Communication and relationship management skills Examples from practice

Annex A

A resource for practice supervisors and practice assessors

All scenarios represent the lived experiences of practitioners and have been included verbatim to ensure content was not misrepresented by the editorial group.

Please note patient refers to all patients, clients, service users, and residents.

Patient details have been anonymised to ensure confidentiality adhering to the Nursing and Midwifery Council (2018) The Code Professional standards of practice and behaviour for nurses, midwives, and nursing associates.

Foreword

Following the introduction of the 2018 NMC Future Nurse: Standards of Proficiency for Registered Nurses, practitioners requested a resource to support them in their new roles as practice supervisors and assessors. A national group of Practice Education Leadership Forum (PELF) members was convened to work collaboratively with practitioners to develop this resource. Practitioners developed examples of how the communication skills and approaches for providing therapeutic interventions were used in practice. On behalf of PELF, we would like to extend our thanks to the practitioners who contributed to this resource.

This resource has been developed to assist you in your role as practice supervisors and practice assessors to support students to achieve Annexe A: Communication and relationship management skills.

The NMC state: "Effective communication is central to the provision of safe and compassionate person-centred care. Registered nurses in all fields of nursing practice must be able to demonstrate the ability to communicate and manage relationships with people of all ages with a range of mental, physical, cognitive, and behavioural health challenges.

Those skills outlined in Annexe A, Section 3: Evidence-based, best practice communication skills and approaches for providing therapeutic interventions also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field of practice. Registered nurses must be able to demonstrate these skills to an appropriate level for their intended field(s) of practice."

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3.1 Motivational Interview Techniques

Motivational Interviewing can be described as an approach that involves enhancing the patient's motivation through change, this has 4 main guiding principles, and there is an acronym that is useful for remembering the 4 principles; RULE:

R – Resist the urge to advise what to do, do not attempt to influence or convince the person, they must come to their conclusion.

U – Understand their motivation, you should aim to understand their needs, desires, values, abilities, strengths, and any potential barriers to change.

L – Listen with Empathy, treat the person with respect and compassion, ensure to remain non-judgemental throughout, and utilise active listening skills.

E – Empower the person, and work in partnership with the person to set SMART (Specific, Measurable, Achievable, Relevant and Time) goals. Support the person to identify any techniques/strategies which will enable them to overcome any barriers to change.

Motivational interviewing is an important skill to learn/utilise regularly and will benefit you throughout your nursing career, this is most commonly known to be used when working with patients who experience Alcohol and/or Substance Misuse, however, this skill is transferrable to many situations and can be used to support patients in a variety of ways, for example, if a patient experiences depression and is lacking motivation, the nurse can use Motivational Interviewing skills to support/encourage the person to attend to personal hygiene.

Scenario 1

A 59-year-old patient had a below knee amputation due to peripheral arterial disease. The patient had returned home 2 weeks before his physio appointment at the gym. On the ward, the patient had avoided smoking for the period of his inpatient stay. The patient did not currently have a prosthetic limb and was stuck in his house as there were 4 external steps with no handrail. The patient reported that he had returned to smoking 20 cigarettes per day (CPD) and was disappointed in himself as he had hoped he would have managed to quit after avoiding cigarettes for so long in the ward.

I allowed the patient to talk, he was frustrated with himself and aware he had started out of boredom and depressed about the changes in his life. I asked him what his concerns were with returning to smoking and he stated that it was part of the reason he had lost his leg and by smoking again could put his health at risk further or cause another amputation. I agreed with the patient that this was a risk, but I empathised with his situation as he was at home, on his own, and unable to get out of his house. I asked him what his hopes were, and he said he wanted to get out of the house to return to the bowling club and socialise with his friends which is normally did 3 x per week- he felt this would distract him from the boredom and prevent him from smoking as much. I asked him to think about how this would be possible. The patient reported he would need a leg but was scared

he would not manage the stairs or be able to go out on his own. I asked the patient if he had any friends that lived nearby who could assist him, in the initial stages of using a limb and he agreed this would be a promising idea which would make him feel more confident.

He reported he was anxious that he would not manage at all and that he would be stuck in his house forever. I then used the PPAM aid (an early walking aid that is an inflatable bag with a metal frame supporting it) which allows patients to walk within a rehab setting. It was clear his anxieties around the stairs were a key factor for the patient, once I knew he was safe in the parallel bars, we tried the stairs. The patient managed this successfully and he was proud of himself. He reported it had boosted his confidence and given him hope. The PPAM aid does not allow for your knee to bend so when he was to get a limb this task should feel easier.

I asked the patient if he had any other concerns and he reported that the stairs did not have a rail. I asked him how this could be resolved, and the patient reported he could contact the council. I reassured him this was a great idea and I advised him that he would be looking to speak to the community occupational therapy department. I was able to provide him with the number for his local council. By the end of the session, the patient reported he felt more confident about the future and less worried about some of the aspects as he felt he would "get there."

When the patient returned for his next session, he had cut down his cigarette intake to 10CPD and was keen to resume smoking cessation. I asked the patient if he needed any assistance with this and he reported he had used this service before via his chemist. I congratulated him on working so hard to have implemented a change at a difficult time in his life and advised him on some of the benefits he would gain from continuing to decrease smoking.

Within the next month, the patient had cut down to 5CPD was limb fitted and was able to walk out his steps with 2 x elbow crutches to get back to the bowling club. He did after another few weeks cease smoking completely!

Suggested application to other areas of practice

Smoking cessation input would be more common within the inpatient setting and additionally, motivating and encouraging patients to problem solve as a new amputee is just as important at the early stage of rehabilitation as the patients get used to using a wheelchair and transferring with 1 or no lower limbs.

There would be lots of lifestyle changes that would be encouraged and motivated to change such as being more physically active, positive changes to diet, and decreasing alcohol or drug intake.

Motivational interviewing and encouragement are a huge part of our practice to empower the patients to adapt to living life as someone who has had an amputation and overcome the mental and physical challenges that this can cause.

Scenario 2

Mr X experiences co-morbidity of mental illness (diagnosis of Schizophrenia) and alcohol misuse. Mr X was previously dependent on alcohol many years ago however was successful in hospital detoxification. He remained abstinent for a period, however when facing life stressors/challenges Mr X admits struggling to cope with his emotions healthily, and this results in him consuming alcohol and binge drinking. When under the influence of alcohol Mr X's risk of aggression/violence increases and this is known to be a contributing factor to his offending behaviours and overall risk to himself and others. He tends to binge drink when on a pass from the ward which affects his possibility of discharge to community living as being a forensic patient means staff must ensure public safety/risk management, and alcohol consumption increases risks.

Throughout his admission, staff continues to provide psychoeducation on the negative effects of alcohol consumption and encourage Mr X to utilise staff support when he has the urge to consume alcohol or is struggling to cope with stress. Nursing staff adopted the approach of using motivational interviewing techniques to benefit the individual's short and long-term outcomes.

When having a 1:1 interaction with Mr X (to carry out a comprehensive mental health/alcohol use assessment), it is important to work in partnership with the individual and for the nurse to demonstrate unconditional positive regard, empathy, compassion, and ensure a non-judgemental attitude throughout all interactions. During this discussion the nurse empowered the person to take responsibility for their care and treatment plan, Motivational interviewing involves using open questions, no closed questions were used as this could influence/limit the individual's answers.

