

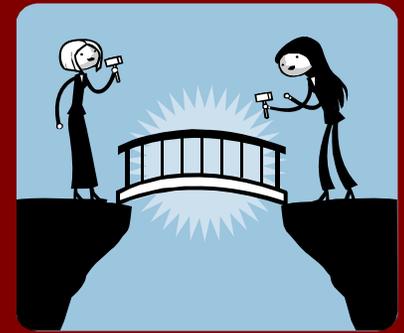
# Bridging the Gap

## An Experiential Enquiry-Based Learning Approach in Mental Health Education

University of Manchester  
School of Nursing, Midwifery and Social Work

Collaborating Team : Lindsay Rigby, Ian Wilson,  
Tim Walton, Andy Hall, Kate Dunne, Dr Philip Keeley

# Bridging the Gap



- BNurs (Mental Health) – 3<sup>rd</sup> year students.
- Enquiry Based Learning (EBL) - within the 'real life' environment
- Adopts principles from both Problem Based Learning (PBL) approach and clinical supervision
- A blend of e-learning and face-to-face supervision groups

# What did we want?



## A model of learning that would ....

- Facilitate student nurses to gain confidence in their ability to identify and resolve clinical, theoretical and ethical dilemmas as they arise in their clinical placements
- Encourage students to reflect on their clinical knowledge, research and policy guidance and application to their clinical practice
- Enable students to gain an experience of the supervisee's role in a structured and formal supervisory setting

# Seven Step Approach

(Dolmans & Schmidt. 1994)

1. Clarify your understanding about the situation
2. Define unfamiliar terms, concepts and vocabulary
3. Analyse the main issues
4. Sift and sort by considering the area/s to focus on
5. Identify learning outcomes and agree on  
• 'SMARTER' goals
6. Decide where or who to find information from
7. Report back to group by discussing your findings

# Problem based learning as a platform...



- PBL can facilitate student MH nurses to become reflective, enquiring lifelong learners for their professional role by engaging them in **authentic** situations during clinical training (Barrow et al 2002, Ehrenberg & Häggblom 2007)
- Student nurses view the use of ambiguous scenarios unhelpful (Yuen et al 2008, Tiwari et al 2006)

# Incorporating a Supervision Approach.....



- Develop knowledge and competence, promote a sense of security in nursing situations and enhance personal development and professional solidarity (Arvidsson et al 2001)
- Feel emotionally and psychologically supported in dealing with the unfamiliar demands of practice (Saarikoski et al 2006, Carver et al 2007, Benjamin & Sohnen-Moe 2007)

# The Development of the Model

- **Previous PBL Model – until 2006**

Using 'paper' case studies based on clinical practice generated by tutor

- **Peer Supervision Groups - EBL Approach – 2007**

Using 'real life' case studies

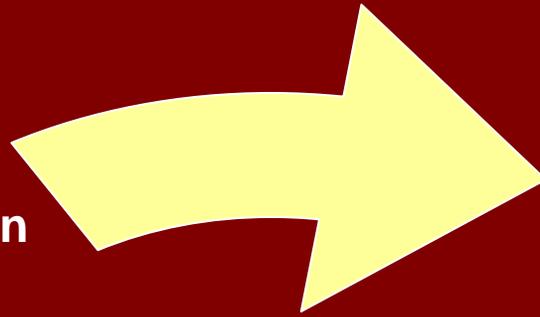
- **E- Learning EBL Approach – 2008**

EBL model with on-line delivery (Blackboard) -  
Some limited face to face input from tutors

- **Blended E-learning/Supervision 'EBL Model' – 2009**

A combination of face to face supervision and on –  
line delivery with service user involvement

**Stage 1** - 'Trigger issue' from clinical practice is identified, clarified, discussed and prioritised in supervision group and placed onto blackboard to initiate a blog

