**RMN PRA Short Life Working Group **

**23rd June 2017**

**1pm – Meeting Room A**

**JB Russell House**

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| **Chair:** | Joyce Brown : Chief Nurse, Clyde Sector |
| **Minutes** | Michelle Magennis: Business and Programme Manager (Corporate) |
| **Present:** | Jennifer Armour: PDN Acute South Sector |
|  | Elaine Burt: Chief Nurse, Regional Services |
|  | Catriona Kent: Nurse Consultant, PSI |
|  | Danny Lascelles: Violence & Aggression Lead Practitioner |
|  | Elaine Love: Chief Nurse, NMAHP |
|  | Toby Mohammed: Assistant Chief Nurse, NMAHP |
|  | Nancy O’Brien: Lead Nurse, Acute South Sector |
|  | Eleanor Sommerville: Head of Nursing & Quality, Regional Services |
|  | Julie Tomlinson: Professional Lead, Nurse Staff Bank |

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| **Apologies:** | Dallas Brodie: Consultant Liaison Psychiatry |
|  | Lyndsay Lauder: Head of People and Change |
|  | Barbara Mc Menemy: NHSGGC Acute Addictions Manager |
|  | Katrina Philips: Head of Adult Services, North East |

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| **1.** | **Welcome/Apologies**  J Brown welcomed all present to the meeting and apologies were noted. | **Action** |
| **2.** | **Minutes of briefing note for approval – 26th May 2017**  The briefing note was approved by the group. |  |
| **3.** | **Review of actions from previous meeting – 26th May 2017**  **Restraint Policy**  D Lascelles advised members that the current policy does not provide any clear guidance on the role or level of training required by staff who should use restraint. As it stands, the policy states that the staff who can use restraint are those who have been trained in the use of restraint, which is open to interpretation.  J Brown also highlighted a conflict between what is stated in the policy i.e. that a RMN is required in situations where a patient is detained and what was discussed at the previous meeting, as D Lascelles and C Kent had both confirmed at the meeting that this was not always the case. Each case has to be assessed in a person centred way to assess what support the individual requires.  D Lascelles agreed that there was some confusion about the use of physical restraint from RGNs and other acute staff and made the following points by way of clarification:   * From a legal perspective, any use of force (e.g. for self-defence and for the use of physical restraint) must be reasonable and proportionate to the situation and those involved must be able to justify their actions. **It is important to note that this applies to any restrictive intervention. Since enhanced observations can be classified as a restrictive intervention, the staff need to go through the same process of justification and rationale (i.e. is it necessary? is it proportionate?) whether they are using physical restraint or enhanced observations or any other type of restriction they may be required to use.** * There is no legislation that states that a RGN cannot use physical restraint. Rather, the law would ask if the member of staff can justify their actions and demonstrate that they used reasonable and proportionate force. * **This criteria is exactly the same for RMNs and other staff working in MH areas and would still be the case even if the patient was detained under the MH Act or the AWI Act.** * These Acts grant staff the legal powers to give certain prescribed treatments to that specific patient without their consent. However, they do not state that the route to achieving this is by using physical restraint and all staff are still required to look for the least restrictive/invasive option possible. * It may be the case that physical restraint is the least restrictive/invasive in order to facilitate this process and administer the treatment. However, staff would still need to evidence that the force and type of restraint used was necessary and proportionate to the situation**.** * **What is a requirement, is that staff (any staff) who work in an area where there is an ongoing risk of them having to use physical restraint then they must be appropriately trained in how to do so lawfully and safely.**   Another area of confusion is around the nurses’ power to detain. This power (Section 299) from the **Mental Health (Care & Treatment) (Scotland) Act 2003,** gives RMN and LD registered nurses the right to detain informal patients for assessment with a view to detention. However staff without these qualifications can use **the Common Law** **principle** (duty of care) if immediate action is required.   Treatments warranted by other sections of the Act e.g. prescribed medications can be administered by RGN’s.  