We explored the reasons why Mr X consumes alcohol and discussed if there are any positive or negative impacts of this on the person's life, by doing this it led to Mr X being able to independently identify that the negative impacts outweighed the positives, we also discussed reluctance to change and what are the reasons for this (barriers against change). If the nurse were to convince the person or tell them what to do this could result in setting the person up for failure as they must find their motivation/reasons for changing their behaviours. Active listening skills were used throughout, and this allowed Mr X to discuss his views, thoughts, and feelings. The nurse encouraged/empowered the patient to reflect and come to their conclusion and overcome ambivalence.

The nurse continued to utilise these techniques daily to ensure a consistent approach towards Mr X and this also allows the therapeutic professional relationship to be developed/maintained and for Mr X to develop trust toward the nursing staff. When Mr X came to his conclusion that he would like to change his behaviours, he requested support to access information regarding Alcoholic Anonymous (AA) meetings and telephone support, the nurse supported Mr X to set realistic and achievable goals, and the goals that were set were reviewed/evaluated regularly to ensure they continued to be suitable and went at a pace that Mr X was happy with.

Mr X is now successfully discharged to his tenancy in the community, and remains abstinent from alcohol at this time, regularly utilising the support services put in place before discharge.
Reflection
Points to consider guiding reflective discussion: • What are the principles of this communication skill/approach/therapeutic intervention? • Why was this approach successful for the patient? • What was the role of the practitioner? • What new learning did you gain? • Discuss examples of when this approach could be used in other areas of your practice?
Additional resources
Miller, W.R., & Rollnick, S. (2002). Preparing people for change. Motivational Interviewing https://www.rcn.org.uk/clinical-topics/supporting-behaviour-change

3.2 Solution Focussed Therapy

Solution Focussed Therapy is facilitated by a trained therapist who may be a nurse who has completed specific training in this field. The therapist engages the patient in a therapeutic relationship and skilfully uses a series of precisely constructed questions. This enables the patient to build solutions rather than problem solve specific emotional challenges they may be experiencing.

This approach focuses on helping the patient move forward through a process of constructing solutions instead of attempting to understand problems. It differs from traditional problem-solving approaches in that it does not require detailed assessment, diagnosis, problem formulation, and set resolution plans, but instead seeks to identify the patient's solutions.

Scenario 1

Susan is a 14-year-old young girl who has been refusing to attend school for 3 months. She attended her GP with her mum complaining of disturbed sleep, poor appetite, and feeling very tearful. The GP referred Susan to Primary Care Adolescent Mental Health Services where she was seen for a triage appointment. Susan engaged in the triage appointment and the nurse therapist completed a risk assessment and mental health screening tool. Susan was provisionally diagnosed with mild anxiety symptoms. Using a person-centred approach and engaging Susan in discussion the nurse therapist offered Susan six structured appointments to use Solution Focussed Therapy.

Engagement in Solution Focussed Therapy allowed the nurse therapist to ask specific open-ended questions to support Susan in identifying that she can manage her anxiety symptoms. Susan was encouraged and given the safe space and opportunity to move forward through a process of constructing solutions instead of attempting to understand why she was feeling anxious and tearful. Susan worked in partnership with the nurse therapist during the sessions to make minor changes, using the solutions she identified during her reflective discussions. For example, engaging more with her Pastoral Care Teacher, returning to school on a part-time timetable, and using a blended approach to her schoolwork. This use of Solution Focussed Therapy enabled Susan to understand and accept the importance of recognising and encouraging small steps which have a positive effect on her mental health and reduce her anxiety symptoms.

Scenario 2

B attends community drug treatment services on a fortnightly basis, where he sees a community mental health nurse (CMHN). He has recently stabilised on a substitute prescription for opiate addiction. His focus had turned to social areas of his life, including employment, housing, and finance. He had been struggling to find motivation and talked about feeling overwhelmed. His CMHN suggests a solution focussed approach to moving forward. B and the CMHN collaboratively agree to 5 structured sessions over 6 weeks.

Research points towards the first interview of SFT being the most important. The CMHN adopted a cooperative and respectful stance. B 's ideas and thoughts led the session. The focus was to find out the specificity of the problem, look at where

he would like to be, and think about the other areas of his life where he has been successful at achieving his goals. B was able to score each component on Likert scales. The CMHN used the miracle question toward the end of the session to promote creative thinking and hope for achieving his goals. It also allowed B some time to take out of therapy and think about this more constructively.

Suppose you woke up one morning and by some miracle, everything you ever wanted, everything good you could ever imagine for yourself, had happened -your life had turned out exactly the way you wanted it.

Think about it now.

What will you notice around you that let you know that the miracle had happened? What will you see? What will you hear? What will you feel inside yourself? How would you be different?

B's 2nd session continued 1 week later. It remained client-centred and made use of B 's own language and ideas. The CMHN was careful not to analyse or make assumptions regarding B's progress. The CMHN noticed that using the same words and repeating those goals back to B strengthened the therapeutic rapport. B decided he wanted to explore employment options. His lack of money and housing was important. He was able to set the goal of looking at modern apprenticeships scheme on the internet. B asked for additional time to do this as he was not good with computers. The CMHN encouraged B to take note of any challenges and barriers to complete this and any successes he felt he had achieved.

B's 3rd session occurred 2 weeks later. B disclosed feeling despondent about the task. The CMHN listened carefully and acknowledged and in the spirit of SFT was keen to look for any successes and strengths within the exercise to enable B to feel more empowered. B was able to outline he was able to use information technology (IT) but could not find an apprenticeship he liked. The remainder of the session focussed on his learning and development using IT and thinking about how he can take those skills forward toward his goals.

By the 4th and 5th sessions, B had managed to access IT regularly and had been exploring opportunities around employment in catering. While he had been doing this his support worker had arranged a shadowing opportunity working in social bite café Edinburgh. He enjoyed this and began to focus his goals on working more there.

In session 6 the CMHN and B worked together to recognise the steps he had made during his and out of his sessions. The focus was on making minor changes often leading to bigger changes and enabling B to master his future.

Reflection

Points to consider guiding reflective discussion:

- What are the principles of this communication skill/approach/therapeutic intervention?
- Why was this approach successful for the patient?

- What was the role of the practitioner?
- What new learning did you gain?
- Discuss examples of when this approach could be used in other areas of your practice?

Additional Resources

Murray, H (2021). *Solution focused therapy*. Simply Psychology. https://www.simplypsychology.org/solution-focused-therapy.html

3.3 Reminiscence therapy (RT)

"RT involves discussing events and experiences from the past. It aims to evoke memories, stimulate mental activity, and improve well-being. Reminiscence is often assisted by props such as videos, pictures, and objects." (Cochrane Dementia and Cognitive impairment group 2018)

Cochrane Dementia and Cognitive impairment group (2018) Reminiscence therapy for dementia
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001120.pub3/full

Scenario 1

Mrs Kay a 69-year-old lady admitted to an orthopaedic ward for a planned minor surgical operation. Mrs Kay was diagnosed with dementia at the age of 55. On admission to the ward, Mrs Kay was very confused, agitated, and aggressive toward staff, making it difficult and challenging for the staff to carry out a full assessment before surgery. To ensure consistency we allocated our dementia champion to care for Mrs Kay.

Mrs Kay's daughter had attended the ward with her mum and was anxious and upset as the journey to the hospital had been challenging. As a staff nurse, I sat down and spoke with both mum and daughter, listening and trying to gain a better understanding of how such situations may be managed at home.