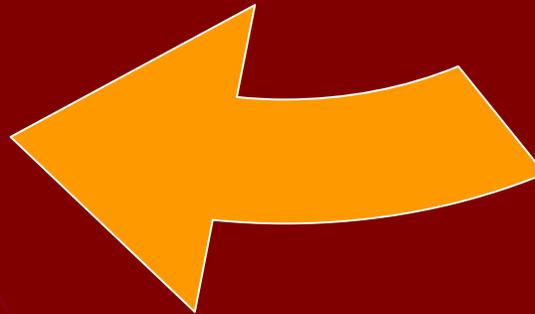


**Stage 2.** A blog is then used to clarify the terms of reference and to identify what they need to know about to resolve the identified issue using the 7 step approach



**The EBL Model**

**Stage 4** – The final supervision group involves students reporting their findings and applying these to the identified clinical situation



**Stage 3** – Issues from the blog are discussed in the supervision group. Each student identifies relevant information to aid in the resolution of the problem. This is then placed onto an on-line discussion board

# Components of this EBL Model

## REFLECTIVE SKILLS

Students must reflect on the workplace experiences to identify problem issues which they observe practitioners attempting to overcome

## COMMUNICATION SKILLS

Skills include the ability to communicate issues to groups, utilising on-line discussion board in a professional and focused manner and to enhance the skill of reporting findings succinctly

## RESEARCH SKILLS

Encourages curiosity by asking questions from the perspective of different stakeholders and evaluation of existing evidence base

## INTEGRATION of KNOWLEDGE with PRACTICE

Application and synthesis of newly acquired knowledge and understanding to the identified problem

# Examples of clinical issues

Questions	Themes
<ul style="list-style-type: none"> <li>➤ What do you do/say to someone who has just attempted suicide?</li> <li>➤ How can I assess if someone has capacity to care if they have mental health problems and so does the one they care for?</li> <li>➤ What is the evidence base for treatment of someone who self harms?</li> <li>➤ How do you deal with inappropriate/sexual comments in clinical practice?</li> </ul>	<p>Clinical skills</p> <p>Clinical skills / Theory</p> <p>Evidence based Practice</p> <p>Clinical skills / Ethics</p>
<ul style="list-style-type: none"> <li>➤ What are the possible interventions for a client with co-existing mental health &amp; learning disabilities at high risk of self neglect and vulnerability?</li> <li>➤ How can I manage a client who has a 'dependent' personality disorder who threatens to kill themselves?</li> <li>➤ What should I do if I hear a patient being verbally abused by a member of staff?</li> </ul>	<p>Clinical skills / Evidence based practice</p> <p>Clinical skills / Theory Evidence based practice</p> <p>Ethics</p>

# Examples of Potential Business Related Issues? ( or not .... )

Questions	Themes
➤ How do you introduce a new manager into a well established team?	Organisational Change
➤ The marketing manager seems to be 'burnt out'. What does this mean and how can I deal with it?	Human Resources
➤ One of my managers has asked his brother to join his project team on an 'unofficial' basis – he has started to bully one of my junior managers and I am not sure how to manage this situation	Ethics / Law / Human Resources / Communication Skills
➤ What is the best way to manage the redundancies which are expected in my dept?	Communication Skills / Human resources
➤ The company is distributing a product which I believe to be flawed – how do I manage this ?	Ethics / Law

# Stage One – Initiating the Issue

**MessageSubject:**

P.R.N medication **Topic:**

ACTIVITY ONE - POST YOUR ISSUE (ORANGE GROUP)

**Author:** Joe Bloggs **Date:** 26 January 2010 17:49

Activity One

Identification of a clinical issue

During my placement a new patient was consistently asking for P.R.N. medication. The patient had been using cannabis frequently before and during admission. I notice that some nurses would administer P.R.N. quicker than other nurses. When should the nurse administer/refuse the P.R.N. medication? Is there a time frame for the nurse to consider? Or is it solely based on the nurse's discretion?