Members requested that M Magennis take these points back to the owner of the policy for action.  **Action: M Magennis to highlight this point with Kenneth Fleming**  **as the Lead Manager for the policy.**  D Lascelles informed the group that he is currently working with S Pettigrew, PNA MH Services, to update the current Violence and Aggression policy and that the Restraint Policy will also be reviewed as part of the process. A discussion has also been arranged with J Gilmore, Team Lead Violence and Aggression Reduction Specialist MH Services, to ensure that the needs of acute services are captured in the reviews and that staff and managers are much more re-assured and clearer in their rights and responsibilities.  J Armour expressed the view that the severity of the patient’s symptoms and the safest route to deal with them is the key issue when making decisions on their treatment and care. J Brown stated that this information will be recorded in the patient’s therapeutic treatment plan and that a thorough review of this should be a clearly stipulated stage within the revised escalation policy. All members agreed that staff need to be able to differentiate between patient needs stipulated in the treatment plan and what is legally required. At present, because the language is ambiguous, requesting a RMN has become the default position.  J Brown suggested that the development of an online resource pack for staff in all in-patient areas to refer to when support with challenging behaviour is required would be helpful. This would be similar to the current desktop resource for Child Protection containing key messages from the SLWG, samples of relevant documentation, flowcharts, policies and presentations and a description of the Maybo training programme. J Armour stated that she was currently developing a similar resource for the South Sector which she was happy to share.  **Action: C Kent/ M Magennis/ J Armour to draft a staff resource**  **pack for the July meeting.**  **Key Contacts**  J Brown reiterated K Philips’s caution from the previous meeting that the key contacts list should be circulated with a clear statement about the level of advice and support that staff can reasonably expect to receive when contact is made, as this will vary and is dependent on availability of resource.  J Brown referred to a recent case in QEUH where the patient displayed complex and challenging behaviour compounded by learning difficulties. J Brown queried whether colleagues knew where to access LD information, advice and support in relation to challenging behaviour when required. All present agreed that information and sign-posting stored on a central point would be beneficial to services. | **MM**  **CK/MM/JA** |
| **4.** | **Education**  **Evaluation of Maybo Training**  T Mohammed updated members on recently delivered Maybo training as follows:   * 2 days of Maybo training were delivered on 7th and 8th June; * 22 staff attended (out of 24); * The training evaluations were provided by Maybo and focused mainly on course delivery – all responses were extremely positive; * T Mohammed circulated a further evaluation to participants to assess their confidence – participants who responded, reported that their attendance at the training had provided them with an increased level of confidence in relation to managing challenging behaviour; * A full 5 days of Maybo training will take place w/b 26th June; * 3 days will be delivered in the Teaching and Learning Centre & 2 days will be delivered in RAH; * T Mohammed is still awaiting numbers from the North Sector – 6 places have been allocated to the North Sector but remain unfilled; * Agreed that any unallocated places should be offered out to Nurse Bank Staff who regularly cover enhanced observation shifts; * Chief Nurses need to be explicit in their communications to staff in relation to prioritising attendance at the training and also in terms of what will be expected from them after the training.   **Future Plan for Maybo Training**  T Mohammed presented a draft proposal for future Maybo training with key points highlighted below:  **Short term (until end of Sept 17)**   * The focus for Maybo training in the short term will be on staff working in acute high risk areas; * Acute sectors will need to identify the numbers of staff to be trained from high risk areas and forward to T Mohammed by Friday 30th June; * A decision will need to be made re the inclusion of Regional Services in the training schedule as they are developing and delivering their own bespoke training programme.   **Medium Term (until December 17)**   * Chief Nurses to identify the total number of from high risk areas that will require training; * T Mohammed willagree the % of staff within these areas who can be trained by December 17 with Chief Nurses; * T Mohammed and D Lascelles to identify how many days oftraining can be provided by in-house Maybo trainers between now and December 2017; * Nurse Bank to identify funding to support HCSWs who cover frequent enhanced observations.   **Long Term (January 2018 and beyond)**   * Robust evaluation of Maybo training completed; * Development of an in-house programme of Maybo training to meet the on-going needs of high/medium risk areas; * SLWG established to explore the applicability of the Forensic MH/Institute model for delivery across acute services; * Consideration given to a ‘train the trainer’ model for Maybo training, mentored by D Lascelles, to increase capacity and capability in high risk areas; * Continue to promote and encourage uptake of in-house available training – both online and trainer-led.   T Mohammed advised that he has scheduled a meeting with D Lascelles to scope the level of existing Maybo in-house training resource and its capacity to deliver sessions moving forward. D Lascelles advised that he is meeting with line managers (C Raeburn and J Green) w/b 26th June to discuss these issues. All present agreed that utilising existing Maybo training resource will help to build capacity on wards and reduce costs on an ongoing basis.  **ACTION: Sector/Directorate Leads to forward training numbers to**  **T Mohammed by close of play Friday 30th June 17.**  **ACTION: D Lascelles to discuss in-house Maybo trainers’ capacity**  **to support the programme with C Raeburn and J Green.**  J Brown suggested that areas should also consider allocating some of the training places to nursing staff and HCSWs from non-high risk areas. J Tomlinson was also asked to forward names of Nurse Bank staff who regularly cover enhanced observation shifts for Maybo training in the medium term (Sept – Dec 17).  T Mohammed also highlighted that there is a need to increase uptake of training that is currently available in-house. The group were advised that there are 2 further days of GCU training running this year (1x August and 1x September) and that GCU have been asked to include de-escalation into the existing programme.  **ACTION: Sector/Directorate Leads to identify acute MH Champions**  **to attend the GCU training in August and September and**  **forward to T Mohammed by early July.**  E Burt asked if T Mohammed could advise on the sections in the new Maybo training that are not included in the Regional Services bespoke programme. D Lascelles advised that the current one day training programme remains the same but that the Training Needs Analysis and Risk Assessment components that need to be carried out on the wards will be additional.  D Lascelles informed the group that he will be making the following recommendations to improve the current one day training course:  1. Training Needs Analysis and Risk Assessment components will  need to be developed and included in the content:  2. Increasing training capacity is a priority and DL will be  recommending a model comprised of a core group of dedicated  Maybo trainers plus a ‘train the trainer’ approach for new staff  trained in Maybo, mentored by D Lascelles, and delivering to staff  teams locally.  C Kent queried whether there was a recommended follow-up to the Maybo training programme. D Lascelles advised that the guidelines stated that staff trained in physically restrictive skills should have an annual update and those trained in conflict management should attend an update every two years. Currently the only group of staff in NHSGGC who routinely receive the annual update are security staff as the numbers are small enough to accommodate this.  **Online Modules**  T Mohammed informed the group of the current position regarding online training modules:   * Online modules on ‘Violence and Aggression’ and ‘Conflict Management and Challenging Behaviour’ are currently available for staff to access on the Learnpro platform; * M Gillespie has advised that the new online module developed by the Institute will go live at the end of July 17. This module is a precursor to the half day workshop that is being delivered with the Institute – there is potential to review the content of the module from an acute perspective and to work with Maybo on the delivery of the half day workshop. This would need to be part of the long term plan.   T Mohammed reiterated the need to promote all new modules widely and to encourage staff to access and complete the current modules on Learnpro.  **ACTION: M Magennis to contact L Lauder and D Campbell to**  **request a report on the staff number/area/ role who have**  **accessed the Maybo online module to date.