Nightingale Mental Health Team Standard Operating Procedure

Version 2.3

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Contents

Overview

Frontline healthcare staff working in the current pandemic are likely to face a range of stressors including traumatic exposure, moral injury, workplace stress and home pressures. The currently 'unprecedented' circumstances also come at a time when NHS teams are already stretched, often understaffed and when organisational morale may be far from ideal within the NHS as a whole. This plan outlines the support that the Nightingale will put in place to support staff carrying out vital but challenging duties.

This document describes a range of possible interventions, following a preventative model of occupational mental health; the Mental Health Team will work closely with the onsite Occupational Health team, and these are provisionally located next to each other at this time. As a reminder, primary prevention refers to interventions which aim to avert the onset of mental health; secondary prevention to interventions which focus on those who have early signs of possible mental health disorder and tertiary prevention to the treatment of those who have developed mental health disorders. This document does NOT set out plans to consider and protect the mental health of staff who complete their work with the Nightingale Hospital London; this aspect of the overall mental health plan will be addressed in due course.

Primary Prevention Measures

Preparatory information/briefings:

There is good evidence that frontline, trauma-exposed[1], staff are likely to gain some benefit from being made aware of the realities of the work they are being asked to do and the associated psychological challenges of their work. This requires those in positions of responsibility to be upfront about what the likely occupational exposures might be and not to either over- or under- state the traumatic nature of a particular role. In the current crisis, preparatory briefings should include discussion of the moral and ethical challenges of the current situation as well as the likely workplace pressures and traumatic exposures as well as fears of becoming infected and by implication infecting others.

[1] Traumatic situations are ones involving death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence once or on multiple occasions. In their course of their duties, staff may be exposed to traumatic situations directly, as a witness or through indirect exposure to aversive details of the trauma in the course of their professional duties.

PLAN:

1. All staff who join Nightingale should be written to before they attend the induction to make them aware of the challenging role they will be undertaking. The provided information should be mentioned in the introductory letter and a brief 'non sugar coated' page of information should be provided about the nature of the work mentioning specifically: trauma exposure and the potential for moral distress, the challenges of wearing PPE for extended periods, worries about Covid-19 and the support options being made available by Nightingale to mitigate the potential distress that individuals may experience.
2. The induction briefing will provide similar information given by a clinician who understands the realities of the roles that frontline staff will undertake. The Mental Health Team contribution to this briefing will include: the realities of the role, the challenges and associated psychological risks, self-help techniques including apps/information that might help (e.g. headspace, umind, sleepio, and daylight apps are now free for NHS staff to access) and the other support options available to Nightingale staff (including the national NHSE/I offer e.g. Samaritans).

Screening:

The Nightingale Welfare Team are aware that there is no role for formal pre-recruitment screening in predicting psychological vulnerability in trauma-prone roles. However, appropriate consideration of someone's fitness for role by self-assessment assisted where required by occupational health colleagues should be advised. Where occupational health colleagues have concerns about someone's psychological health history then discussion with a psychiatrist, with an interest in occupational mental health, may be of benefit.

PLAN:

3. Prior to joining the Nightingale, potential recruits will complete a self-assessment form which will help them decide if they are psychologically suitable. Potential recruits will be asked to self-assess their suitability to work at the Nightingale and to seek appropriate advice from professionals and/or trusted family or friends and to provide confirmation that they consider

themselves fit to work at the Nightingale having taken account of the information in the introductory letter (Plan item 1. above). This information is self-declaratory, rather than part of any formal pre-employment screening.

Social support:

There is very good evidence that fostering cohesion between staff, both horizontally [camaraderie] and vertically [leadership] is consistently associated with good mental health. Essentially, much of the resilience of an organisation may lie in the social bonds between staff members rather than within individuals. It may also be helpful to advise frontline teams to adopt a buddy-buddy approach in which team members are paired up in order to check on each other's welfare during a particular shift as this can be an effective way of actively monitoring staff to identify early signs of distress.

PLAN:

4. All staff should be told about the buddy-buddy system that the hospital will use during the induction briefing. The induction briefing will also encourage staff to take an active interest in each other's mental health and provide a brief outline of indicators that someone may be having trouble coping and instructed to not be reticent in either speaking to the potentially distressed colleague or raising their concerns to a supervisor.
5. At the start of each shift, the team leader will ensure that staff are buddied up and buddies will be asked to make active efforts to keep an eye on each other for potential indicators of distress. Where possible, buddies should take their breaks together.