It became apparent that when Mrs Kay was younger, she was a keen tennis player and had won many medals for the sport. To make Mrs Kay feel at ease and comfortable in an unfamiliar environment, I began asking her about tennis, what she enjoyed about it, and how long she played for when/where she won her medals. This allowed me to build up a positive relationship with the patient. It was noticeable that she became less agitated and aggressive while sharing her experiences and talking about a skill that she remains passionate about. This was a wonderful opportunity for Mrs Kay to share her experiences rather than being the one always listening.

She was happy and cheerful sharing her experiences of her tennis days, allowing her daughter to feel she could safely and confidently leave her mum in our care. On her return, the daughter shared some precious photos of Mrs Kay with her medals.

Scenario 2

As a staff nurse working in a dementia unit within a care home, at times can be challenging both for the staff, families, and residents. However, our particular care home has made some additions to the unit making the environment more beneficial for the residents.

The care home has some small unused areas and corridors with a lot of wasted space, to utilise these spaces we developed memory areas within the home. One area had a desk with a typewriter, paper, and chair, another had a variety of different telephones, and we have a table set up with magazines and papers. One

area used well is the area that is set up as a small nursery, with cribs, baby bottles and dolls, etc.

These areas were chosen as a response to the interests and previous jobs of residents allowing them to reminisce on their memories and interests. Memory areas bring happy memories for both residents and families and allow staff to build relationships with their residents, ask questions, and gain an understanding of their lives before they lived in the care home.

This allows our residents to feel, content, valued, and peaceful by remembering and recalling experiences that made them happy in the past. In addition to this, our activities coordinator plays music that is special to an individual resident which also allows the resident to enjoy music familiar to them.

Reflection

Points to consider guiding reflective discussion:

- What are the principles of this communication skill/approach/therapeutic intervention?
- Why was this approach successful for the patient?
- What was the role of the practitioner?
- What new learning did you gain?
- Discuss examples of when this approach could be used in other areas of your practice?

Additional resources

Social Care Institute for excellence (2020) Reminiscence for people with dementia. Available from https://www.scie.org.uk/dementia/living-with-dementia/keeping-active/reminiscence.asp

3.4 Talking therapies

Talking therapies are treatments that involve talking to a trained professional about your thoughts, feelings, and behaviour (Mind 2021). There are many types of talking therapies, including Cognitive Behaviour Therapy (CBT), guided self-help, counselling, behavioural activation, mindfulness approaches, and 1:1 interaction between nurse and patient to assess mental health.

It involves the use of verbal and non-verbal communication to provide support to the individual and can focus on several topics. To use these skills the practitioner should be aware of their body language, ensuring they have an open and non-threatening posture, use active listening skills, and use a steady pace and tone when speaking. If the individual is agitated or experiencing pressured speech, then the nurse should ensure not to mirror their rate of speech. If the practitioner continues to be aware of their speech (rate, rhythm, tone) then the individual will become more likely to mirror this.

It is about utilising your skills, knowledge, and personal qualities/attributes that led you to pursue a career in nursing.

Scenario 1

When working in inpatient mental health settings, it is crucial to develop and maintain a professional therapeutic relationship with patients to enable you to assess their presentation, monitor, and review/evaluate any care and treatment plans.

Mr X has a diagnosis of treatment resistant Schizophrenia and is undergoing assessment/treatment within an inpatient setting, following a rapid deterioration of mental health whilst in the community setting due to non-compliance with the medication regime.

During his admission, Mr X's mental health continues to fluctuate. He often experiences periods of wellness and periods of deterioration/instability. Mr X has undergone various medication changes to be able to find a suitable medication for him which alleviates his symptoms. Following a period of overt psychotic symptoms, Mr X can then experience low mood and suicidal ideation.

As the primary nurse for Mr X, I encourage his engagement in daily 1:1 interaction to allow me to objectively assess his mental health and risk factors to himself and/or others. A 1:1 interaction may not initially spring to mind when you think of talking therapies however this is an effective way of not only engaging patients in their care and treatment plan but also providing emotional and practical support. During a 1:1, I would ensure to ask open questions, I asked how Mr X felt about his mental health is and if he experiences low mood or anxiety. You can ask the patient to rate their mood/anxiety on a scale of 1-10. I asked if he had any thoughts/intent to harm himself or others.

We discussed what Mr X does to provide himself with a positive daily routine, and healthy coping mechanisms which he has learned throughout admission that he utilises when struggling, or that will aid his overall recovery journey throughout his life and when discharged back into a community setting. We also discussed if he was having any urges to consume alcohol, substances, or gamble.

In a 1:1 the nurse should aim to carry out a comprehensive assessment of the individual's current presentation, needs, risks, circumstances, etc. Mr X is involved with his family and friends and maintained contact with them throughout admission to an inpatient setting, we discussed if there were any issues within these relationships and assessed if the people in his life provided positive or negative support to him.

The practitioner should aim to discuss all aspects of the persons care and treatment plan including prescribed medication regime, short and long-term goals/wishes, activity levels, motivation, sleep hygiene, diet, and physical health. I empowered Mr X to be involved in his care and treatment plan and reviewed care plans in partnership with Mr X, this allowed him to review and evaluate his progress and outcomes and to then gain self-management skills that will aid him in both the short and long term.

Before discharge from the inpatient setting Mr X thanked staff for providing him with consistent support via 1:1's and informed staff how these helped him to build trust towards healthcare professionals and encouraged him to reflect on his own needs/circumstances and make positive and realistic goals to allow him to progress on his recovery journey.

Scenario 2

Sally attended her GP as she was suffering from shortness of breath and a tightening feeling in her chest, she was worried something was seriously wrong. Following discussion, her GP recognised that Sally's symptoms were linked to anxiety. She was offered Beta Blocker medication to relieve the physical symptoms and a referral was made to the Primary Care Mental Health Nurse (PCMHN) to discuss her anxiety symptoms further.

Following an initial assessment with the PCMHN, Sally opted for Guided Self-Help Sessions. Self Help is based on the Cognitive Behavioural Model that is guided by the concept that what you think and do affects the way you feel - emotionally and physically. Guided self-help is beneficial in mild to moderate mental health conditions and offers ownership to the patient by empowering them with self-management options. Guided Self Help is facilitated by a nurse and evidence suggests that guided self-help is more effective than independent self-help. It also helps stop mental health issues escalating to a stage where they require secondary care or admission to hospital.

Sally's Guided Self-Help sessions had key focus points with set work to complete before the next session. Psychoeducation allowed Sally to understand that the symptoms she was experiencing were linked to anxiety and not attached to a more serious health condition. Normalising these feelings allowed Sally to start breaking

the cycle of anxiety. It was useful at this point to introduce the CBT cycle and Sally was asked to populate a CBT cycle template for the following session. The discussion was had about reducing avoidance of situations that cause anxiety as this escalates the cycle.

Sally was introduced to the concept of unhelpful thoughts; she then completed a thought diary to allow her to start the process of cognitive restructuring. It was clear that Sally's thinking was usually 'Mind Reading' – i.e., Sally had to chair a meeting at work and her thoughts were 'they will all think I am useless' and 'they don't think I am good enough for this job.' Sally started challenging these thoughts and was provided with a handout that provided a framework to challenge these thoughts; this included identifying evidence for and against the thought and linking it back to a pattern of unhelpful thinking. Sally found it particularly useful to ask herself 'what would I say to a friend in a similar situation?' as this helped change the way she viewed the situation.