**  Members discussed the frequency of training and it was agreed that the majority of clinical nursing staff should complete the Maybo module as part of their mandatory programme.  **ACTION: M Magennis to send a note to L Lauder advising of this**  **requirement and the need to include in the review of**  **stat/mand training currently underway.**  T Mohammed advised that there was a facility to ring-fence CPD monies allocated to sectors/ directorates to fund Maybo training on an ongoing basis. If this is the agreed way forward, Chief Nurses will need to identify a cost code and an amount and T Mohammed will set up the transfer. All present agreed that a consistent approach to the funding of this priority area of training on an ongoing basis is essential.  E Burt advised that she would need to check with the Institute to see if any additional costs would be incurred due to the change in the content of the updated Maybo programme. | **Leads**  **DL**  **Leads**  **MM**  **MM** |
| **5.** | **Recent PRA RMN Usage**  J Tomlinson highlighted the following points from the above statistical report which covered the period 1st May – 18th June 2017:   * 300 RMN shifts were requested over the 6 week period; * Nurse bank were able to cover 100; * The remaining 200 went to PRA.   J Brown queried, if the training continued consistently, how many shifts requiring enhanced observations could potentially be covered by our own staff in the future and how we would cover the cohort of patients who need a RMN and the bank are unable to provide this.  J Tomlinson presented the current position re Nurse Bank RMN capacity:   * There are approx 800 RMNs registered on the bank; * 80 have undertaken shifts in the past 12 month period; * Acute shifts are not considered attractive by RMNs and are extremely difficult to fill.   E Burt queried the reasons for this and the actions that are being taken to improve the uptake of shifts in acute services. C Kent stated that there is a need to reinforce good practice and ensure a positive experience for RMNs undertaking shifts in acute as there have been some unhelpful perceptions from both sides. Members also discussed the issues around banding and use of the facility within bank to pay staff at a higher banding. J Tomlinson advised that this had recently been raised with senior HR colleagues and that the position is currently on hold.  J Tomlinson agreed to send a further communicaton to all RMNs registered with bank encouraging them to undertake shifts in acute wards.  **ACTION: J Tomlinson to link with Board Nurse Director and J**  **Armour to develop a communication to send out to all**  **RMNs currently registered on the bank encouraging**  **them to take shifts – this should acknowledge that some**  **of their experiences in the past may not have been good**  **and outline the steps currently being taken in high risk**  **areas in preparation for cessation of PRA.**  Members discussed J Armour’s current role in the South Sector and agreed that, ideally, there should be a similar post in all sectors and directorates across GGC. This would ensure a consistent approach to the care and management of patients with challenging behaviour and provide a point of contact for ward staff. J Brown advised staff of the position in Clyde whereby the previous Dementia Nurse Specialist post has now been re-focused to include the type of work undertaken by J Armour in the South. This post will be finalised with MH and HR colleagues next month.  C Kent stated that it was important to acknowledge that J Armour came to Acute Services with a wealth of MH experience and a unique skill-set which is not easily replicated. She expressed the view that unless you can appoint a member of staff from the Liaison Psychiatry team there is a risk that it could take 12 months or more for the person to upskill to the level required coupled with the potential for conflict between Liaison Psychiatry and addiction teams and their role.  N O’ Brien, Lead Nurse South Sector, commented that J Armour’s role has been essential in resolving differences between ward staff and RMNs in relation to roles and responsibilities.  J Brown acknowledged that whilst this would be the ideal situation that the current ongoing financial situation may well be prohibitive.  E Love stated that this should still be presented to the Chief Executive and Acute Directors as a viable way forward for consideration. The proposal should describe the role and the particular skill-set required both in terms of the effectiveness of the service that can potentially be delivered to staff and patients and the potential for reduction in costs in the longer term.  D Lascelles advised that Edinburgh Royal Infirmary, in addition to Liaison Psychiatry, have a MH Assessment Service which links into A&E and in-patient wards delivering a similar role to J Armour’s.  J Brown stated that she was happy to take this back to the Board Nurse Director as a recommendation from the group. | **JT**  **JB** |
