/DVDs are permitted (subject to the listed content, ratings etc) however, 'home made' CDs/DVDs are not. It was noted that this is due to the fact that allowing home burned CDs will require manual examination of each disk followed by searching for corresponding permissions in the person's iTunes store. This view was corroborated by another service. It was added that it is easy to have 'hidden' files within disks and other media devices and it would require specialised knowledge to access these, leading to the possibility of uncensored or inappropriate material/information entering the unit.</p>

Date posted	Topic	No. of posts	Response
13/01/09	<p>Staff support re violent incident</p> <p>Advice was sought as to the procedures units have in place to support staff following a violent incident.</p>	2	<p>This post received one response. It was reported that within this particular service they offer a debrief session after any incident; this is conducted by a dedicated member of staff.</p>
22/01/09	<p>Gym equipment</p> <p>A request was made for standards that services have in place regarding access to the Gym equipment for medium and low secure residents, particularly the equipment on offer (e.g. should the equipment focus on cardiovascular needs).</p>	4	<p>One service reported to have a wide variety of gym equipment within their unit, to include free weights, powerbags, cable machines and cardiovascular equipment. It was reported that all patients are required to complete a competency, Par Q and induction of all the equipment, starting with the cardiovascular machinery then the service users are able to progress to powerbags and then finally a weights induction. All gym access is carried out on a one to one basis and only when staff have assessed the patients over a number of sessions. Lastly, it was noted that all free weight equipment is kept in a lock cupboard and only opened for patients who have the correct pass status. Another service reported to have similar equipment. In addition, the respondent noted that there has been some research conducted as to the use of different activities with different patient populations. For example, team sports for personality disorder patients due to the need for pro social behaviour and adherence to rules etc.</p>
26/01/09	<p>Mechanical restraint</p> <p>Policies, guidance notes or procedures were requested from the discussion group regarding the use of mechanical restraint in their services.</p>	3	<p>One respondent reported that, as far as they are aware, on every occasion where mechanical restraint has been considered it has either been rejected or has been tried and failed. It was noted that it may be suitable to use to protect patients against harm they may do to themselves, such as biting in Lesch Nyham syndrome.</p>

Date posted	Topic	No. of posts	Response
03/02/09	<p>Mental health Act 2007</p> <p>A request was made for copies of the 2007 Mental Health Act in languages other than English.</p>	2	<p>One response was received to this post, which stated that they thought that currently the Mental Health Act has only been provided in English and noted that within their Trust they arrange for an interpreter to inform service users of their rights.</p>
04/02/09	<p>Low secure units</p> <p>Advice was sought from the discussion group regarding what works well in the development of low secure services.</p>	3	<p>One respondent suggested that the service should wait for the publication of the forthcoming low secure additional guidance information as a starting point. It was suggested that they can be obtained from local Forensic Commissioners.</p>
16/02/09	<p>Using broken CDs as weapons</p> <p>An issue was raised by one service as to the potential risk posed by broken CDs. Advice was requested from other units as to how they address this.</p>	4	<p>Respondents reported that they are aware of the potential issues in this area. Different strategies were reported with regards to addressing these issues. For example, one service reported that each case will be judged individually, if a service user persists in using CD/DVDs as a tool for self-harm or as a weapon they will be restricted access to these items. This is then reviewed if the deemed appropriate.</p> <p>Alternatively, another service reported that they operate a risk stage system, whereby allowable room contents vary according to the stage an individual is on.</p> <p>Another service reported a similar approach; whereby these issues will be addressed in individualised care plans if it is thought necessary to prevent particular service users having access to disks. In addition, it was noted that particular care is taken when completing inventories to ensure that none go missing. This service reported that they have installed equipment to rip CDs to mp3 files in order that they can be transferred to media players, and the CD stored as a back-up.</p>