Sally described spending substantial amounts of time worrying and she asked for support with this. The PCMHN advised writing her worries down as this sometimes helps process and rationalise thoughts; Sally did not find this beneficial. The PCMHN explained that she would not necessarily find all the methods of managing anxiety beneficial. The concept of worry time was introduced to try and regain control from worrying thoughts. Sally was slightly sceptical of this but agreed to try it and found it useful. Distraction techniques and grounding were also covered to enable Sally to have the tools to manage any time of greater anxiety.
When the sessions finished, Sally was worried about no longer having the support from the Primary Care Mental Health Nurse but recognised that she now hopefully had the coping strategies to manage any future episodes.

Reflection

Points to consider guiding reflective discussion:

- What are the principles of this communication skill/approach/therapeutic intervention?
- Why was this approach successful for the patient?
- What was the role of the practitioner?
- What new learning did you gain?
- Discuss examples of when this approach could be used in other areas of your practice?

Additional Resources

NHS inform (2020) Talking therapies explained.
https://www.nhsinform.scot/healthy-living/mental-wellbeing/therapy-and-counselling/talking-therapies-explained

Mind (2021) What are talking therapies and counselling?
https://www.mind.org.uk/information-support/drugs-and-treatments/talking-therapy-and-counselling/about-talking-therapies/

3.5 De-escalation strategies and techniques

Stress and distressed behaviours are caused by an unmet need that the person is either attempting to meet on their own, trying to communicate in the best way they can, or frustrated they cannot meet this need. Increased stress often leads to distressed behaviour in people living with dementia.

When people with dementia become distressed, it can lead to symptoms such as increased aggression, anxiety, apathy, agitation, depression, delusions, hallucinations, and sleep disturbances (NICE 2019). There may be other causes of the distress, including pain, delirium, or inappropriate care. Understanding the causes of these behaviours and addressing them before offering treatment can prevent things from getting worse and prevent any harm. It can also avoid the use of unnecessary interventions, such as antipsychotic medication and antidepressants, which may not manage the symptoms effectively." (NICE 2019).

De-escalation strategies may be used to manage aggression and agitation symptoms. De-escalation is "the use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. 'When needed' medication can be used as part of a de-escalation strategy but 'when needed' medication used alone is not de-escalation. (NICE 2015).

The skills used include trying to understand the persons unmet need based on the persons verbal and non-verbal communication and meeting this need. When doing this we consider contributing factors that could be biological, psychological, or environmental triggers.

NICE (2019) Dementia, Quality standard [QS184]. Available from https://www.nice.org.uk/guidance/qs184

Scenario 1

James lives in a care home and staff report he is appearing distressed throughout the day. They describe this by explaining he continuously walks around the care home, kicks, and punches doors, shouts, and becomes increasingly irritable and driven within the environment. The staff also report he is extremely distressed when being supported with personal care and has attempted to hit out at staff, his appetite is fluctuating, and his sleep pattern is poor. They state this is a sudden change in James's presentation voicing he usually is a relaxed happy man who has always accepted support from staff, slept well and ate well, and would enjoy his day watching old films and engaging in a meaningful activity he enjoys such as drawing as he used to be a graphic designer.

James has a diagnosis of dementia which has progressed over time, this progression has affected his language and communication skills and therefore makes it difficult for him to communicate his needs. On review, James appeared frustrated and was unable to sit for any period to engage. On observation, it was noted James would appear to be shielding the right side of his body when walking around the home and when someone approached him from that side he began to shout out and move towards the nearest door which was locked and began kicking and punching the door. James became increasingly distressed when approached making de-escalation more difficult. As such the area was cleared to allow James to feel safe in his environment and to ensure the safety of others. He was observed from a distance and eventually, we noted he began to appear slightly more relaxed and tolerated minimal engagement from a distance. It was ensured people would approach him from the left side and within his eye line to avoid James having any further distress reactions. James was encouraged to a quieter area so other residents would not approach and relaxing music he likes was put in this area to offer stimulation and distraction which was effective at this time. Although this intervention was effective at this time, it did not identify the trigger to allow for proactive and preventive strategies to be utilised to reduce his ongoing distress. Due to the fact this is a sudden change in James' presentation and the above observations, it was clear biological factors needed to be ruled out. As obtaining bloods would be too distressing for James, less restrictive assessments were requested being a sample of urine to rule out a urine infection and a pain assessment to rule out symptoms of pain. A pain assessment was completed straight away and detailed that James was experiencing a great deal of pain. This was discussed with his GP that day and he was commenced on pain relief. That night the staff reported some improvement in his sleeping pattern and over days James distressed symptoms reduced to the point he was back to his usual presentation. His pain management is now regularly reviewed to avoid James becoming distressed by symptoms of pain.
Scenario 2
Mr X was an inpatient in a forensic setting, he had issues regulating his emotions due to a complex history of trauma, and he has a diagnosis of schizoaffective disorder and borderline personality disorder. He did not get along well with his peers in the ward which often led to the potential for aggression and violence between him and select peers, or for this to be directed towards nursing staff due to the nature of a secure environment. The staff made attempts to keep these individuals separate to avoid further conflicts between them, however, on one occasion they bypassed each other in the corridor and began shouting and threatening each other with physical violence, staff immediately intervened with the use of de-escalation skills. Both patients were redirected to different areas of the ward which provided a low stimulus environment, both were supported by different staff members, whilst other staff members ensured they supported and protected the safety of all other patients in the ward.

The nurse knew the patient well, therefore was able to identify and understand the person's triggers and warning signs which helps in the process of de-escalation. The therapeutic relationships which were built with Mr X also supported this process as the patient had trust in the nursing staff and would therefore be more likely to accept support and reassurance.

Throughout the process of de-escalation, the nurse ensured they demonstrated a calm approach with appropriate rate, tone, and rhythm of speech and ensured that body language was in no way threatening or closed as this may increase the agitation levels of Mr X who is already heightened and hypersensitive to perceived threats. To come to a resolution the nurse must show genuineness to the patient and use their interpersonal skills to aid with this. The nurse used active listening skills to understand the person's account of events, and used paraphrasing, reflecting, and open questions. The nursing staff aimed to maximise communication with Mr X whilst also ensuring to minimise any factors which could increase agitation.

Initially, Mr X's levels of aggression continued increasing which was leading him to a crisis phase (where physical violence is most likely to occur). At this point, the nurse outlined the possible consequences and outcomes if the behaviours were to continue, discussed boundary setting, and used distraction and diversion techniques to enable Mr X to redirect his focus/attention to a calming task which he found relaxing. This allowed Mr X time to alleviate his distress levels whilst in a low stimulus environment. Following this Mr X was then able to calmly discuss/reflect on the situation with the nursing staff and to explore the underlying triggers which led to this situation occurring, to prevent episodes of aggression/violence in the future.

Reflection

Points to consider guiding reflective discussion:

- What are the principles of this communication skill/approach/therapeutic intervention?
- Why was this approach successful for the patient?
- What was the role of the practitioner?
- What new learning did you gain?
- Discuss examples of when this approach could be used in other areas of your practice?