| **6.** | **Communication Plan**  J Brown queried whether the recent communication circulated by L Hall encouraging CPNs to join the Staff Nurse Bank had produced any increase in uptake. T Mohammed advised that L Hall had circulated a number of emails in relation to this but that to date there had been little appetite from CPNs to register. J Tomlinson confirmed that those seeking to join would be accommodated without delay and for those already employed by GGC there would be a 24 hour turnaround at most.  E Burt requested that staff bank continue to prioritise RMN shifts for a patient currently being treated in Neuro. E Burt informed the group that this need is likely to continue beyond the 1st July.  Members proceeded to debate the level that staff should be trained to before being allocated enhanced observation shifts for particular patients. All present agreed that being overly prescriptive in relation to training requirements was not helpful and could potentially create barriers to accessing staff to cover these shifts in acute.  Members agreed to send their comments on the draft communication to nursing staff to M Magennis by close of play on Monday 26th June.  **ACTION: Members to forward comments to M Magennis**  **Monday 26th June 17.** | **ALL** |
| **7.** | **Escalation Policy**  J Brown advised that she had discussed the work of the group with Dr Michael Smith, Medical Director for MH Services, and that he had requested a summary of relevant key issues and actions to inform a communication that he would issue to medical staff.  C Kent advised that the draft Standard Operating Procedure previously circulated to members had been circulated to Liaison Psychiatry for comment by Lynne Mc Curdy, Operational Manager for the service, and that this was now the agreed approach. It was agreed that the SOP would be re-formatted and circulated to the Liaison Psychiatry team as a final version and that the wording from the document could be provided to Michael Smith for his communication to medical staff.  C Kent also advised that there are three different teams who will need to be advised of the outcomes of the SLWG:   * Glasgow Liaison Psychiatry * The team at RAH * The on-call medics who run the service in Inverclyde   The Glasgow team has been informed but the other two areas will also need to be included in the update.  **ACTION: C Kent to forward wording to Dr Smith for**  **Communication to medical staff.**  D Lascelles advised that he is meeting S Pettigrew w/b 26th June to discuss the review of the Safe and Supportive Observation Policy. As observations are currently undergoing a national review, D Lascelles proposed that rather than producing an adjunct to the current policy for acute services, it would be more helpful to produce a set of guidelines for acute staff to refer to in the short to medium term. Members agreed with the proposal and D Lascelles will circulate draft guidelines for comment before Wednesday 28th June.  **ACTION: D Lascelles to circulate draft guidelines for**  **Services as an interim measure.**  **Enhanced Observation Notification Form**  Members discussed the current notification form used by staff when requesting enhanced observations for patients. During the course of the discussion it became clear that there were two versions of the form in use; one used in Clyde and one that had been developed and circulated by Regional Services/ Institute.  C Kent agreed to review both versions and to produce a version of the form that covered all required areas. This will then be added to the Liaison Psychiatry documentation and added to the resource pack for staff.  **ACTION: C Kent to develop final version of the Enhanced**  **Observation Notification Form for inclusion in resource**  **pack for staff.** | **CK**  **DL**  **CK** |
| **8.** | **Future Actions and Monitoring Arrangements**  All members agreed that it was important to ensure that a positive and consistent message is presented to staff in relation to the cessation of PRA and that a firm stance is taken by managers and senior staff when requests for PRA RMNs are made, but that it was absolutely essential that safe patient care was always provided.  Members requested a further meeting of the group in July to update on actions and review progress. |  |
