

**Protected Engagement Time on older adult mental health wards: a thematic analysis of the views of patients, carers and staff.**

**Abstract**

During Protected Engagement Time (PET) ward routines are adjusted so that staff can spend time together with patients without interruption. The aim of PET is to increase staff and patient interaction on wards and ultimately patient wellbeing. Although PET has been implemented on inpatient wards within the UK, including older adult wards, there is no systematic evidence as to how PET is carried out or how it is experienced by staff, patients and families.

Semi-structured interviews were conducted with 28 participants (8 patients, 10 family members and 10 ward staff) from three different wards with PET and transcriptions were analysed using thematic analysis. Three themes were identified: *the patient is at the heart of care; PET depends on staff; and tensions in how PET operates*. There was support in our sample for the principles of PET and its potential for a positive impact on patient wellbeing. However, the implementation of PET was identified as challenging, highlighting an existing tension between an individual's needs and the wider needs of patients on the ward as a whole. The impact of PET was generally described as being dependent on how PET was organised and the level of staff commitment to PET. Participants emphasised that if PET is to be successful, then it should be a fluid process that fits in with the local context.

**Key words:**

Dementia, Caregiving, Long-term care, Nurse-patient relationships, Nurse-interaction.

## **Introduction and Background**

A lack of activity for people affected by dementia living within institutional care is strongly associated with boredom, agitation and other signs of distress (Edvardsson and Nordvall 2008, Cohen-Mansfield, Marx and Rosenthal, 1989). Lack of activity on older adult mental health wards is also associated with a number of factors affecting nurses: a lack of time, competing administrative commitments and a lack of knowledge of appropriate methods of engaging with patients with severe cognitive limitations. Given that care in the UK and elsewhere is increasingly being delivered by unregistered staff, any deficiencies in training and confidence may be more apparent in this group (Pulsford, 1997; Hussein and Manthorpe, 2012).

A report from the Acute Care Collaboration identified Protected Engagement Time (PET) as one way of placing the interpersonal relationship between staff and patients at the centre of ward practice by re-organising ward routines thus enabling staff to spend uninterrupted time together with patients (see Table 1). The concept of PET has been developed to increase the amount of high quality contact between ward staff and patients, including those with dementia. Amongst the anticipated outcomes of implementing PET are a decrease in distress and agitation whilst at the same time avoiding the use of psychotropic medication which has consistently been identified both as being over-prescribed for older patients and as having significant effects on their morbidity (e.g. Banerjee, 2009; Fox et al, 2014).

(Table 1 here)

Although the use of PET on older adult wards has the potential to improve the experiences of patients only one evaluation has been identified, which was carried out on adult acute care wards (Edwards et al 2008). Therefore robust evidence as to its effectiveness on either adult or older adult wards is lacking.

This study was the qualitative component of a larger, mixed methods investigation of PET within older adult wards funded by the National Institute for Health Research (NIHR, Nolan, 2016). Papers

examining other aspects of the study (e.g. a national survey of the use of PET on older adult wards, the impact of PET on adverse events as well as the findings of the main study including fidelity measures) have either been submitted for publication or are in preparation. For this study we interviewed staff, patients and carers from three wards, each from a different NHS trust and report a thematic analysis of how these participants viewed PET.

### **Study aims**

This study aimed to explore the experiences of PET within older people's wards and its impact on three stakeholder groups: patients, carers and ward staff.

### **Methods**

The study as a whole received ethical permission<sup>1</sup>, with the trial<sup>2</sup> protocol registered. The reporting of results in this paper is consistent with Relevance, Appropriateness, Transparency and Soundness (RATS) guidelines for reporting qualitative research (Clark, 2003).

*Setting:* Interviews were conducted with participants recruited from a ward using PET in each of the three NHS trusts involved in the study. Two wards (named here as A and C) were exclusively for people affected by dementia and one ward (ward B) admitted older adult patients with a range of mental health needs. Each of these wards had participated in the main study.

*Sampling:* we used a purposive sampling strategy, aiming to recruit thirty participants to reflect a diverse spread of opinion. Staff participants from a variety of professional backgrounds, salary bands and levels of experience were selected in order to provide a broad range of perspectives on PET.

