Using simulated practice in pre-registration education to explore mental health issues

Amanda Collins Eade and Claire Winter

ABSTRACT

UK policy advocates that all nurses should have the skills to work with individuals experiencing mental health problems. However, barriers exist in that mental health placements for child student nurses are brief or difficult to arrange. This hinders opportunities to develop a therapeutic working relationship with young people, consolidate skills and ultimately develop confidence in working with young people presenting with mental health problems. A 3-day simulated practice strategy with child nursing students was designed to give students the knowledge, skills and confidence to work with young people who present to services with mental health problems. Students were approached 6 months after their simulated practice training to evaluate their opportunities to put their skills into practice while on placement. Once back in practice, 100% of students said they had improved confidence in working with young people who present with mental health problems

Key words: Simulation ■ Assessment ■ Empathy ■ Adolescents ■ Children's nurses ■ Mental health

In 2013, a simulated practice teaching method was introduced at the University of Greenwich, UK, to arm students with the knowledge, skills and attitudes required to work with young people presenting with mental health problems.

Simulated practice is attached to a 30-credit course on the ethos of students collaboratively meeting the specific healthcare needs of young people who present with long-term physical and/or mental health problems. The focus of the simulated practice is on teaching undergraduate children's nursing students early recognition, referral and evidence based interventions for young people aged 12 to 18. The first author and co-facilitator is a mental health nurse lecturer by background, experienced in working with young people. The second author is co-facilitator and is the programme leader for children's nursing at the University of Greenwich.

Simulated practice is imitation in a simplified form, sometimes using mannequins or computer-generated software in order for students to practise assessment and using decision-making skills with communication and team work activities that they will encounter in placements (Ganley and Linnard-Palmer, 2012)

While simulation can be interpreted as either role play or computer-based programmes, it allows students to reflect and practise safely under supervision. It is considered a useful strategy in pre-registration children's nurse training to encourage students to apply what they have learned when they go out to clinical practice, without making professional errors or causing harm to patients (Wilford and Doyle, 2006; Ganley and Linnard-Palmer, 2012; Ricketts et al, 2012). It develops greater self-awareness and allows students to acknowledge bias, stigma and stereotypes (Moxham et al, 2010). Development of empathy and rapport can help to reduce stigma and improve perceptions towards young people who experience distress, which may also facilitate better service user engagement (Timson et al, 2012).

UK policy background

The Centre for Social Justice (2011: 204) outlines that mental health is everybody's business regardless of the field of nursing: all nurses should have the knowledge and skills to support patients who present with mental health issues as well as physical health issues.

Recent prevalence figures suggest a dramatic increase in admissions for boys and girls who self harm in the UK (Health and Social Care Information Centre, 2013; Childline and NSPCC, 2017). In England and Wales, 18 778 children and young people were admitted to hospital in 2015/16 for self harm injuries. This is compared to 16 416 in 2013/14. (Childline and NSPCC, 2017). Public Health England (2016a) identified 150 000 children and young people present to A&E in England each year with injuries as a result of self-harm. Despite National Institute for Health and Care Excellence (NICE) (2015a) guidelines and Department of Health (DH) (2014) priorities, 12 emergency departments in England were criticised by the Care Quality Commission (2015) for judgemental attitudes towards young patients in crisis who had self-harmed.

Current policy illustrates that the earlier we recognise and intervene, the better the outcome for young people. In the UK, Public Health England (2016a) identified 111 600 children aged 5–16 are diagnosed with a mental health problem though only 25% are treated. The rate of children admitted for mental health problems in London is currently greater with 94.2 children per 100 000 in London as opposed to 87.4 children in England. (Public Health England, 2016b).

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Preparing children's nurses to develop the skills to work with young people

Buckley (2010) undertook a mixed methods study and found that 66.6% of a total of 70 children's nurses felt ill equipped to work with young people who present with complex mental health needs. Moxham et al (2010) conducted an action research study, which included 9 children's nurses from a team of 20. They found that while children's nurses often hold assumptions about young people with mental health problems, they lacked knowledge of skills in communicating with young people who have mental health problems and would avoid family psycho-education owing to lack of confidence to provide information, particularly if nurses believe they do not possess the 'answers' that parents seek. Pryjmachuk et al (2012) conducted a qualitative study of 33 school nurses to explore their attitudes towards working with young people presenting with mental health problems. The authors found that while school nurses were positive about this aspect of their work, they all lacked the knowledge and confidence around what to say or were worried about making things worse for the young person.