| **9.** | **AOCB**  **None raised.** |  |
|  | **Summary of Actions**  **Attached at Appendix 1 below** |  |
|  | **Date and Time of Next Meeting:**  **Friday 21st July 2017**  **11am, Meeting Room A**  **JB Russell House** |  |

**SLWG for the Cessation of RMN Premium Rate Agency**

**23rd June 2017**

**Action Points**

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| **Action** | | **Leads** | **Timeframe for completion** | **Update**  **30th June 17** |
| 1. | **Escalation Policy/Enhanced Observations Policy/Staff Memo**  Members to forward comments on the communication to staff to M Magennis by **Monday 26th June 17**.  C Kent and D Lascelles to provide a form of words from the Liaison Psychiatry SOP to inform M Smith’s communication to medical staff. Forwarded to M Magennis **w/b 26th June 17.**  E Burt to forward a copy of the Institute’s 1:1 Enhanced Observation Notification Form to M Magennis and J Brown for circulation to the group. **Friday 23rd June 17.**  J Armour and J Brown to provide a copy of the escalation flowcharts used in Clyde and South Sectors. **Monday 26th June 17.**  D Lascelles to provide draft guidelines for Enhanced Observations for Acute Services for circulation to the group by close of play **Wednesday 28th June 17.**  Group members to review the draft guidelines and provide comments to M Magennis by close of play **Friday 30th June 17.**  J Armour/C Kent and M Magennis to meet to develop a resource pack for staff. 1st meeting scheduled: **Wednesday 28th June 17.** | C Kent/ D Lascelles/ J Armour | All actions to be completed by Friday **30th June 17.** | **Completed**  **Completed**  **Completed – comments collated and new form developed for resource pack.**  **Completed – copies in resource pack.**  **Completed – added to resource pack.**  **Completed**  **Completed and now on Nursing Portal – few more resources to be added between now and the July meeting.** |
| 2. | **Restraint Policy**  C Kent and D Lascelles to provide a clear description of the circumstances when a RMN is required (for the minutes).  M Magennis to liaise with D Lascelles to review the above position in the current NHSGGC Restraint Policy. | C Kent/D Lascelles  D Lascelles/ M Magennis | Update presented at the SLWG meeting on the **21st July 2017**. | **Completed**  **Completed – email sent to Kenneth Fleming 29/6/17.** |
| 3. | **Communication Plan**  Chief Nurses to ensure that they have a local communication plan in place for the cessation of RMN PRA before **1st July 2017**. |  | Before switch-off date – **1st July 2017** | **In place.** |
| 4. | **MayboTraining**  Representatives from sectors/ directorates to provide nominations for Maybo training to T Mohammed by **Friday 30th June 17.**  T Mohammed to liaise with J Stuart in relation to training nominations from the North Sector.  T Mohammed to liaise with J Tomlinson re unfilled Maybo training places. JT to offer these out to bank staff who regularly fill EO shifts. **W/b 26th June 17.**  Chief Nurses to identify Mental Health Champions to attend the GCU training course. Names to be forwarded to T Mohammed by **Friday 30th June 2017.**  D Lascelles to discuss and identify available in-house resource for the delivery of Maybo training with colleagues. **Update provided at the July meeting.**  M Magennis to request training figures for the Maybo Challenging Behaviour online module from L Lauder and D Campbell. Circulate to group members and present at **July meeting**.  M Magennis to forward members’ decision that the majority of all nursing staff should complete the online Maybo training module on ‘Conflict Management and Challenging Behaviour’ as part of mandatory training to L Lauder for inclusion in the current review. **W/b 26th June 17**  Chief Nurses to discuss and agree consistent approach to future funding of Maybo training. Liaise with T Mohammed re possible use of CPD budget for this purpose. | T Mohammed/Chief Nurses |  | **Still awaiting numbers form Chief Nurses**  **Complete**  **No bank staff offered slots. Will include new bank staff in future short, medium and long term dates**  **To be confirmed**  **Update at July meeting.**  **Stats requested and report will be available w/b 10th July 17**  **Completed – email sent to L Lauder 29/6/17**  **Ongoing** |
| 5. | **Nurse Bank**  J Tomlinson to link with Board Nurse Director and J Armour to develop a communication for circulation to RMN bank staff.  J Tomlinson to send out a communication to bank staff offering the opportunity to attend Maybo training – numbers provided to T Mohammed. **w/b 26th June 2017.** | J Tomlinson | Report forwarded to members of the **SLWG 26th May 17.** | **Completed**  **Completed** |