[Reply](#) [Forward](#) [Lock Message](#)

*Messages in the thread* [Display Complete Thread](#)

# Another clinical issue....

[Close this window](#)

## Compiled Messages

Print

Save as File

**Subject:** Clinical Issues - Personality Disorder

**Topic:** POST YOUR CLINICAL ISSUE - Green group

**Author:** Michelle

**Date:** 13 May 2009 14:03

Hello green group

I had an issue when I was leaving my last placement which was an acute ward. We had a lady who had a personality disorder and was a self harmer. She was getting distressed because the ward was particularly noisy that day, she was finding it difficult to find a quiet place and staff were finding it hard to spend time with her with other pressures. I found her in her room hitting herself in the face. I managed to calm her down and she took some Lorazepam. We discussed what would help her to not get so distressed and have to take medication. She explained that she finds it therapeutic to spend time in the chapel but finds it difficult to get over there given her size and the pressure it puts on her feet. I said I would talk to my mentor and see if there was anything we could do. We agreed that we could possibly arrange for a porter to take her over and agree to pick her back up after a certain length of time. I discussed this in handover and the team of staff and the ward manager said we should make her walk rather than agreeing to her request.

Is this ethical and fair to the patient? What else could we have done for her?

Reply

# Stage two - Blog

**Subject: P.R.N. Empowering the patient**

**Author: Joe Bloggs**

**Date: 04 March 2010 12:13**

I have asked nurses on my placement about when P.R.N. should be used.

The majority of nurses seem to agree that P.R.N can be helpful in reducing clients/patients symptoms when in distress. However this differs depending on the setting. As P.R.N in the community differs from P.R.N on the ward, for example; the nurse decides when it is appropriate to use P.R.N medication whilst the person is in a hospital setting. Clients within the community can decide when they need to take P.R.N. Reflecting on my experiences within both settings; this is a good starting point for the nurse/patient relationship to take place. I feel that this can empower patients. For example;

- When to use their P.R.N. medication safely?
- Empowering the patient/client to manage their P.R.N medication safely prior to discharge.
- Recognising/spotting possible side effects and what to do if a client suspects that are experiencing them.

However I feel that I have not seen this practiced as much on the wards than the community. Has anyone observed this within their placements?

Comments (1 Comments / 0 New)

# End of Stage Two

## Message

**Subject: Issues to be brought onto postings Orange Group -PRN meds Topic: ACTIVITY SIX – FINAL POST (ORANGE GROUP) Author: Lindsay Rigby Date: 19 March 2010 14:02**

Following the PBL we have generated some questions which need to be answered by putting the information you find onto this part of the discussion board . For those of you who were absent today we have allocated you with a subject area !

1.

1. What is the evidence base for PRN provision in community settings and In- pt wards ? Tom
2. How has the evidence linked to policy guidance ? Peter & Paul
3. is the use of PRN included in advanced directives and crisis planning? Bonnie

2.

4. What the psychological alternatives for PRN? Elvis
5. What are the guidelines for medication reviews when PRN is frequently used ? Jane
6. What are the potential side effects of PRN medication? Kate
7. What are the safest types of medication for PRN in the community? Bob
8. How do we monitor prn use in clients with dual diagnosis? Beth

Edit Message [Reply](#) Forward Lock Message

*Messages in the thread* [Display Complete Thread](#)

**Name Rating Author Date**

# Stage three – Feeding back Information

**Subject: Activity 5 MMHSCT Policy PRN Substance misuse Author: Bob**

**Date: 15 March 2010 19:13**

**Hiya, been looking at the Policy and guidelines for the use of 'as required' or extra medication for behavioural disturbance including rapid tranquillisation (2009) it gives guidance/answers on all the questions raised at the PBL. I was really interested about the guidance given to patients who are suspected in taking recreational drugs?**

**Substance misuse - Care should be taken to identify concomitant substance misuse and the drugs involved. Consideration of possible interactions between illicit substances consumed and psychotropic medication must be taken into account when prescribing. Physical monitoring must occur when psychotropics are given when there is suspicion that illicit substances have been taken. (MMHSCT 2009).**

**I was reflecting my own experiences on the wards and in the community about patients/clients who take recreational drugs. Patients don't get regular drugs test on the ward and especially in the community, what does anyone think about this?**

**Web:**

**[www.mhsc.nhs.uk/.../Test%20a%20Clinical%20Protocol%20to%20Enhance%20Use%20of%20P...](http://www.mhsc.nhs.uk/.../Test%20a%20Clinical%20Protocol%20to%20Enhance%20Use%20of%20P...)**

# Examples of blog

**Subject:** Some info sources with regards SH

**Topic:** Stage Two: Blogging the Issue - Red group

**Author:** Karen

**Date:** 21 May 2009 21:18

As well as the NICE guidelines: <http://www.nice.org.uk/guidance/CG16>

42nd Street (which is based in Manchester) has published a couple of books which specifically deal with Self Harm and working with people (albeit young people - but quite a lot of the information with be transferable).