Date posted	Topic	No. of posts	Response
20/02/09	<p>Carers education and support programme</p> <p>Advice from other units was sought regarding any carer education and support group programmes they have developed.</p>	4	<p>One service reported to hold quarterly carers events which provide education, support and carer involvement for carers and families. It was reported that this service would like to provide more of such events.</p> <p>Alternatively, another service reported to have run psycho-educational groups for families in the past. However, it was noted that attendance was generally low. The respondent noted that this may have been due to families not responding favourably to this particular approach.</p> <p>Lastly, it was reported by another respondent that in a previous role they established bi-monthly meetings for carers, each lasting 2 hours. It was reported that representatives from carers groups such as Rethink and the Trust Carers Consultant were invited to attend. It was reported that the focus of these meeting was largely on providing carers with information about the service; trying to improve communication between the service and carers and offering carers support.</p>

Date posted	Topic	No. of posts	Response
03/03/09	<p>Freeview adult channel access</p> <p>The issue of access to adult channels available on Freeview boxes was highlighted by one service. It was noted that service users are able to purchase these channels using credit or debit card details provided by family/friends by letter or on the phone. Additionally, it was noted that codes can be obtained to over ride the parental lock system.</p>	13	<p>This topic sparked much debate and interest from the discussion group.</p> <p>One respondent reported that if the box does not have a Conditional Access Slot then it would not be able to access certain providers. It was noted that most of the Freeview boxes available in supermarkets do not have this Conditional Access Slot. This view was corroborated by another respondent who noted that within their service for those at risk the IT department have boxes on which certain channels cannot be accessed. However, this view was challenged as apparently service users are able to phone the channel provider and are given an access code that they then type in with the remote control when the programme starts. In response to this, one service noted that they run checks of the boxes during searches as the technology is advancing at a much quicker pace than procedures and policies can be developed. In addition, it was reported that this service perform targeted checks if they have suspect that a patient has beaten the system. Another service reported to have had problems in this area. To address these issues they blocked 0900 numbers from the patients phones, as these were being used to telephone the providers and access the passcodes required for certain channels. In addition internet access was restricted was such passcodes can be found on certain websites.</p> <p>In addition to Freeview boxes another respondent noted that the issue extends to televisions that have built in Freeview. This respondent reported that they spoke to television X who confirmed that all a patient need do to view a channel is register over the phone with their name, address, payment details and a four digit pin number. Then when the channel is viewed it displays a viewer ID number which is given to Television X when the customer calls to book the film they wish to view, the pin number will then unlock the channel.</p> <p>Another respondent raised the view that some of the programmes shown after 11pm on channels such as Virgin are quite graphic, therefore the issue does not only relate to pay as you go provisions. However, this was noted to raise the issue of what parts of 'normal' culture should be withheld from service users.</p>

Date posted	Topic	No. of posts	Response
12/03/09	<p>Classification of patients presenting high risk of sexual offending in ICD-10 or DSM-IV</p> <p>Advice was sought as to how to appropriately classify patients who present with a heightened risk of sexual assault and offending, as they may not fit into a mental illness or PD classification.</p>	2	<p>This post received one response. The respondent suggested that the appropriate classification would be 'criminal' and suggested that the service would benefit from seeking legal advice.</p>
27/03/09	<p>Providing for patients' spiritual needs</p> <p>Advice was sought from the discussion group as to the ways in which services provide for patients' spiritual needs. For example, security procedures surrounding visits from officials from various faith groups (e.g. CRB checks); how to establish links with people who will visit the service and how to support these visitors with the medium secure environment.</p>	2	<p>The response to this post was posted by a chaplain from an MSU.</p> <p>It was reported that this particular service has established an external voluntary panel of world faith community leaders; it was noted that all have enhanced CRB checks and are locally inducted to the service by the chaplain, which includes documentation regarding visiting protocols. These visitors were reported to be supervised during visits and are never left alone with patients; they are supported by the head chaplain in all aspects of their role within the service. It was noted that all members of this panel will make an appointment with service users before they arrive and will wear a visitor's badge. Finally, it was reported that these members are encouraged to refer all difficulties experienced in visiting patients both to the nurse in charge and to the head chaplain. It was noted that the service prepares representatives for patients who may express notions and ideas outside religious and cultural norms and are encouraged to respond with sensitivity recognising the right of the patient to express their view and, when appropriate, to very gently challenge or offer a different view. If the patient is in a psychotic state the service reported to advise not challenging their views but changing the topic.</p>