Similarly, patient participants with a variety of diagnoses were selected (five out of the eight had a

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<sup>1</sup> Ethics approval was received from the NRES Committee London - Camden & Islington on the 25<sup>th</sup> of March 2013 (reference number 13/LO/0191). Three substantial amendments approved on the 15th August 2013, the 3rd of December 2013 and the 20th October 2014.

<sup>2</sup> ISRCTN31919196

diagnosis of some form of dementia). Mini Mental State Examination (MMSE<sup>3</sup>) scores were available for three participants with dementia (mean=18; SD=4.0) and for three with other diagnoses (mean=26; SD=1.5). In order for patients to have had the opportunity to become familiar with PET, recruitment was restricted to patients who had been in hospital for 14 or more days. Carer participants had all visited the ward regularly (at least three times in the month prior to interview) and continued to be actively involved in the lives of their relatives. Neither patient nor carer participants were required to have been involved in the main study in order to participate in this sub-study. Staff and carer participants were recruited from all three wards whereas patients were recruited from wards A and B only. Table 2 describes the breakdown of gender by ward and participant type. Table 3 and 4 illustrate the representativeness of this sample compared to the main study with all five staff professional groups represented.

(TABLE 2, 3 & 4 HERE)

*Ethics - Capacity:* assessing the suitability and capacity of patients to consent to take part in the study was carried out in a collaborative process involving discussions between the research team and the ward staff involved in the patient's care and had access to patient notes, including any relevant cognitive assessments. Patients were excluded if they lacked capacity to consent for themselves, if they had verbal deficits, were unable to communicate in English or to take part in the interview.

*Consent:* participants from all three groups who met the inclusion criteria were approached by a member of the nursing staff who outlined the study and provided them with a Participant Information Sheet. If they were interested, then their name was passed to the researcher, who met them within one week. All participants gave their informed consent prior to their inclusion in the study and the interview being conducted.

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<sup>3</sup> MMSE is a tool used to diagnose and assess progression of dementia. Scores between 24-30 indicate no cognitive impairment; 18-23 indicates mild impairment and 0-17 indicates moderate to severe impairment

*Data collection:* standardised semi-structured interview guides (see table 5) for each of the three participant groups were modified by the study team from versions piloted and used in a preceding study of PET in acute care psychiatric wards. For pragmatic reasons, we selected interviews as a means of generating data about participants' experiences.

(Table 5 here)

*Data storage:* all interviews were digitally recorded and professionally transcribed. Both recordings and transcriptions were stored in password protected sites. All personal information reported in these files were altered or removed to maintain anonymity. Non-personal data will be stored securely for five years.

*Thematic analysis:* the transcripts were analysed by ED, CP and RC following the six phase guide to thematic analysis process described by Braun and Clarke (2006), and using NVivo version 10 (see Table 6).

(Table 6 here)

## **Results**

Researchers who carried out interviews received brief training from members of the research team. Patients were permitted to have their carers present but all declined this option.. Interviews took between twenty and twenty-five minutes. None of the interviewers were compromised by having dual roles within that clinical area (i.e. acting as both clinicians and researchers).

*Staff participant interviews:* ten staff participants across three wards<sup>4</sup> were interviewed. Three members of staff declined to take part. All who were approached had already participated in the overarching PET study through completion of a comprehensive questionnaire. Details of staff participants are provided in Table seven.

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<sup>4</sup> CP for ward A, SH for ward B and JW for ward C (all female researchers)

*Carer participant interviews:* ten carers across three wards<sup>5</sup> were interviewed. Two declined to take part. Details are included in Table eight.

*Patient participant interviews:* eight patients were interviewed across two wards<sup>6</sup>, All patients from ward A who were approached agreed to take part in the study, but five from Ward B declined. Table nine provides further details of these participants.

INSERT TABLES 7, 8, 9 ABOUT HERE.

### *Thematic analysis*

In order to ensure that researchers' views about PET did not compromise the validity of the analysis, the 28 transcripts were divided between the two researchers analysing the data (see figure 1). These were balanced for the different sites and different types of participant interview. As a validity check RC independently read ten of the transcripts.