Additional Resources

NICE (2019) Reducing the risk of violent and aggressive behaviours. A quick guide for registered managers of mental health services for young people. https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/reducing-the-risk-violent-and-aggressive-behaviours

NICE (2015) Violence and aggression: short term management in mental health, health, and community settings NICE. https://www.nice.org.uk/guidance/ng10

3.6 Cognitive Behaviour Therapy

Cognitive Behavioural Therapy (CBT) is a talking therapy that was developed in the 1960s. It is a popular psychosocial intervention with a substantial evidence base and is commonly used to treat mild to moderate mental health problems such as anxiety and depression.

Cognitive behavioural therapy focuses on how your thoughts, beliefs, and attitudes affect your feelings and behaviour, and teaches you coping skills for dealing with negative thinking that leads to distress.
CBT is facilitated by a trained therapist and can be delivered in both inpatient settings and the community.

Scenario 1

Scenario: Supporting a patient suffering from low mood using CBT.
John is a 45-year-old gentleman who has been seeing his GP over the last six months for low mood. John was made redundant from his job a year ago, which caused a financial strain on the family. Unable to attain employment, he has steadily increased his alcohol intake and has started to drink most nights. He has admitted to being bored and struggling for motivation. As his alcohol consumption increases, he has become increasingly withdrawn. He denies any thoughts of self-harm but admits that his mood has been causing him distress. The GP recommended CBT.

Process:
CBT uses a cognitive and behavioural approach. The cognitive aspect is concerned with patterns of thinking. The behavioural aspects aim to change the individual's behaviour.

At its core, CBT aims to identify negative thinking patterns of behaviour which in turn lead to problematic behaviours which are often distressing and self-destructive. In John's case, the inability to source employment leads to boredom and frustration is causing depressive symptoms, which he is attempting to alleviate by using alcohol.

The solution would therefore be to address the boredom and unhelpful thinking patterns by exploring the negative thoughts that are causing low mood in the first place. Examples of the negative thoughts which John has been "I am useless" or "I can't even get a job" with associated feelings of worthlessness. These negative thoughts can be explored to prevent them from progressing and increasing in frequency and severity. Using CBT John can be supported to challenge these

negative thinking patterns. This is known as 'cognitive restructuring' which aims to break down the thoughts of loss and rejection and rationalise them. An integral part of CBT is learning how to employ different strategies and build resilience and new interpretations so that patients do not become fixated on the unhelpful thinking styles and therefore maintain unhelpful behaviours. By using CBT, John would be encouraged to identify a different coping strategy to prevent engaging in negative thought patterns which lead to unhelpful behaviours. An action plan may be developed, ranking John's goals from easiest to most difficult. As he achieves these goals, his sense of achievement increases as his depression decreases. If we can reduce his symptoms of depression, we can promote mental well-being and consider further treatment for his use of alcohol. Thought diaries may also prove useful to capture thoughts that can then be challenged. John may also benefit from setting goals for his therapy around the values he has and how he would like to meet those value-based goals. It may be that he would benefit from using an activity and mood diary to ascertain his current activity and what he would like to reintroduce. When considering matching to services, Primary Care Mental Health Teams (PCMHTs) are resourced to treat patients with mild to moderate mental health issues which can be treated within 8-12 sessions. Community Mental Health Teams (CMHTs) treat patients with more complex presentations where the issues are long standing, with some co-morbidity. Single, one-off traumatic incidents can be treated within a Primary Care Mental Health team (PCMHT) but those with complex trauma would be seen by CMHT. CBT has a robust evidence base for physical pain presentations and these patients can be assessed and treated within a variety of health care settings.
Scenario 2
Scenario: supporting a patient with anxiety using Cognitive Behavioural Therapy. Ellie is a 30-year-old woman who has recently visited her GP and has been prescribed an anti-depressant and referred for CBT. Ellie lives with her husband and 2 young daughters, aged 6 and 8. Ellie reports that she has always been a bit of a worrier and that she recognises that anxiety has been a long-standing issue since she was small. Ellie is reporting increased anxiety around her children and their well-being. She reports that she will be anxious if they are out playing and that she frequently checks them during the night to ensure they are well. She struggles with the idea of them going for sleepovers with friends. She worries about how they will be cared for and kept safe. Ellie sought help as she does not wish her anxieties to impact the quality of her children's lives, and her husband is becoming frustrated by the lack of time they have as a couple. CBT uses a cognitive and behavioural approach. By cognitive we mean exploring the thought patterns of individuals and by behavioural we explore how people are coping with their distress. CBT aims to challenge automatic negative thoughts and begin to modify behaviours. At its core, CBT aims to identify automatic negative thought patterns which lead to behaviours designed to keep self and others safe. In Ellie's case, she views the world as threatening and overestimates

the harm that may come to her children. She is always also assuming sole responsibility for keeping her children safe.

The treatment targets would be to address Ellie's anxiety and subsequent behaviours and begin to identify ways in which she can recognise and challenge her automatic negative thoughts and begin to make small but significant behaviour changes using exposure. By exposure, we mean addressing the behaviours which may be maintaining the issue such as checking on her children or not allowing them to visit their friends. You would do this in a graded, consistent way by developing a hierarchy of feared situations and identifying a gradual, repeated path of reaching the least feared situation to the most feared. Those "what if" thoughts can be explored and challenged using cognitive restructuring. When we use cognitive restructuring, we note down all the automatic thoughts and begin to challenge them (are they based on fact or opinion) and then identify a more realistic thought. Once Ellie has insight into the future-based nature of her thoughts, she can begin to challenge these and identify the behaviours she may wish to change. For example, reducing her checking behaviours and allowing her children to spend more time with others.

Using CBT Ellie would be supported to understand what keeps her worries going and how she can use thought diaries to recognise and challenge these. She would be taught basic anxiety management strategies such as breathing exercises and distraction techniques and would begin to list her behavioural goals using a hierarchy of least to most difficult.

When considering matching to services, Primary Care Mental Health Teams (PCMHTs) are resourced to treat patients with mild to moderate mental health issues which can be treated within 8-12 sessions. Community Mental Health Teams (CMHTs) treat patients with more complex presentations where the issues are long-standing, with some co-morbidity. Single, one-off traumatic incidents can be treated within a PCMHT but those with complex trauma would be seen by CMHT. CBT has a robust evidence base for physical pain presentations and patients can be assessed and treated in a variety of health care settings.

Reflection

Points to consider guiding reflective discussion:

- What are the principles of this communication skill/approach/therapeutic intervention?
- Why was this approach successful for the patient?
- What was the role of the practitioner?
- What new learning did you gain?
- Discuss examples of when this approach could be used in other areas of your practice?

Additional Resources

Mind (2021) Cognitive Behavioural Therapy (CBT).
https://www.mind.org.uk/information-support/drugs-and-treatments/cognitive-behavioural-therapy-cbt/about-cbt/

3.7 Play as a therapeutic intervention

Everyone knows what we mean by play and at some point, we all play, however, it is difficult to define as a therapy utilised across the age ranges.

Play therapy could be described as a therapeutic intervention utilised as an indirect medium for building rapport and enhancing communication, through both action and language, to promote physical, psychological, and social benefits. Play therapists, nursing, and allied health professionals use play in the assessment, planning, and implementation of care interventions.

For example
Using games to promote fine motor skills, in a remedial activity, to improve a patient's physical ability before starting activities of daily life such as washing and dressing or making a snack.

Scenario 1

A 6-year-old boy has arrived for a blood test. On arrival, mum informs you her son had been taken ill on holiday abroad and had an unpleasant experience having a blood test. Mum describes that they did not use any topical anaesthetic, the language barrier was difficult, and she was not allowed to be present during the blood test. Her child was taken into another room screaming. Mum advises me that 4 staff "held her child down" to obtain the blood.