Supervisory leadership:

There is very strong evidence that psychologically savvy supervisors play a critical role in supporting the mental health of team members. Studies have shown that teams operating even the most arduous of environments are more likely to function well, and avoid the onset of serious mental health difficulties, if their supervisors create the right team ethos. Good supervisors have a range of important skills and attributes including looking out for team members' safety, communicating with team members regularly, not taking on extra work to make themselves look good at the expense of their team members and not criticising team members in front of others.

PLAN:

6. All team supervisors will be provided with training on topics such with active listening skills, a basic understanding of the likely impact of psychological trauma and exposure to significant moral/ethical dilemmas. This training should ideally be carried out by the in-house mental health team and it will specifically aim to help supervisors develop the confidence to have a supportive conversation with staff about their mental health and to be aware of what to do if they identify a problem. The mental health team will regularly reach out to the various clinical teams to offer such expertise and training; the nature of this can vary with need and circumstances, for example from face to face, through telephone or digital contact, to helping identify existing resources. It is recognised that the unique nature of the Nightingale Hospital means that individuals and teams might be transitory and subject to rapid change: the Mental Health Team will work with human resources to ensure they have correct up-to-date information on relevant personnel.

7. Team leaders will also carry out a post-shift review meeting with all members of staff which will include specific consideration of how staff are coping. Staff should be encouraged to share their experiences although care should be taken not to allow negative perceptions of one team member to distress others. Where someone appears to have been affected by the shift, team leaders should offer to speak with the individual on a 1:1 basis or to have another supervisor call the person back at a more convenient time.

‘Team training’:

As well as developing individuals and team skills (e.g. resuscitation, infection control etc.) group staff training presents an important opportunity of fostering strong links between team members and helping staff develop a sense of being in control over otherwise unpredictable, and anxiety provoking, situations. The Mental Health Team will engage with the clinical, education, and corporate teams to ascertain how they might usefully contribute to this: both directly through developing mental health awareness, and indirectly through their expertise in interpersonal and team dynamics more generally.

PLAN:

8. The Nightingale clinical skills/induction training team should be encouraged to use team training events as opportunities to improve the mental resilience of their teams and foster camaraderie. We anticipate that most staff will have a significant sense of pride at working in the new Nightingale hospital, and this represents a good opportunity for the educational teams and others to tap into. The Mental Health Team can assist with this as is deemed useful.

Psychological wellbeing interventions:

There are a range of positive wellbeing techniques available which claim to bolster mental fitness or increase psychological resilience. These include mindfulness, yoga and meditation although there are many other such interventions that have come into and out of vogue from time to time. Whilst the evidence supporting these approaches protecting user's mental health is relatively weak, it is likely that some staff will find them beneficial and it is unlikely that they will cause harm.

PLAN:

9. If possible wellbeing interventions (such as mindfulness, yoga, meditation or similar initiatives) should be made available for staff either at the Nightingale before or after shifts and the free app-versions of these approaches should be advertised to staff who wish to make use of them. However, it is recognised that there is insufficient evidence to support such wellbeing interventions being strongly recommended or made mandatory. Those offering such interventions should discuss their intent with the mental health team prior to delivery in order to ensure an evidence-informed consistent approach is offered within the Nightingale.

Secondary prevention measures

Active monitoring:

It is anticipated that a range of mental illnesses will be seen in staff. The unprecedented nature of the pandemic, and the Nightingale Hospital itself in terms of size and work, mean that it is difficult to be certain at this time about the exact nature and numbers of such problems. However, it is reasonable to assume that a range of psychiatric disorders will occur, including anxiety, depression, adjustment disorders,

and post-traumatic stress disorder (PTSD). It is also possible that various other conditions such as psychosis and substance misuse will be seen. The National Institute for Health and Care Excellence's (NICE) guidance on the management of PTSD recommends active monitoring of people who have been exposed to traumatic events in order to identify whether any early symptoms resolve [which is to be expected in most cases]. Where early symptoms do not resolve, individuals should be assisted to access sources of professional assessment and support. Whilst NICE recommend active monitoring to identify PTSD symptoms, it is just as useful an approach for any form of post-trauma mental ill-health such as depression, phobias or other anxiety disorders.