INSERT FIGURE 1 HERE

During the initial analytic steps, themes were identified by each researcher independently, and were discussed between the two researchers to increase reliability. Five themes which were common to all three participant groups were provisionally identified. The researchers then reviewed and refined these themes by blending together information from those transcripts that they had not previously read. ED worked with two themes ("*staff-patient relationships*" and "*patient-centred care*") while CP worked with the remaining three themes ("*the environment*", "*safety*" and "*the P part of PET*"). All three researchers then further refined the themes, reducing the main strands to three. The relationship between the provisional and final themes is illustrated in Figure two. The sixth stage of

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<sup>5</sup> Interviews were carried out by AH (a female researcher) on ward A, by SH and JW on wards B and C

<sup>6</sup> Ward A interviews conducted by RC (a male clinical psychologist with 25 years' experience of working with people affected by dementia) and ward B interviews conducted by MEK (a female Research Associate with 8 years' experience as a Registered Mental Health Nurse).

thematic analysis involves drafting of the paper. For this study, the paper was critically reviewed by all the remaining authors providing a final process of validation<sup>7</sup>.

INSERT FIGURE 2 ABOUT HERE

The following quotations are evenly distributed across the three sites and participants groups (see tables 7, 8 and 9 for more information).

**Theme 1: the patient is at the heart of care.**

The overarching theme that was identified was the importance of patient centred care. This extended to ensuring that the person affected by dementia was able to engage in activities that occurred during PET:

*We want to spend this quality time with them no matter what level of engagement the person has, just trying to engage the person in any way you can. [S8, Activities co-ordinator, Ward B].*

Four sub-themes arise from this theme.

*Sub-theme A: a flexible approach to meeting individual needs.* A consensus emerged from the interviews that in order for PET to succeed a 'one size fits all' approach was inappropriate. Instead it was important that PET was delivered in an adaptable manner that attempted to meet the individual's needs:

*Sometimes you get patients that only want to eat when they are with their family, in which case I need their families there at mealtime or evening ... These are things that you can't - you have to assess the patient. [S10, Charge Nurse, Ward C]*

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<sup>7</sup> The authors come from a variety of backgrounds; mental health nurses, psychiatrist, psychologist and occupational therapist

One staff member put themselves in the shoes of the patient to reflect on the importance of flexibility:

*For people with dementia if you know their life story, it's mostly for things that matter to them. It could just be a walk with somebody, looking through the window, the view will just make a change for somebody. It could be that you are making tea or you are standing and they are helping ... and you are engaging with them. So it's these little things that really matter for people with dementia I think. So knowing the person. If you know the person you will know exactly what they would like and it makes a change. [S6, Charge Nurse, Ward B]*

However, some carers in particular, questioned whether there was always such a smooth fit between the individual and the activities available to them. One carer commented that PET activities lacked any element of individuality:

*Throw a ball from one to another that's all I've seen going on. [C3, Ward A]*

Similarly, the types of activities chosen may not always be appropriate with the consequence that they distress rather than stimulate patients:

*Have a big sheet and thing and fling it up in the air and fling it back again - that's what you do with children ... they get them wound up and it's a hell of a job then to get them to settle ... some of the things they do I think are a bit babyish. [S2, Health Care Assistant, Ward A]*

*Sub-theme B: accommodating cognitive differences.* The impact of the individual's presentation and their ability to engage was seen as another important aspect to putting patients at the centre of care. In particular, the person's cognitive and verbal abilities seemed to be crucial to determining when and how staff could engage with them:

*[It's] because of the level of concentration from our patients. You want to engage, it's like we can engage on a brief period of time. So for me we cannot waste this precious time ... most*



*patients are cognitively impaired and they aren't able to concentrate.* [S8, Activities co-ordinator, Ward B]

This issue was identified not just by staff, but also by carers and one patient participant:

*You've got various educational standards. You got various mental standards and varying ages.* [P4, Ward A]

Having a strong patient/staff relationship was widely seen as the key to providing person-centred care and providing the most appropriate engagement opportunities to patients:

*How you truly get to know somebody and really get to understand what makes them tick and what their needs and desires are.* [S10, Charge Nurse, Ward C]

Indeed, in one instance, a carer was encouraged to incorporate their thoughts into the care plan of their relative, and believed that this may have allowed engagement during PET to be more productive:

*More than one member of staff said to me that they all realised that he did not like to be rushed. So I actually wrote that on his ward chart. They encouraged me to say his likes and dislikes.* [C10, Ward C]

*Sub-theme C: PET works!* For some staff, the positive impact of PET was that spending more time with patients helped them to understand them and to improve their mood:

*But it's quite – it can be incredibly profound and quite subtle, you draw certain emotions or information out of individuals ... If I can actually see somebody ... through activity ... just to be happy, I think that's a wonderful thing.* [S3, Occupational Therapist, Ward A]

Similarly, a staff nurse added:

*That time gives us a specific time to see and talk to the patients ... they may not talk to you but even sitting next to them it does make a difference in somebody's life ... 15, 20 minutes with them. Being in the room, playing their music. It does make a difference. [S6, Charge Nurse, Ward B]*

Some staff also expressed their belief that the potential for an improvement in mood and well-being in patients was also linked to other improvements, such as reduction in anxiety:

*Well I like that time because we can see that the staff go towards the patients because this is what we are here for really. ... certain patient will get to know that the nurses will definitely be out at that time if there are any problems and need to talk. They benefit because they feel less anxious about being in hospital ... when we are with a patient doing PET I think the atmosphere calms. I think everything comes together really ... it's talking, it's one-to-ones ... [S5, Staff Nurse, Ward B]*

However, as well as having the potential for positive change, a psychiatrist expressed concern that if PET was implemented without appreciating the needs of individual patients it could be unhelpful:

*Although he was viewed as enjoying participation in the group I think ultimately it actually caused a deterioration in him mentally. [S1, Psychiatrist, Ward A]*

*Sub-theme D: PET on its own is not enough.* Some carers and patient participants commented that no matter how committed nursing staff were, the dominant experience for many patients was of boredom:

*No one sees me ... I feel very frustrated ... there's nobody to discuss it with ... just sitting in that room all day long, nothing seems to be progressing. Give me my drugs, that's it and nothing for days ... Nothing moving on. Nothing going forward ... I've got nothing else to do ... just sitting here all day long, day and night and ... absolutely nothing is happening. [P5, Ward B]*

*I would like more things to do. [P2, Ward A]*

Overall, this theme reflects a broad agreement from staff, carers and patient participants that while PET may facilitate nurses and other staff spending time with patients, it needs to be implemented in a flexible manner so that it can meet individual needs. This entails staff understanding their patients and being mindful of their differing abilities. At the same time, patients and carers reported that PET on its own was not enough to overcome feelings of boredom and a lack of meaningful activity.

**Theme 2: PET depends on the staff.**

The second overarching theme that we identified relates to concerns expressed by staff, patients and carers that the amount of energy that nursing staff were able to commit to engaging with patients during PET would determine its success. In this sense the nursing staff were seen to *make or break* PET. Three subthemes were identified.

*Subtheme A: carer and patient ambivalence towards nurses.* Comments by carers and patients about nurses frequently mentioned their professionalism, friendliness and caring nature:

*I've been in hospital before but not so good as what this is, because these [staff] really care for their people. [P1, Ward A]*

Carers commented on the support given to them during a difficult time:

*I could never, ever have managed without them, truthfully, really. [C8, Ward B]*

However some carer and patient participants also expressed more ambivalent views about staff:

*They are pleasant enough ... I know they probably mean to do well but it is very hard to get contact with people you don't know. [P5, Ward B]*

Some carers, in particular, recounted mixed experiences of visiting on the wards, in which there seemed to be all too little interaction between patients and staff from carers:

*I don't see much staff interaction ... [some] can seem to be not very co-operative, others are very, very nice. So there's a mixture here. [C3, Ward A]*

*Subtheme B: not enough staff.* There was a sense from participants that no matter how hard nurses worked, there were simply not enough of them, and that consequently a lack of staff time impacted on the ability of those nurses that were available to deliver PET effectively:

*Another thing is exercise, I don't think there's half enough of that, probably due to staff shortages and not having enough time ... I do understand the financial side, but they can't put on as many staff as they would like to. I'm sure they feel like that too. [C7, Ward B]*