Observation and Assessment skills:
Valuable information can be obtained from observation of how the child/parent interacts. Is the parent anxious as this anxiety can be passed on to the child? Offer reassurance and acknowledge the experience they have had previously. Offer clear explanations on how we can try things differently here. Explain the role and how you can help. Introductions to a child should be done at their level, make eye contact, and be aware of your body language. Be aware of the environment can you take them to a child-friendly quieter space. Introduce something familiar to the child; Play is the tool that children learn from and communicate with. If the child can be engaged in play/age-appropriate conversation, they may relax more. As soon as the child relaxes the parent will start to relax also. If you enter the child's world, then you will establish a relationship quickly and effectively. Observe the child at play, can the child settle at play, and is there a theme to their play. Join the child at play. This is when hospital play/preparation can be introduced. A child-

centred approach is required research has demonstrated that preparation reduces anxiety and encourages cooperation. Communication: Play can act as a communication bridge between child and adult. Direct the play and conversation onto the specific topic of why the child has come to the hospital today. Use age-appropriate language. Children can understand and cope with procedures if this is explained to them at a developmentally appropriate level. Language and the words you choose are important as some words might represent something else to a child that as an adult we would not even consider. Acknowledge his fears and his perception of what is about to happen. Use a combination of closed and open questions. Listen to the child as they speak about their past experiences, reflect, check facts, and reduce their misconceptions. Give them choices, explain freeze spray, and cream, and demonstrate how it works. When he has a negative you give a positive alternative thing that we are going to try. Discuss one worry at a time and break the situation down into small steps. Be positive. Form a plan with him, give him choices, spray/cream, use 'Buzzy,' what are we going to do during the procedure, where are you going to sit. Involve the parent at every step of the process. Plan distraction therapy during the procedure, this gives the child an alternate focus to cope with the procedure, diverting their attention, this needs to be age appropriate and delivered promptly. It needs to be well planned and well executed to be of benefit. Ensure you have planned how you are going to do this and prepare any equipment you require. Do not do this in front of the patient. Communicate with the team to be involved, and ensure they are aware of the child/parents' anxieties and past experiences. Decide on access points, are veins visible, do we need a vein finder, is it an experienced person taking the bloods. Form a plan: Who is required to be present during the procedure, who is going to take the lead and talk/support the child through, and who is going to do the procedure. Advocate for the child if required. There needs to be a clear plan so that not all the professionals, parents, etc all talk at the child and add to the pressure, plan together to keep the situation as calm as possible. Is everyone in agreement on a plan if this child is uncooperative, or the doctor cannot access the vein? This helps create a more positive and safer experience for everyone involved. Once the procedure is complete reassure the child and praise how well they have done. Finish the session with a positive let the child choose a reward such as a certificate. Reflect on how the session went and if you could have done anything differently.
Scenario 2
Katie is an 8-year-old girl who has been involved with the Child and Adolescent Mental Health Services (CAMHS) for obsessive compulsive disorders (OCD) behaviours for 6 months. Her OCD behaviours are impacting her ability to participate in her activities of daily living. Katie lives with her parents and younger brother and gets 'stuck' in her behaviours, she washes her hands for extended periods of time and remains in the shower for over an hour and brushes her teeth for over 15 minutes and needs to be prompted several times to move on from this activity. Katie requires almost constant reassurance from her parents, that should

she not carry out the OCD behaviours that nothing negative would happen to her or her family. She also refuses to touch handles in the kitchen or door handles and had difficulty playing out with her home. The Occupational Therapist (OT) worked with the Psychologist to create an Exposure Response Prevention Programme and utilised play to engage Katie. Parents were very worried about Katie's presentation and would often respond by raising their voices and becoming frustrated which exacerbated the issues and caused increased stress within the home.

To help build rapport with Katie, the OT played some games around the house and ensured she did not feel like it was another 'assessment' as such. Also played football with her brother in the garden and assessed OCD behaviours and reassurance seeking, which assisted in the formulation of her difficulties.
Using a psycho-education approach to Katie's understanding of her difficulties – we played 'Operation' and she had fun thinking about how the different areas of her body are affected by anxiety and how this can trigger the 'Flight, Fight, Freeze Response.'

Katie lay down on some paper and her parents and brother outlined her. They and Katie then helped with coloured pens to highlight where Katie experienced anxiety in her thoughts, physical symptoms, and feelings. This allowed Katie to understand in an age-appropriate way how the OCD behaviours were affecting her. It also informed her parents, and her brother of the reason's Katie was acting in this way.

To help Katie touch handles and doors around the home – we played 'Tag/Tig,' and she received a sticker for every time she touched an item that she would usually consider contaminated. This age-appropriate game also allowed Katie to see that she was able to touch items without issue in a fun way. Discussing the effectiveness of this approach with her parents encouraged them to approach Katie's difficulties with a non-blaming and understanding, fun attitude. Katie was given a choice of which game to play, and OT would then adapt the game or use it as a teaching aid to reinforce her learning and understanding of how OCD was impacting her functioning. We would also involve her brother in many of the games to normalise her experience while also reassuring him that Katie was improving at each session.

We continued to use a psycho-education approach but made this fact-finding fun by using age-appropriate resources and using positive feedback and a reward system to help Katie see the positives of helping her stay on track in her treatment. Involving the parents throughout treatment helped them see that remaining consistent and using humour/fun was a positive way to deal with stressful situations and this helped de-escalate in many circumstances.

Katie's parents felt this approach was helpful and informative allowing them to adapt their approach when dealing with her needs for reassurance seeking. The introduction of play and fun also involved her brother, and both sets of grandparents, and this is instrumental for success in Katie's recovery. Katie's response to using play as a therapeutic intervention was positive – she made the OT a beautiful, creative hand-made card at the end of their intervention. Katie

often commented that she loved learning and playing in this way and would miss our visits but was happy she was able to do the things that had become difficult.

Reflection

Points to consider guiding reflective discussion:

- What are the principles of this communication skill/approach/therapeutic intervention?
- Why was this approach successful for the patient?
- What was the role of the practitioner?
- What new learning did you gain?
- Discuss examples of when this approach could be used in other areas of your practice?

Additional resources

Mayers K.S. (2003) Chapter 11, Play therapy for individuals with dementia, Play Therapy with Adults.
https://books.google.co.uk/books?hl=en&lr=&id=yFaOsNkWTvsC&oi=fnd&pg=PA271&dq=benefits+of+play+dementia&ots=Km4EOv8AIW&sig=lmX2dzPpnETQlIdQWVNbqtuAcl8&redir_esc=y#v=onepage&q=benefits%20of%20play%20dementia&f=false

Whitebread, D. (2012) The importance of play.
https://www.waldorf-resources.org/fileadmin/files/pictures/Early_Childhood/dr_david_whitebread_-_the_importance_of_play.pdf

Henrikson D (2017) Playing with ideas for creativity and learning: Play as a transdisciplinary habit of Mind. The 7 Transdisciplinary Cognitive skills for creative education pp65-74
https://link.springer.com/chapter/10.1007/978-3-319-59545-0_8

Pietrangelo A. (2019) How play therapy treats and benefits children and some adults Healthline
https://www.healthline.com/health/play-therapy

British Association of Play Therapists (2013) History of play Therapy.
https://www.bapt.info/play-therapy/history-play-therapy/

3.8 Distraction and diversion strategies

Distraction and diversion refer to a classification of coping strategies that are employed to direct attention away from a stressor and toward other thoughts or behaviours that are unrelated to the stressor. They are approaches that are used to redirect a person's attention and focus to another task, by doing so it can allow the person to regain focus and can force the person to think about something different, as opposed to focusing on their current negative emotions for example agitation, frustration, intrusive thinking and many more. They teach the patient self-soothing strategies which they will be able to practice and integrate into their care and treatment plan. The best way to identify which therapeutic activities will benefit the person is by getting to know them well, and understanding their interests, hobbies, strengths, and desires These strategies may be implemented in all fields of nursing. For example, asking someone to tell you about their last holiday may be used to deal reduce anxiety during a medical procedure.