Pre-registration nursing programmes have been criticised for not preparing student nurses to work with young people with mental health problems (Terry et al, 2009). While acknowledging there are challenges, it can be a basis from which students will develop their confidence when working with young people. There are limited simulated practice opportunities around mental health skills training designed for general nurses and children's nurses (Felton et al, 2013; Moxham et al, 2010).

However, children's nurses rarely work with young people with complex needs if they are with an agency nurse, who has been brought in specifically to care for the young person one-to-one in order to maintain their safety (Buckley, 2010). This seeks to perpetuate the isolation that tends to happen with vulnerable young people on children's wards, increasing stigma. While there should be specific adolescent mental health units to meet young people's needs, there is a need for children's nurses to develop underpinning knowledge and skills to work with children and young people presenting with affective disorders, self harm or psychosis, as well as knowing how to refer (Honeyman, 2007; Buckley, 2010; Haddad et al, 2010).

Children's nurses work directly with vulnerable young people and families in emergency departments and paediatric wards. If they are given more knowledge, skills and supervision to work with young people with mental health problems, their confidence in working with this client group will increase. Cooke and James (2009) suggested training should include awareness of stigma, a knowledge of symptoms, brief psychological interventions, emotional support, skills in raising self-esteem, self-help strategies, types and prevention/management of self-harm and awareness of care pathways in the UK to promote signposting. In the UK, CAMHS (Child and Adolescent Mental Health Service) nurses often supervise children's nurses in practice for a brief period, usually for just 2–4 weeks. Feedback from ex-students who have contacted us once qualified suggests that they struggle to consolidate their skills when they graduate and become registrants. While a need for training has been acknowledged, there is also a need for children's nurses to spend time in placements that can increase their confidence in caring for young people with mental health problems (Richardson, 2011).

Simulated practice: the need for psychological safety

It is our experience that children's nurses by their own admission find the concept of simulation and role play challenging, particularly when asked to perform in front of each other (Ricketts et al, 2012). Student nurses fear feeling ridiculed or embarrassed, feeling unprepared, de-skilled or feeling set up to fail, which can exacerbate anxiety in performing in front of their peers (Ganley and Linnard-Palmer, 2012).

For this reason, a number of safety strategies were planned. It was essential to discuss a rationale of practising skills safely in the clinical skills laboratories that students are likely to face in clinical practice. Students like to feel safe in learning new skills and in order to promote a positive learning environment for those who do not feel comfortable in role play, an alternative active role of being a process observer can be brought in where they observe the verbal and none verbal communication skills of those who role play and are involved in suggesting alternative strategies when we stop to debrief. This way no student is passively opting out of the experience and all feel that they have contributed positively. The roles can be rotated and a checklist can be used to help the student focus (Ganley and Linnard-Palmer, 2012; O'Regan et al, 2016).

Organisation of the simulated practice

Simulated practice takes place over three days (*Table 1*). On the first morning, students are encouraged to negotiate ground rules for the week. For example, the students are given several options, such as respecting each other's contributions, exercising tolerance and acknowledging the Chatham House rule. This stipulates that people may use the information given, but the identity of those involved should not be revealed (Chatham House, 2017).

'Warm ups' are necessary before going into role play. A warm up is an initial activity designed to engage the students before the main activity. They can raise energy levels and promote less inhibited, enthused behaviour in students in a light-hearted atmosphere (Baile and Blatner, 2014). For example, on day 1, many students are visibly uncomfortable. A 'trust' warm up usually helps increase motivation for them to get involved and feel less inhibited before going on to role play.