They are:

Who's Hurting Who? by Helen Spandler

and

Beyond Fear and Control by Helen Spandler and Sam Warner.

Also I have a friend who works in non-stat services, with a particular interest in harm minimisation is SH. I'm seeing him on saturday, so I will try to get his viewpoint.

Comments

Forward

## Comments

1 **Author:**

**Date:** 25 May 2009 23:52

[http://www.bbc.co.uk/headroom/wellbeing/guides/rr\\_selfharm.shtml](http://www.bbc.co.uk/headroom/wellbeing/guides/rr_selfharm.shtml)

It's a short movie about SH made for the BBC's headroom campaign. I have my opinions on it, but it does include an interview with someone who used to SH which is quite interesting.

2 **Author:** Lindsay Rigby

**Date:** 29 May 2009 16:37

Thanks Karen

If you needed to write a care plan for someone who self harms I guess provision of information is important - what information should be provided , to whom and how ?

# Example of feedback

**Subject:** Origin and History of CPA

**Topic:** Stage 3: Posting feedback - Red Group

**Author:**

**Date:** 18 June 2009 15:58

The CPA originated from the Spoke's Inquiry into the care and after-care of Sharon Cambell; and was introduced to improve the delivery of services to people with severe mental illness and minimise the risk that they lose contact with mental health services (Kingdon, 1994). On 6 July 1984 Isabel Schwartz, then a social worker employed by Bexley Council, was killed at her office at Bexley Hospital in Kent. She had been stabbed to death by a former client, Sharon Campbell. Ms Campbell was arrested and charged with murder. On 22 August 1985 she was committed to Broadmoor, having been found mentally unfit to stand trial. Almost two years later, following extensive pressure from Dr Victor Schwartz, Isabel Schwartz's father, a Public Inquiry was appointed by the Secretary of State. By the time the Inquiry reported in July 1988, fully four years had elapsed since the death had taken place. The Sharon Campbell Inquiry, while admitting the benefits that hindsight provided, nevertheless identified a series of matters, which, it believed, were wrongly underestimated as factors in influencing the care provided to her. On one occasion a knife was found in Ms Campbell's locker during a period of inpatient treatment. There were other instances where evidence suggested that she was often in possession of such implements. Yet, the finding of the knife at the ward was not recorded in either the clinical or nursing notes. Given that the death of Isabel Schwartz was caused by stabbing, the view reached by the Inquiry was that the discovery had been "played down" when more serious attention might have discovered a pattern of behaviour that could then have been addressed. The Inquiry concluded that there had been a break-down in the delivery of services and that this effectively resulted in the death of Isabel Schwartz (Kingdon, 1994). The inquiry recommended that the secretary of state issue to health and local authorities a written summary clarifying their statutory duties to provide after-care from former mental health patients (Kingdon, 1994). The CPA contained four key elements: • assessment of health and social needs • an agreed plan of care and treatment • allocation of a key worker • regular reviews, changes to care plans (Tummey, 2005). The government did not however prescribe how it would work, leaving this to individual authorities to interpret and implement (Tummey, 2005). Around the same time that the CPA was introduced, local authority care management in social care was also emerging due to the policy of care in the community, which included an additional mechanism for the management of funded social care packages (Kirby et al., 2004). In April 2001 following guidance from the NSF for Mental Health this was combined with the CPA to produce the care coordination role, in an attempt to provide a more integrated system (Kirby et al., 2004). The government has since reviewed the CPA policy several times (Tummey, 2005).