PLAN:

10. The hospital will employ a small cadre of experienced welfare staff who may be come from a range of health backgrounds who are not in frontline clinical roles, and have had specific training, to follow up on staff identified during, or at the end of, a shift as having difficulty coping or staff who do not turn up to a rostered shift. As a broader principle these welfare healthcare staff will make contact and check on the staff's psychological wellbeing in order to decide if: a. no further action is indicated: b. the team member is considerably distressed but not is content to make contact with their own GP and/or use the nationally provided resources or c. the team member is very distressed, speaks about a red-flag risk[2] or appears reticent to access support in which case one of the Nightingale Mental Health Team (MHT) will be asked to call the person back in order to assess what follow on action is needed. The Mental Health Team aims to be nimble and quick in responding to needs, and adapting to these as they change. The Nightingale MHT will also provide regular supervision of the welfare healthcare staff in order to ensure that their mental health is protected and are available to provide advice to the welfare healthcare staff on more complex cases.

[2] i.e. significant risk to themselves or others including safeguarding risks.

Psychological debriefing.

The Nightingale Welfare Team are aware that psychological debriefing, or post incident counselling, has been shown to be more detrimental to the psychological wellbeing of traumatised individuals than not being provided with any psychologically focused intervention at all. NICE specifically recommends against the use of psychological debriefing. However, it is important to distinguish psychological debriefing from leader-led operational review/debriefing [i.e. identifying the reasons for specific outcomes and identifying ways of improving practice] which is likely to be a facet of good leadership and should thus be encouraged [see PLAN: 7. Above].

Screening:

Post incident psychological health screening aims to identify personnel who have developed early signs of, or have established, mental health difficulties in order to help them access professional care. Whilst this is well intentioned, there is no evidence that this approach works in organisational settings. It is likely that concerns about what employers will do with screening results, concerns about reputation and confidentiality and screening only being a 'snapshot' in time, which does not take account of the usual fluctuating course of mental health disorders, are some of the varied reasons why screening within organisational settings is not effective. Post incident screening, may also do harm by falsely reassuring employers that staff members are psychologically healthy when this is not true. The Nightingale Welfare Team are aware that post incident screening initiatives, or ongoing psychological health monitoring, is not an effective tool in workplace settings.

Peer support programmes:

There are a number of protocols for training peers to actively monitor and support colleagues within the workplace. Examples of these are Mental Health First Aid, Psychological First Aid and Trauma Risk Management (TRiM). These programmes may have some utility in encouraging staff who are reticent to speak to their managers, or use more formal support mental health processes such an Employee Assistance Programme (EAP), to speak about their difficulties. Team leaders may also use peer supporters to carry out active monitoring of trauma exposed staff which is discussed above.

PLAN:

11. The Nightingale should identify any staff members who have completed specific peer support training and are 'in date'. It may also be that the welfare healthcare staff [PLAN: 10.] will complete peer support training to allow them to carry out their role. Peer supporters can be used as a hospital-wide resource which can be advertised as available for staff members to speak to as part of the overall Nightingale welfare offering. The Nightingale MHT should provide supervision for the peer support team to ensure that they do not become vicariously traumatised when carrying out their work, helping them to implement practical measures with staff members they are supporting and being available to discuss difficult cases with them in a supervisory relationship.

Overcoming barriers to seeking care:

There is considerable evidence that mental health stigma, perceived fears about one's reputation and the impact on careers of developing mental health difficulties can act as barriers to care. A reluctance to seek help may be particularly evident in staff who work in routinely high-risk roles, as such staff may believe there is a need to be mentally and emotionally 'strong' in order to maintain their reputation and indeed their employment.

PLAN:

12. Senior managers within the Nightingale, advised by the head of Mental Health Welfare, should devise and implement a communications campaign aimed at reducing stigma, reminding staff to be alert for each other's welfare and of the various avenue of support available in order to encourage staff to seek appropriate care. This campaign should be ongoing and use different forms of communication to achieve the desired effect. It should be led by the most senior managers and promulgated downwards to all levels of supervisors.

Mental health team outreach:

Even with the best will and intent to pay attention to staff's mental health, it is inevitable that supervisors and more senior managers will rightly focus the majority of their efforts on ensuring that high standards of clinical care are delivered to the patients who are bought to the Nightingale. Furthermore, whilst this plan requires all supervisors to

actively consider their team's mental health, it may be that some of the more mobile staff members will not have their mental health status monitored to any great degree.