Date posted	Topic	No. of posts	Response
08/04/09	<p>Security and Out Of Hours Cover</p> <p>A question was posed to the group as to whether patients at other MSUs are able to use disposable razors and what security measures are in place if they do so. Additionally, if service users use electric razors, are they individualised and how are they funded.</p> <p>In addition, advice was requested as to what level of senior staff cover is provided out of hours.</p>	5	<p>Responses to the first part of this query were consistent.</p> <p>It was noted that all disposable razors are checked in and out of storage by staff (and is documented) and their use is monitored and supervised. With regards to electric razors it was reported by all respondents that these are personalised and that they are not funded by the service, but are bought by the patients or their family/carers. Further to this, one service reported that after a patient has been risk assessed they can have their own electric razor stored in their bedroom.</p> <p>In response to the second part of the query one service reported to have band 6 and 7 staff on duty on a rota from 17.00 – 21.00 and then from 21.00 – 07.00. It was noted that these are not necessarily nurses, some are occupational therapists.</p> <p>Another service reported to operate a senior nurse co-ordinator role to cover 3 wards, who is a band 6 member of staff. In the event of any issues emerging they will link into a “manager on call system” which is operational at this particular Trust.</p>
09/04/09	<p>Urgent referrals to MSUs</p> <p>Advice was sought as to how other MSUs manage urgent referrals for admission.</p>	4	<p>One respondent reported that urgent referrals will be seen by the relevant team and then will be planned through the bed management team. The service was reported to have a catchment area system, which allows teams to build up a relationship with the area they cover.</p> <p>Another service reported to have a slightly different system. It was noted that there is a weekly referral meeting, and that the majority of referrals are covered in this meeting. However, there is a consultant rota in place (with 5 consultants) and the duty consultant would be expected to deal with any urgent referrals.</p> <p>Lastly, an alternative system was reported to be in place at another service. It was reported that the ward doctor and ward manager (or at times the psychologist) would carry out assessments for urgent referrals.</p>

Date posted	Topic	No. of posts	Response
21/04/09	<p>Assessment of suicide and self harm</p> <p>Advice was sought regarding how services assess risks of suicide and self harm, what tools units use and how effective they are in terms of risk identification and ease of use.</p>	6	<p>The responses to this post were varied, and a range of assessment tools were reported to be used by services.</p> <p>One service reported using START (Short Term Assessment of Risk and Treatability). This was reported to cover self-harm, suicide risk and risk of neglect. It was noted to be a user friendly and effective tool.</p> <p>Alternatively, another service reported to use the HCR-20 and the S-RAMM for suicide risk assessment and risk management. Further to this, it was reported that on the admission units and high dependency unit nursing staff use the DASA every day, and the SVR-20 is used in appropriate cases.</p> <p>A further tool was noted to be in use at another service, the Estimate of Suicide Risk (ESR-20) which is a short term assessment of risk of suicide and self-harm. It was noted that this needs to be completed by an experienced and qualified practitioner and is used to provide a model for decision-making. In addition, it was noted that this service uses the HoNoS, which is completed by the clinical teams at each patient's CPA review. It was noted that whilst this does not require formal training, it is important that there is consistency in rating.</p>
21/04/09	<p>Caffeine use in MSUs</p> <p>As a result of a policy that has been implemented in one service, which restricts the availability of caffeinated drinks on the wards for service users, a request was sent out to see if other MSUs have similar policies/practices.</p>	5	<p>One respondent reported that they do not allow drinks which have a stimulant effect, such as Red Bull and strong coffees, at their service.</p> <p>Another respondent noted that with one patient who was taking Ritalin, it has a marked effect to reduce their intake of highly caffeinated drinks.</p> <p>Lastly, another respondent reported that they only provide service users with decaffeinated coffee on their wards.</p>