Table 1. Structure of simulated practice

	Day 1	Day 2	Day 3
Morning	Skills in developing therapeutic working relationships with young people	Managing hygiene needs of young people focusing on collaborative care planning	De-escalating aggression
Afternoon	Role plays on working with young people presenting with suicidal thoughts, self-harm and hearing voices	Managing hygiene needs focusing on dignity	Recap breakaway techniques

Table 2. Sample and cohorts

Sample	Number of students in cohort	Number of students who responded
Cohort 1	34	23
Cohort 2	12	12
Cohort 3	37	18

Table 3. Student feedback after 6 months on placement after simulation seeing different presentations

Patient presentation. N= number of students who gave that response. (%)= SPSS percentage of those students	Number of students (%)
Depression and self-harm	4 (7.5)
Self-harm	17 (32.1)
Anorexia	2 (3.8)
Depression, suicidal thoughts and hearing voices	3 (5.7)
Suicidal	6 (11.3)
Autism	2 (3.8)
Personality disorder	1 (1.9)
Eating disorders, self-harm	1 (1.9)
All mental health problems (some students encountered all presentations of the above mental health problems)	2 (3.8)
No comment (students could give only one answer)	15 (28.3)

Table 4. Student feedback after 6 months on placement asking how simulated practice helped them

Feedback	Number of students (%)
Gave me confidence	5 (9.4)
Felt prepared	3 (5.7)
Understand the problem or behaviour	10 (18.9)
Helped me with my listening skills and remaining non-judgemental	3 (5.7)
How to communicate	5 (9.4)
Helped me assess young patients, helped me with sensitive questioning	8 (15.1)
It helped me be non-judgemental and focus on the young person's needs	1 (1.9)
Being in CAMHS helped me develop what we learned in training	1 (1.9)
No comment (students could give only one answer)	17 (32.1)

Students are split into two smaller facilitated groups and the emphasis is on success, praising engagement and not focusing on failures (Ganley and Linnard-Palmer, 2012).

Day 1

The authors have created specific role plays based on their own clinical experiences which are designed in the lesson plans towards successfully engaging and communicating with young people who are unwell. For example, on the first day, students are given a handover of five patients with a range of physical health conditions who also have mental health problems such as obsessive compulsive disorder, psychosis and depression and who self-harm. The students are asked to recap what they have learned in lectures about developing a therapeutic nurse-patient relationship with young people. A full briefing is given before the simulation exercises/role play. The students are taught how to give a rationale to a young person who is about to have a procedure, be empathetic in their interactions, maintain honesty and transparency about the rules of consent and confidentiality (Royal College of Nursing (RCN), 2013), using Fraser guidelines (Sparrow, 2016) and how to respond respectfully when setting and maintaining boundaries.

The facilitators role play scenarios where they ask sensitively about self-harm and suicidal thoughts and talk to someone experiencing auditory hallucinations. These have been introduced to help students empathise with a young person who is intensely distressed with such experiences as students will encounter vulnerable young people with similar presentations. Students practise these skills and then there is a debrief. The simulations and role plays often create additional discussions. These group discussions are often lively.

Day 2

On day 2, students learn to negotiate with young people around collaboratively planning and negotiating a young person's care in relation to hygiene needs. There is a handover before the students take it in turn to play the role of young patients who are bed bound, who may be able to do some tasks for themselves but who are not fully independent. While this may take students out of their comfort zone, the care plan is a collaboration between 'patient' and the 'nurse'. There is an expectation that some self-care will need to be negotiated.

The facilitators also introduce the option of the students fitting and wearing a stoma bag for the shift, with French mustard used to simulate faeces. All the students engaged with this activity and they either wore the stoma bag when being a 'patient' in bed or as a 'nurse'. In order to fully empathise with the young people they will be caring for, the students are expected to stay in character during break times and if needs be are expected to go to the coffee shop with drip stands or in wheel chairs for example. While a student can decline to do so, we have yet to experience any student to do this.

Day 3

Students recap to help them recall what they have learned in lectures on recognising warning signs and using de-escalation techniques for anger and aggression.

Students are given a handover, then role play scenarios. The exercises involve dealing with an angry young person or parent and are given opportunities to de-escalate a number of incidents. The focus is on using interpersonal, non-confrontational de-

escalation skills. Discussion around assessing and managing risk is explored with students to encourage them to think about risk issues and management strategies.

In the afternoon, the students recap on warning and danger signs of aggression and violence in young people, before spending time recapping and practising breakaway skills. Breakaway consists of a set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint (NICE, 2015b:16).

Evaluation

Method

Students returned to clinical placements for 6 months following the simulated practice before being approached for feedback and were asked to complete a brief questionnaire that allowed them to reflect on their experience. Ethical approval was granted from the University of Greenwich UREC. Three cohorts (*Table 2*) were approached to establish whether they had recently worked with young people presenting with mental health problems and to explore their perception of whether their confidence and skills had improved in assessing and negotiating with young people.