PLAN:

13. The Nightingale MHT will proactively make contact with team leaders and mobile clinical staff, when appropriate, in order to ensure that they have a chance to speak about their own, or their team's, mental health. The MHT will be able to help reassure that symptoms and function are not always directly linked and many people who have mild, or even moderate, psychological symptoms may remain highly functional. Having the MHT readily available and working in a proactive manner, will help the organisation adopt and foster a 'nip it in the bud' approach to tackling significant distress and mental health problems.

Early triage assessments:

Many Armed Forces use mental health professionals, deployed alongside or near to, operational troops to carry out fitness for duty mental health assessments. These professionals aim to rapidly assess whether someone who presents with significant distress can be assisted to return to the frontline, possibly with brief advice and/or workplace adjustments which will temporarily lessen their exposure to stress [e.g. moving into an administrative role for a while], or whether they require more formal mental healthcare.

PLAN:

14. The Nightingale MHT will offer rapid assessment of frontline healthcare professionals who cannot be readily managed within their usual team even when a manager has tried to do so (see Annex A). The focus of these assessments will always be to try to find appropriate avenues to return individuals to a functional role, even if it is one which supports the main effort but does not place someone directly in the frontline. The MHT will keep in mind that there is a pressing need to have sufficient healthcare staff on the frontline in order for lives to be saved. Often simple support measures such as advising distressed personnel to get a good night's sleep, communicate with a loved one, take some exercise or have a shower can have a substantial impact on

someone's mental health and ability to continue functioning. At times, the MHT may also be able to reassure staff with mild symptoms that these are normal, to be expected and not indicative of a serious mental health problem. Where frontline workers have profound mental health problems, likely to significantly impact on their ability to carry out their role safely, these risks will be actively managed and care rapidly arranged. Should someone require a period of respite, or care, the MHT will aim for that to be as brief as possible. The principles of returning people who are distressed to duty are often known as PIES and there is good evidence that not only do these principles help people continue to work, but they also have a longer term positive impact on people's mental health possibly by helping them to maintain their self-esteem and avoid them labelling themselves as someone who cannot handle pressure. The PIES principle are: Proximity - which refers to keeping people who are finding the situation tough near the front line [possibly altering their duties for a brief period] and not sending them home; Immediacy – if someone does not seem to be themselves do not wait for them to enter a crisis before finding out how they are doing and supporting them; Expectancy – which refers to keeping a positive outlook in mind be that reassurance that they will cope and are doing a great job or that if they really cannot cope then they will be properly looked after and Simplicity – which refers to the benefits of simple interventions in helping to alleviate distress such as those described above [e.g. speaking to a love one, a good night's sleep etc.]. The MHT will also actively liaise with occupational health colleagues about fitness for duty options where doing so would be helpful.

Primary care liaison:

A significant proportion of people who attend a GP with physical health complaints are in fact suffering from a mental health difficulty. Given the nature of the work at Nightingale, it is likely that the Nightingale Primary Care Centre (PCC) staff will identify that a significant proportion of those attending the GP practice have a mental health difficulty as their primary presenting complaint.

PLAN:

15. The Nightingale MHT will both proactively liaise with the Nightingale PCC staff in order to provide advice, and where appropriate a formal mental health assessment (PLAN 13.) with a focus on return to duty where possible.

Tertiary prevention

Treatment:

The Mental Health Team will follow evidenced guidelines for the assessment and initial treatment of any identified mental illness. However, the MHT will not be offering routine follow-up care, and will rather be signposting and/or referring relevant individuals to appropriate resources. The 2018 NICE guidelines on the management of PTSD recommend that adults should be offered a trauma-focused CBT intervention if they have acute stress disorder, or clinically important symptoms of PTSD, and have been exposed to one or more traumatic events within the last month. These interventions include: cognitive processing therapy, cognitive therapy for PTSD, narrative exposure therapy or prolonged exposure therapy.

PLAN:

16. Where the Nightingale MHT identifies healthcare workers with acute stress disorder, or clinically important symptoms of PTSD, or other mental health conditions (e.g. depression), they will help to arrange for these evidence based interventions to be delivered. This may be possible by the Nightingale MHT advising staff with significant psychological difficulties about how to access evidence based treatment locally or through the national NHSE/I offering.

Conclusions

In summary, the Nightingale will adopt a ‘nip it in the bud’ approach, avoid medicalising ‘normal’ distress and will foster and maintain effective social bonds between team members and supervisors. Expert advice and early assessment in order to support these aims will be available from the MHT. Where staff are unable to have their immediate mental health needs met by their team, or the MHT, follow on care will be arranged but not delivered by the MHT. A future plan will also be developed to take address the requirement to ensure that staff who have worked at the Nightingale have their longer term mental health needs considered. Additionally, it is imperative that

research opportunities are considered and that staff are offered the opportunity to opt in to take part in research activities which will allow for better mental health support plans to be developed in future.