*They are flying about here and there. [P5, Ward B]*

A knock-on effect of this pressure on staff is that they may be too busy to engage or interact with patients:

*I mean they are extremely busy. Sometimes you have to wait ... Some of them seem a bit like they don't really know much about us at all. [P4, Ward A]*

*Sometimes staff can be a bit stressed and they may not feel like up to doing that. [S9, Clinical Support Worker, Ward C]*

*Subtheme C: not knowing about PET.* A number of participants reported being unaware of the existence of PET whilst others were unsure of different elements:

*I don't know what that is. [P6, Ward B]*

*No, I have heard of protected mealtimes, but not protected engagement. [C9, Ward C]*

Although it was generally carers and patients who expressed this unawareness, S10 (a charge nurse, Ward C) also described not being adequately briefed about PET when she took up her post:

Interviewer: *Are you aware of protected engagement time on the ward as a concept?*

Interviewee: *I wasn't*

Interviewer: *Bearing in mind you are quite new to this*

Interviewee: *No I wasn't until this [the research study] came up*

Interviewer: *So it wasn't sort of packaged up and handed over formally to you when you started work here?*

Interviewee: *Nothing like that.*

In summary, the ability of staff to deliver PET on wards is critical. Although nursing staff were often praised for their work and were generally seen as working hard, they were also clearly busy and this limited their ability to engage or interact with patients. Moreover, a lack of awareness about elements of PET extended beyond carers and patients to staff.

### ***Theme 3: Tensions in how PET operates***

The third theme that emerged was that participants were concerned that the way in which PET was implemented was not based around a realistic understanding of the nature of the patient group at which it was aimed. In particular, the extent to which it was truly possible to *protect* staff time in this way when staff were caring for people with high levels of need, such as those on dementia wards, was occasionally questioned by nurses:

*It may sound great but the concept isn't being drawn up by the people that actually work on the ward. [S10, Charge Nurse, Ward C]*

*Subtheme A: it's not always possible to protect time.* While staff participants acknowledged that it is important to protect time to engage with patients, there was recognition that PET did not always occur and that even when it did, the boundaries around PET may not be respected. Some participants noted that tensions could arise from protecting time to spend with patients:

*We claim to have protected engagement time. ... breakfast will run from about 8 in the morning until about 10. I've got doctors on the ward at 9 o'clock and I've got a cleaner. I've*

*got social workers that might pop in. That's not protected then is it? ... So you can try and protect it and I do because there's a huge dignity thing involved in that... Other professionals do not work 24/7. ... social workers don't just have patients they represent on my ward. They've got set times. I understand that. The cleaners, there's all this big stuff isn't there about infection control. They've got to get a certain amount of work done. They get audited. Everyone gets audited. So you can say it and they understand it and they will apologise but it doesn't stop them from coming in. [S10, Charge Nurse, Ward C]*

For staff working on the ward, these interruptions can be enormously frustrating:

*Supertime we get disturbed a lot ... relatives are in and out, in and out. One says "oh, can you go and get this for me" and you have to leave and go in another room, and then somebody will come again ... it needs to be addressed, we need to be protected (S7, Health Care Assistant, Ward B)*

For one nurse, there were concerns that the commitment that the ward had made to PET might leave staff unable to respond appropriately to the fluctuating demands of ward life. The nurse felt that senior managers visiting the ward might not appreciate that it could sometimes be in the best interests of a patient to cancel a scheduled activity:

*If the inspectors come in and they see a timetable and see it's not happening then they see that as a negative...it can be a bit of a stick to beat you with. [S4, Charge Nurse, Ward A]*

*Subtheme B: the need for dynamic administration.* A number of participants questioned whether the way in which PET was organised on the ward, for instance by policing its boundaries, acted to ensure its effectiveness:

*Generally the nurses are very supportive of therapy staff but don't generally get involved. They tend to be, as we've just sort of described, bogged down with the running. [S3, Occupational Therapist, Ward A]*

On ward A, there seemed, at times, to be a divide between different professional groupings, with nurses sometimes looking to Occupational Therapists, Physiotherapists and the Art Therapist to provide structured activities during PET:

*Really we should be working collaboratively ... and I'm not sure how much that happens really. I think they're quite distinct groups.* [S4, Charge Nurse, Ward A]