Results

A total of 87% of students (n=46) said they had the opportunity to develop a therapeutic working relationship with one or more young people since returning to practice, and 77% (n=41) had negotiated with young patients and collaborated on their care. A total of 55% of the students (n=29) had experienced opportunities where they had to de-escalate a situation, while 100% of the students identified feeling more confident in working with young people presenting with mental health problems. Of the respondents, 66% (n=35) had used specific skills in working with young people and 64% (n=34) had worked with young people presenting specifically with mental health problems.

The children's nursing students had mainly encountered young people presenting with depression and self-harm (40%, n=21). However, 11% of students (n=6) also described situations where they had worked with young people presenting with suicidal thoughts and plans. Some 6% (n=3) had worked with young people experiencing depression and hearing voices.

All the students fed back that they felt more confident and skilled when working with young people presenting with complex mental health needs. However, only 19% of students (n=10) fed back that it helped them to understand mental health problems and behaviour that might be associated with it. This suggests that future work and training is required to help children's nurses understand mental health presentations before the simulated training takes place. A total of 15% (n=8) identified that it helped them with sensitive questioning in assessing young people (*Tables 3, 4* and *5*).

Table 5. Student reflection on simulated practice 6 months after education sessions

Feedback	Number of students (%)
Enjoyed simulated practice, very useful, beneficial	9 (17.0)
Improved my de-escalation and negotiation skills	2 (3.8)
Greater understanding of mental health conditions	6 (11.3)
Greater understanding of my role in terms of decision making and other care pathways	1 (1.9)
We covered many skills and scenarios to prepare us to work with young people, which is needed on the children's nursing programme	4 (7.5)
Practising in a safe environment was valuable and much needed as we see more mental health issues on paediatric wards	1 (1.9)
How to approach and how not to approach young people, more practising	3 (5.7)
Improved communication skills and improved knowledge about challenges facing adolescents	1 (1.9)
Getting involved more	1 (1.9)
Having a teenager be involved in the simulation would be good	1 (1.9)
I'd like to know more about the process of referrals and what happens next	2 (3.8)
Would like more discussion of self harm and methods to stop self harm	1 (1.9)
All students should have CAMHS mental health placement as add-on to simulation	1 (1.9)
I would like to know about therapeutic restraint	1 (1.9)
I would now have liked to have done some work in engaging with children with mental health problems rather than adolescents	2 (3.8)
No comment	17 (32.1)
Total	53 (100)

Conclusion

The findings suggest that confidence is increased after simulated practice in dealing with situations similar to those in clinical practice, which may put students out of their comfort zone initially, but prepares them for working with young people or carers who present with mental health problems. From recent feedback from students, there is clearly a need to allow them to consolidate their skills in CAMHS placements, as well as emergency departments and children's wards. Some students identified a need for a better understanding of mental health presentations, and this has now been incorporated into lectures prior to the simulation sessions.

Future plans include: involvement of CAMHS health professionals in simulated practice; a potential development of an electronic-interactive game where students can engage young people as avatars; and a problem-solving e-simulation and a consideration of using adolescents and parents in simulated practice.

KEY POINTS

- A 3-day simulated practice strategy for child student nurses was devised to cover assessment and negotiation skills, being empathetic, maintaining honesty and maintaining boundaries with young people
- Simulated practice consists of exercises allowing students to engage in safe role play to give them confidence when working with young people with complex needs
- Simulated practice is an ideal training opportunity to help children's and adult nursing students improve their knowledge, skills and attitudes around mental health and help reduce stigma
- Students have identified that more placement time is required in Child and Adolescent Mental Health Service (CAMHS) placements to consolidate their skills

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CPD reflective questions.

- Have you avoided caring for young people with mental health issues because you felt you lacked the skills, knowledge or confidence to do so?
- What training do you think you and the team you work with might need to improve communication with, and care for, young people with mental health issues that you meet in your setting?
- Reflect on whether you consider caring for distressed young people presenting with mental health symptoms as a specific part of your role as a children's nurse
- Reflect on whether you felt your training prepared you to work with young people with mental health issues