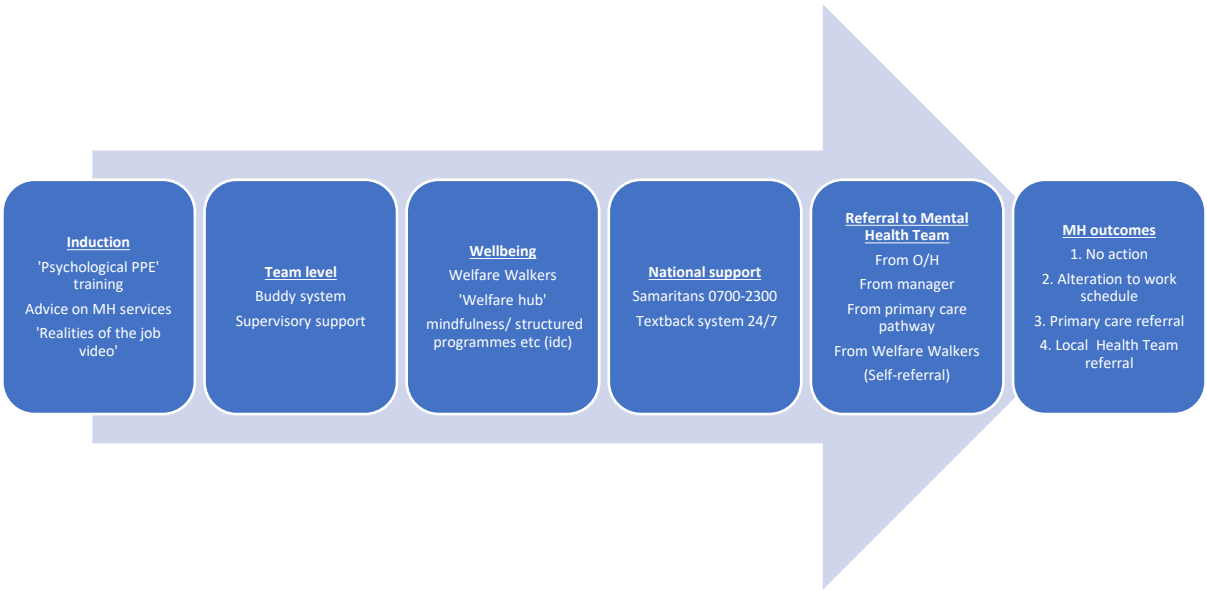
Annex A. Mental Health Team Assessment pathway

Mental Health referrals may come from team managers, occupational health, the Nightingale Primary Care Pathway, or by self-referral, although individuals considering self-referral will be encouraged to go via a manager or another trusted senior colleague. Working to the 'nip in the bud' principle, it is anticipated that many referrals or requests for support will be managed by brief advice or reassurance.

On occasion, face-to-face assessments will be required, and suitable confidential space has been identified for this at the Nightingale. It is recognised that the nature of the shift-work means that staff might have short periods out of PPE to see the team before being required to return to duty. The Mental Health Team will actively try work with this limitation to provide optimal flexible, rapid assessments, potentially with follow-up at later more convenient times.

All assessments beyond brief advice [such 'informal assessments' will be recorded by the MHT but not distributed further unless the individual wishes this to happen, will result in a letter to Occupational Health if 'patient consents', who will determine if it needs to be further forwarded (e.g. to the person's GP). Some outcomes will need directing to other agencies, for example primary or secondary care.

The mental health team will keep records of the numbers and types of referrals, the basic demographics of those referred, and pathway outcomes. Data will be stored in accordance with information governance practice of the Nightingale Hospital.


Induction
'Psychological PPE' training
Advice on MH services
'Realities of the job video'
Team level
Buddy system
Supervisory support
Wellbeing
Welfare Walkers
'Welfare hub'
mindfulness/ structured programmes etc (idc)
National support
Samaritans 0700-2300
Textback system 24/7
Referral to Mental Health Team
From O/H
From manager
From primary care pathway
From Welfare Walkers
(Self-referral)
MH outcomes
1. No action
2. Alteration to work schedule
3. Primary care referral
4. Local Health Team referral