*Subtheme C: balancing the needs of the ward and the needs of the individual.* Although participants were clear that it was important to meet the individual needs of patients, there was also an acknowledgement that there could be a tension between meeting person-centred care and the overall needs of the ward. This can sometimes be a difficult balance:

*By trying to keep everyone happy sometimes you keep nobody happy and it may be better that you just try and keep four people happy.* [S4, Nurse, Ward A]

At the same time, groups sometimes had a calming and positive influence:

*But there were times when I would get six or seven patients into a group setting and that was quite powerful and potent effect. It used to calm people down.* [S3, Occupational Therapist, Ward A].

More generally, if time is to be protected by making sure that staff do not perform administrative tasks and are able to work with patients without being interrupted, then someone, somewhere needs to make sure that this happens. Some staff were confused around who should lead or deliver the intervention, as well as frustrated that their colleagues did not always respect its importance. Finally, doubts were expressed that PET did not always fit well with the particular needs of older adult patients.

## **Discussion**

The aim of this paper was to look at the way in which Protected Engagement Time in three older people's mental health inpatient wards in England was experienced by three groups of stakeholders:

staff, carers/families and patients. Our findings suggest that while there was support for the principles of PET across all three groups, to deliver person-centred care during PET, all staff need to take into account the level of patients' cognitive functioning and to balance the needs of individual patients against ward demands. Consequently, PET in isolation, may help to make the best out of the available levels of staffing, but there was concern that in itself, PET wouldn't be able to make up for wider deficiencies in service provision. This mirrors findings from a similar evaluation on mental health acute care wards that staffing levels may disrupt the ability to deliver PET (Edwards et al 2008).

The lack of an established model or guidance for PET is likely to have contributed to the different ways in which it was implemented on each ward. On Ward A, OT and art therapy staff ran groups during PET, which may have resulted in increased time for nursing staff to spend with the patients who did not participate in the groups. By comparison, on Wards B and C, PET was implemented almost entirely by the nursing team. The use of PET within wards for older adults may also raise specific issues. Differences exist between the needs of patients in adult psychiatric and older adult wards, not least of which is the level of physical dependency of many older people, especially those with severe levels of cognitive impairment caused by dementia. For example, in the ward evaluated by Edwards et al, there was a focus on one-to-one talking sessions with nurses. In contrast on the three older adult wards in this study other methods of engagement, such as activities and groups were given equal importance.

If implemented, PET needs to be well managed, identifying sufficient resources to enable it to work smoothly. The findings from this study support those from Edwards et al (2008) who argued that it is important that participating staff, patients and visitors to the ward are informed about PET including its importance in improving patient-staff relationships.

*Limitations:* this qualitative study is one component of a much broader investigation into the use and effectiveness of PET on older adult wards. Consequently, we have not addressed issues related to fidelity or changes in behaviour, which will be the focus of forthcoming papers. Unfortunately due to



time constraints and researcher availability only four staff and carer participants (and no patient participants) were recruited from ward C. Moreover, while the interview questions were initially piloted and used in a study on PET in adult acute care wards they were not piloted on the older adult wards. Had they been so then it may have been possible to explore the differences between life on the two types of ward.

### **Conclusions**

PET was perceived by staff, carers and patient participants in this study as a way of increasing opportunities for staff and patient relationships to develop. However, whether or not such interactions occur during PET, and whether or not this then impacts on quality of care was thought to depend on other factors including the commitment and availability of nursing staff and the extent to which PET is dynamically administered rather than passively implemented. Although this study indicates general support for the principles of PET amongst stakeholders, there is need for further investigation of this intervention, specifically around how it has been implemented, its use in different clinical settings and its effectiveness in improving patient and staff experiences.

### **Relevance for clinical practice.**

The aim of Protected Engagement Time (PET) is to increase staff and patient interaction on wards so that staff can spend uninterrupted time with patients. While there was broad support in this study for the principles of PET, balancing the needs of individuals and the wider needs of the ward as a whole is often challenging and needs to be underpinned by clear policies that address these challenges. Successful implementation of PET involves a fluid, flexible process that fits in with the local context and which is continually reviewed.

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