Scenario 1

This scenario follows from previous Mr X example for 3.5 de-escalation techniques

Following the successful de-escalation of Mr X who had earlier displayed aggressive/threatening behaviour towards peers and staff, the nurse utilised distraction and diversion techniques to enable Mr X to redirect his focus/attention to a calming task which he found therapeutic and beneficial. Mr X had a particular interest and was very skilled in origami. He got enjoyment and pleasure from this activity. The nurse suggested engaging in origami with staff support to provide a therapeutic activity. Mr X agreed to this and began focusing on this activity. When participating in origami his attention quickly shifted from feelings of frustration/agitation to a more relaxed and rational state of mind allowing him to physically relax, as well as unwind emotionally.

It was incorporated into Mr X's care plans that there was a list of activities he particularly enjoyed participating in and which enabled him to gain healthy coping skills and to aid the prevention of episodes of violence/aggression. Other examples of distraction/diversion techniques that were useful included discussing

topics of interest. For example, bird watching and gardening as he was passionate about these topics and enjoyed informing people of his knowledge. Examples of activities he enjoyed included: Carrying out bird feeding or gardening activities. Physical exercise for example escorted walks Music therapy Arts and crafts therapy. Watching undemanding TV programmes which provided appropriate humour and background noise.
Scenario 2
Pain is often an issue with patients following an amputation. Sometimes the more focused a patient is on this or the more we ask and focus on this aspect the more it becomes an issue. Often if we distract or divert their attention to something else, it allows the patient some relief. As Physiotherapists we often distract patients using a functional task which is even more beneficial as the patient can feel a sense of achievement and progress. Therefore, they are more likely to feel positive following the experience and not think about their pain for longer periods. A 63-year-old female had an above knee amputation due to peripheral arterial disease (PAD). The patient had pain in her stump following the surgery and this had hindered her progress within the acute setting. The patient was now discharged home and attending the gym for assessment to see if she would be suitable for a prosthetic limb as this could not be assessed due to pain limitations. The patient lived with her husband. She had 2 daughters who live nearby and 1 had 3 grandchildren aged 7, 5, and 2. The patient's main goal was to be able to play with the children in her garden. The patient reported phantom pain (pain in the absent limb) which was a pins and needles sensation that worsened at night and, she was also very tender to touch on her stump which appeared hypersensitive as her wound was healed. The patient would jump even to the lightest touch of her stump. The patient had been reviewed by the pain team on the ward and her GP was monitoring her medication. On attendance at the gym, we provided her with a desensitisation pack (a bag with different materials for the patient to rub and pat over her stump e.g., massage ball, towel, leather, foam, etc), and her stump was also reviewed to ensure no neuroma was growing. The patient's pain remained similar after 3 weeks. The patient's mood was low as she could not see how she could move on with her life due to this pain. However, we mobilised the patient using a femurett (a type of early walking aid). This allowed the patient to get up and walk in the bars and she even progressed to using a wheeled zimmer frame. We also got her standing in the bars, throwing and catching a ball, moving her weight from side to side, etc. During this time, the patient did not complain of any pain as she was distracted doing a functional task where she could see a purpose and goal. The patient proceeded to limb fitting and got her prosthetic limb. The patient did continue to report pain in her stump, but this lessened the more active she became and the more she was able to return to

her “new normal” life. The patient got to the point where she was sleeping better, could walk out of her flat and into the garden, and being able to play with her children during the summer months was a huge benefit to her.

Application in other areas:

This skill is also applied without specialist prosthetic patients who have received a microprocessor knee We try to get them to walk down slopes and stairs and trust the knee will control them and support them. In the later stages, we will often get them to throw and catch a ball, carry a cup of water, chop, and change direction. They will find that they are concentrating extremely hard on the task with their upper limb that they let the knee do the work for them and they are not so anxious or worried about what the new knee component is doing.

Similar distraction skills are used in all settings to get patients away from their pain and improve function e.g., orthopaedics, medical, and care of the elderly. A lot of the time the pain can remain (short or long term) but as they become more functional and less fearful that the pain is causing damage, they tend to be able to distract and focus on other things other than pain. Adding in tasks that are fun such as skittle bowling, throwing, and catching with other patients, group exercises can all be helpful in seeing how others are doing and working on different tasks.

Reflection

Points to consider guiding reflective discussion:

- What are the principles of this communication skill/approach/therapeutic intervention?
- Why was this approach successful for the patient?
- What was the role of the practitioner?
- What new learning did you gain?
- Discuss examples of when this approach could be used in other areas of your practice?

Additional resources

Lazarus, R. S., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.

Distraction Techniques for Panic Disorder (verywellmind.com)
Emily's Coping Strategies - Prompts, Direction & Distraction - Alzheimer's and Dementia Support Services (alz-dem.org)

3.9 Positive Behaviour Support

Positive Behaviour Support (PBS) is a human rights and person-centred based approach reflecting each person's individuality. It aims to promote quality of life, enhance community presence, and increase independent living skills. It places an emphasis on respect for the person being supported. It focuses on promoting proactive interventions to meet the individual's needs (The British Psychology Society, 2018).

Behaviour that challenges always happens for a reason and the person's only way of communicating an unmet need. PBS helps us understand the reason for the behaviour so we can better meet people's needs, enhance their quality of life, and reduce the likelihood that the behaviour will happen.

A PBS plan promotes pro-active and preventive strategies and includes teaching new skills It may include strategies to avert crises and keep people safe. If this involves using restrictive interventions, then these must be the least restrictive and there must be a plan about how to reduce reliance on restrictive practices (NHS Health Education England)

NHS Health Education England (n.d.)
https://www.hee.nhs.uk/sites/default/files/documents/The%20key%20messages%20about%20Positive%20Behaviour%20Support_0.pdf

The British Psychological Society (2018) Positive Behaviour Support (PBS)
https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Positive%20Behaviour%20Support.pdf

Scenario 1

Freddy is on the autistic spectrum with a mild to moderate learning disability. Freddy lives in supported accommodation. He has a sister who has teenage children. The family are close and Freddy benefits from weekly visits. He is proud to be an uncle and his nephews are fond of him.

Freddy has always loved pop/rock music and has a vast collection of compact discs (CD's). His nephews enjoy listening to music with him. They have introduced him to Spotify and have shared a playlist of music they enjoy together on a smartphone the family gave him at Christmas. For his recent birthday, the

family bought him a pair of wireless headphones. Staff helped Freddy to utilise these devices and the playlist. He is delighted that he can now listen to his favourite songs everywhere.