# Evaluation in progress

Cohort of 2007 (Group Supervision, n=7)  
compared with

Cohort of 2008 (on-line, n=8)

and Cohort 2009 ( Blended model n= 8)

- **Focus groups** using a thematic analysis to elicit the feasibility and acceptability of both models
- **Pre/Post Questionnaire** to determine confidence and acceptability of e-learning model
- **Quantitative Analysis** of the data extracted from Blackboard

# Quotes from Supervision Focus Group



- *“I thought that because we were choosing our own topic it was far more interesting & you wanted to do the work”*
- *“Before I felt very unsupported in clinical areas although you had a mentor”*
- *“I found that through other peoples’ problems I learnt a lot about relevant good practice guidelines”*
- *“It’s nice to know that you’re not the only one who has problems in clinical areas, and that other people are feeling unsure as well”*
- *“We talked about things that had been brought up in lectures before but I was still a bit unsure about”*

# Supervision Group Themes.



- **Relevance to study / practice**

More interesting and relevant to clinical practice than traditional models of PBL

Promoted independent learning and enhanced motivation

Provided an insight into use of clinical supervision

- **Acceptability as a method of learning**

Did not suit everyone's learning style

Valued a safe place where issues could be discussed

Learning from experience of others was appreciated

- **Feasibility in relation to practical implications**

Time limitations of the model prevented successful resolution of all issues raised

Consistent facilitation of the model is essential

# Quotes from On – Line Focus Group



- *“I found it quite hard to go back and actually trail through what everyone had written..... there wasn’t enough continuity”*
- *“ it’s too late in the game for our teaching hours to be cut down, we are in our final year and we should have access to a tutor .....”*
- *“I liked the flexibility but having to solve all the technology issues meant extra work for me”*
- *“I thought it was a good idea to have everything on–line. We still had access to tutors through e-mail and could meet up with tutors at any point”*

# On-Line Group Themes



- **Relevance to study / practice**

Valued the use of self directed issues from placement  
On-line resources acquired by the groups were useful

- **Acceptability as a method of learning**

Perceived a loss of tutor support

On-line discussion of clinical issues lost an interactive quality

Preference for concurrent e-learning and face to face

- **Feasibility in relation to practical implications**

Supported students in developing time management skills

Facilitation is initially time-consuming and technically taxing

Process must be made simple with frequent input from tutors

# Quotes from Supervision 'Blended' Focus Group

- *'I quite enjoyed sitting around and discussing things... getting ideas from everyone else that you had not necessarily thought of before'*
- *'I found that the fact that it was online helpful especially when the tutor went on line and gave us pointers ...It was more focused that way'*
- *'Pete (Service User) would come around in the groups and he would say 'what would you do? . It was great having someone real involved '*

# 'Blended Model' Group Themes

## **Relevance to study / practice**

A useful way to get the perspectives of others  
Especially good to have service users involved  
Acquisition of enquiry skills to develop clinical practice and knowledge

An enjoyable way to gain an understanding of clinical issues

## **Acceptability as a method of learning**

Once technical aspect of the model was acquired it was acceptable

It felt laborious at times when other commitments were expected such as assignments

## **Feasibility in relation to practical implications**

It was important to spend time explaining the model



# What we have learnt? - Content

- 'Real' clinically driven scenarios were preferred
- Discussion of clinical issues enabled students to be supported on an emotional level
- Online submission of feedback following enquiry was valued for ongoing professional development
- A useful precursor to clinically based research questions
- Contribution of stakeholders perspective was important to students experience
- Students need more practice in the writing of clinical reports

# What we have learnt? - Process

- Replacing face-to-face learning exclusively by e-learning did not work for everyone blended model was the preferred approach
- Flexibility of e-learning was valued but some struggled with IT although this was quickly resolved for most students
- Face-to-face discussion of clinical issues enabled students to be supported on an emotional level which was not possible using a blog
- Could be adopted and adapted by other units at different academic levels
- **This has been a steep learning curve for teaching staff as well as students**

# Any Questions



For further information please contact:

[lindsay.rigby@manchester.ac.uk](mailto:lindsay.rigby@manchester.ac.uk)

[ian.wilson@manchester.ac.uk](mailto:ian.wilson@manchester.ac.uk)