Date posted	Topic	No. of posts	Response
27/04/09	<p>Bedroom access and smoking times</p> <p>One service reported to restrict bedroom access and smoking times. A request for information regarding how other services address this issue and what restrictions/procedures they have in place was made.</p>	2	<p>One response was posted in reply to this. This particular service reported that there are smoking bans in the unit, and that service users are able to smoke outside (where smoking shelters have been erected). It was noted that service users are not able to access outdoor areas between 12 midnight and 8 am. It was noted that there are occasions when patients have access to smoking within the restricted time, however this is managed on an individual basis.</p> <p>Additionally, in response to the query regarding access to bedrooms, it was reported that this service does not lock bedrooms during the day and patients have unrestricted access. However, if a patient was noted to be spending long periods in their bedrooms then locking off the room would be considered an option, and would be addressed in their care plan. The importance of service users being able to spend time away from staff and other service users was noted, as it can aid in reducing tension on the ward and minimises aggression.</p>
09/05/09	<p>Appropriate response team levels</p> <p>A query was made regarding peoples' opinions as to an appropriate level of response team within a large medium secure setting.</p>	4	<p>One 90 bedded unit (across 7 wards) reported that they have 4 staff on response, headed by a band 6 member of staff.</p> <p>Another service, again with 90 beds, reported their response team comprises of a band 6/7 member of staff on site and one nurse allocated from the ward base numbers (rehabilitation and admission wards).</p> <p>Similar arrangements were reported at another service, whereby they have one band 6 co-ordinator on site and one identified response team member from each ward, plus 'usual' on-call arrangements.</p>

Date posted	Topic	No. of posts	Response
13/05/09	<p>Student placements in medium and high security</p> <p>A request was made for information regarding whether any systems exist to support students who may wish to undertake elective placements in secure units which are outside the catchment area of the university at which they are studying.</p>	2	<p>This post received one response. It was reported that this service has, in the past, taken students on elective placements from universities outside of their catchment area, with some success. However, it was reported that this is generally on an ad hoc basis. It was noted that they will ask such students to come in the summer months, when the service doesn't have students from their local university.</p>
18/05/09	<p>Site co-ordinators</p> <p>One service requested information and advice regarding a new post that is being developed, that of night site co-ordinator.</p>	3	<p>One service reported that they have a band 6 member of ward staff who is the out of hours coordinator, with additional support/cover provided by band 7 nurses. It was reported that the Trust has agreed that the duties are in line with a band 6 nurse.</p> <p>Another respondent replied stating that they have a similar set up in their unit, in that they have a 'unit coordinator' role, which is carried out on a rota basis by band 6 staff. Again, support is provided from a band 7 nurse on call, who would only be expected to come in in the event of a major incident or use of seclusion.</p>

Date posted	Topic	No. of posts	Response
19/05/09	<p>Nursing shift patterns</p> <p>A request was made for information regarding the implementation and effectiveness of 'twilight' shifts. For example, a shift running from 16.10 – 24.00.</p>	4	<p>One service reported to run shifts on the following pattern:</p> <p>Early 07.00-14.30 Late 13.30-21.00 and Night Shift 20.40-07.10</p> <p>However, it was noted that these shifts are to be extended by 20 minutes, in order to reflect the working time directive. In addition to this, it was reported that the service uses twilight shifts according to clinical requirements, which is generally on a voluntary basis.</p> <p>Another service reported to run a pattern of 4 shifts:</p> <ul style="list-style-type: none"> ▪ 07.30 – 16.30 ▪ 11.30 – 20.30 ▪ 2 twilight shifts from Sunday through to Thursday (inclusive) running from 14.00-23.00 and Friday and Saturday 15.00 – 00.00 ▪ 20.25 – 07.40 <p>However it should be noted that this service is an adolescent service and therefore has set bedtimes, which are reflected in the shift patterns. It was reported that the twilight shift ensures that there is an extra member of staff for supper time and at least 1 hour after bedtime, rather than having to have increased numbers of staff on the night shift.</p>

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