Freddy's staff know that loud unexpected noises, and noisy environments, are difficult for Freddy and that these can lead to behaviours that can be challenging. Freddy has ear defenders to aid him in noisy environments. He was not keen on these at first, but his nephews told Freddy that the ear defenders make him 'look like a rock star' and so now he is always happy to wear them.

Freddy has care plans which support positive behaviour through pro-active strategy. One incorporates the use of ear defenders during visits to the supermarket. It is important for Freddy to be independent like his sister. Going to the supermarket to buy his food supports his well-being. However, the noise in the supermarket can overstimulate him causing the supermarket experience to result in behaviours from Freddy that others may find challenging. The use of his ear defenders during shopping has been proven to promote a positive experience in the supermarket for Freddy. This is a clear example of PBS.

However, Freddy can still struggle with the additional beeps, and inevitable chat, at the supermarket checkout. One of Freddy's support workers suggests that his new headphones - and favourite new Spotify playlist - may better support Freddy in the supermarket than the ear defenders. It is agreed that this could be trialled. Staff talk to Freddy and ask if he would like to listen to his music in his headphones as he goes around the supermarket. He is not sure. Staff ask Speech and Language to create a social story. When the family visits staff ask his nephew to mention how he enjoys listening to music whilst shopping. Staff go through the social story with Freddy prior to his weekly shopping trip. Freddy agrees to try this new approach. This is an example of PBS.

The trip around the supermarket with the headphones and music is ok and Freddy copes well at the checkout. However, the shopping trip took much longer than usual because Freddy became stuck in the bean aisle for ten minutes insisting, he was able to adjust the volume. Freddy was not accepting of the staff help which was unusual. He was again delayed in the cereal aisle. This delay caused Freddy to miss his bus home which causes him anxiety. This in turn causes Freddy to shout and swear at members of the public at the bus stop.

This staff member reports this back to the wider team. They reflect on the positives together and begin to plan how to promote a more positive experience at next week's supermarket shop. This is another example of PBS.

Scenario 2
Julia is a 24-year-old lady who lives in a home of multiple occupancies with three other residents, she requires staff to support her both day and night. Julia is bright and bubbly and most of the time enjoys life to the full. She engages in lots of community activities, going to play music, going to dance class, and attends the day centre five days a week. Julia likes to use her laptop during the evening she likes to watch her favourite cartoons and loves a colourful puzzle game, although often Julia will not engage in any activities and sometimes refuses to get up in the morning.

Julia is a very loving daughter who enjoys spending time with her mother a couple of times a week, often meeting up and going for lunch together.

Julia has limited verbal communication she does not use full sentences and uses very few words one of the words she uses a lot is ‘mmmm’ smiling and nodding. Julia will often engage in self-injurious behaviour where she will skin pick and has on occasion pulled her nails out, she also pulls her hair, now revealing some patches without hair, Staff cannot figure out why she does these things, these behaviours are getting worse, and staff have no idea how to manage this there have been lots of staff changes over the last months. One long-term staff member has raised concerns with her manager who advises a trip to the General Practitioner (GP).

Staff accompany her to the G.P. appointment and she in turn referred to the Community Learning Disability Team (CLDT).
Once the referral was received to the team the G.P. had requested Psychiatry support, during the multi-disciplinary meeting it was discussed that Julia had no history of mental ill-health nor had she been prescribed any medication for mental ill-health, a referral was made to the Community Learning Disability Nurse (CLDN).

- If you were the nurse in the CLDT team what would be your priority?
- Where might you concentrate your input first?
- How might you figure out why behaviours are occurring?
- What will you do next?

Make a few notes and compare them with the following information below.

Once the referral was received, CLDN liaised with the G.P. to see what health assessments were carried out, and whether any bloods were taken for analysis, hoping to rule out any unmet health need. The G.P. reported that Julia was not very cooperative, refused any examination, and would not allow bloods to be taken. Whilst in the surgery Julia hit the staff member and was vocalising, clearly unhappy to be there.

The CLDN liaised with the team manager to gather information she was equally puzzled by Julia’s behaviours, describing day-to-day activities of which there were lots. A nursing assessment was carried out but revealed no great unmet health need. Staff were given behaviour recording charts to complete. Over the next months a period of analysis, utilising a PBS approach, was employed which included, analysis of behaviour function, evidence gathering to determine root causes of behaviour, exploring triggers and influences, and determining whether the behaviours were triggered by internal stimuli or external, whether they were environmental or not. A PBS plan was established and utilised to support Julia. It identified some of the main causes for her behaviours and the required subsequent input.

This included the following:

A non-consistent approach by staff everyone supporting differently. A support plan was compiled and detailed how best to support in activities of daily activity.

Staff using too much language, Julia was assessed by a Speech and Language Therapist. Following assessment advised her word recognition was 1 word therefore she could not understand staff. Staff were also over attributing Julia's understanding due to her incorrectly identified social cues, (nodding and smiling) staff were using too much social chit chat. This was increasing Julia's anxiety and in turn hair pulling and skin picking. A communication support plan and passport were utilised to develop and maintain appropriate communication using simple language with only 1 instruction and utilising some simple Makaton gestures.

Julia was experiencing being overstimulated due to having so many social engagements throughout the week and not having any time to relax. Her activity planner was curtailed allowing for some more time to do nothing and the use of active support was employed.
Staff were offering of too many choices; a now and next board was used to help with task, time management, and reduce anxiety caused when transitioning to the next activity.

It was discovered that when Julia was taken to the G.P. she thought she was going on a shopping trip. This was why she was uncooperative in G.P. surgery. Julia's daily/weekly planner was devised, each activity was recorded when it was about to take place.

Julia's mum informed staff that she did not like needles and a desensitisation process was devised by the CLDN. Numbing cream was prescribed which helped to reduce the discomfort Julia experienced. This was a reasonable adjustment to ensure blood tests could be carried out. The blood results revealed low thyroid function and low B12 which may explain the low energy. Julia was therefore prescribed treatment, and her health is slowly improving.

The PBS plan included proactive responses, now and next board, simple language, not informing Julia of any activities too far in advance, and reactive responses. When Julia was displayed anxious before for example, pulling her hair, staff agreed to reduce the noise in the house turn off the TV Music, and ask other residents to go to another room. Julia would then be offered reassurance.

Part of the ongoing PBS plan work also included staff engaging in capable environments. This included the learning resource Improving Practice to enhance their skills and understanding when supporting an adult with a Learning Disability. The Periodic Service Review process was also initiated which ensures a person-centred PBS plan using an evidence base to maintain or adapt strategies.

Reflection

Points to consider guiding reflective discussion:

- What are the principles of this communication skill/approach/therapeutic intervention?
- Why was this approach successful for the patient?
- What was the role of the practitioner?

- What new learning did you gain?
- Discuss examples of when this approach could be used in other areas of your practice?

Additional resources

Challenging Behaviour Foundation (2021) Positive Behaviour Support.
https://www.challengingbehaviour.org.uk/information-and-guidance/positive-behaviour-support/

improving_practice__pdf_.pdf (scot.nhs.uk)

Active support –what is it?
What-is-Active-Support.pdf (bild.org.uk)

Active support Handbook
Active-Support-Handbook.pdf (arcuk.org.uk)

PBS academy
The PBS Academy UK | Home | PBS Academy Website | Positive Behavioural Support (PBS) Competence Framework

BILD PBS
Positive Behaviour Support (PBS) | bild

Capable environments
capable-environments---lizzie-mason.pdf (pbsuk.org)