Exploring multidisciplinary staff experiences of supporting patients psychologically following stroke.

A Service Related Project

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A quick word about the lingo...

- Using the term ‘patient’
- Why?
  - Term used by participants
- Why not?
  - Diagnostic connotations
  - Assumes a biomedical perspective (DCP, 2015)
- Reflections
Psychological needs following stroke

- Up to 75% of patients will have a significant cognitive impairment following a stroke (Nys et al., 2007)
- Emotional difficulties including symptoms of depression, anxiety and post-traumatic stress, are also common post stroke (Campbell Burton et al., 2013; Kneebone, Neffgen & Pettyfer, 2012)
- Hackett, Yapa, Parag and Anderson (2005)’s systematic review of the literature concluded that a third of all people experience depressive symptoms at some time after the onset of stroke.
There is a large body of research to suggest that psychological difficulties following a stroke have been associated with poorer outcomes.

Having a diagnosis of post stroke depression has been found to correlate with:
- a reduced quality of life (Kong & Yang, 2006)
- longer hospital stays (Galynker et al., 2000)
- increased mortality (House, Knapp, Banford & Vail, 2001)

Cognitive difficulties have also been associated with poorer outcomes
- Patel, Coshall, Rudd and Wolfe (2002) found that cognitive impairment three months after stroke was associated with poor long-term survival and greater disability

Impact on family members and carers
Research suggests that services have not provided adequate psychological support.

In 2010 a report by the UK National Audit Office (NAO) highlighted a widespread lack of psychological care provided to people following a stroke, across the United Kingdom.

A patient survey conducted by the NAO found that patients rated psychological care as the least satisfactory service in long term care, with only 24% of people rating this as good or very good.

Provision of clinical psychology staff was found to be very low among stroke services.
Current Guidance

- Stepped Care Model of Psychological Care (NHS Improvement, 2011)
  - all members of the MDT should be involved in the identification and management of psychological difficulties
  - all patients are screened for psychological difficulties by staff trained to do so (but not necessarily the clinical psychologist) within the first month after stroke.
  - The type of psychological support that is then provided, and who provides this, is based on the patient’s identified needs
Figure 1: Stepped care model for psychological interventions after stroke.
Adapted from IAPT model with input from Professor Allan House and Dr Posy Knights

**LEVEL 3:** Severe and persistent disorders of mood and/or cognition that are diagnosable and require specialised intervention, pharmacological treatment and suicide risk assessment and have proved resistant to treatment at levels 1 and 2. These would require the intervention of clinical psychology (with specialist expertise in stroke) or neuropsychology and/or psychiatry.

**LEVEL 2:** Mild/Moderate symptoms of impaired mood and/or cognition that interfere with rehabilitation. These may be addressed by non psychology stroke specialist staff, supervised by clinical psychologists (with special expertise in stroke) or neuropsychologists.

**LEVEL 1:** ‘Sub-threshold problems’ at a level common to many or most people with stroke. General difficulties coping and perceived consequences for the person’s lifestyle and identity. Mild and transitory symptoms of mood and/or cognitive disorders such as a fatalistic attitude to the outcome of stroke, and which have little impact on engagement in rehabilitation. Support could be provided by peers, and stroke specialist staff.
What has previous research found?

- Staff can experience difficulties identifying psychological difficulties and in feeling confident to offer help and psychological intervention to patients (Bennett, 1996)
- Low staffing levels and time
- Rehabilitation was seen to be “separate from and additional to nursing practice” (Clarke, 2013)
- Time pressures and not feeling that they had received the specialist training needed to help counsel their patients (Burton and Connor, 1992)
BUT

- limited research exploring the experiences of MDT staff working psychologically with patients, since the introduction of the stepped care model of psychological care
- What research there has been, has tended to focus on a particular aspect of this guidance, such as psychological screening. Simm (2013)
• Lack of research exploring other aspects of psychological support in stroke services
• Much of the research in this area has tended to focus on the experiences of one discipline within the MDT

SO……led to development of the research question:

**What are the experiences of multidisciplinary staff in delivering psychological care and support to patients following stroke?**
A phenomenological, qualitative design

Semi-structured, face-to-face interview used to generate the data

The data were analysed using thematic analysis

Steps outlined by Braun & Clarke (2006)
<table>
<thead>
<tr>
<th>Participant pseudonym</th>
<th>Team worked in</th>
<th>Position held</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanya</td>
<td>Inpatient</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>Phillipa</td>
<td>Community</td>
<td>Non-registered practitioner</td>
</tr>
<tr>
<td>Rosemary</td>
<td>Inpatient</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>Ben</td>
<td>Inpatient</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>Sam</td>
<td>Community</td>
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</tr>
<tr>
<td>Lily</td>
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<td>Physiotherapist</td>
</tr>
<tr>
<td>Fiona</td>
<td>Community</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Kate</td>
<td>Community</td>
<td>Occupational Therapist</td>
</tr>
</tbody>
</table>
Thematic analysis using steps outlined by Braun and Clarke (2006)

Reflections:
- Find what works for you
- Things change...a lot! And that’s ok.
- Cats can be a nuisance...
## FINDINGS

<table>
<thead>
<tr>
<th>Theme title</th>
<th>Challenges in providing psychological care related to particular points on the patient’s post stroke journey</th>
<th>Experience helped staff feel more able to understand and consider the psychological complexities of stroke</th>
<th>The perceived professional roles of the participants influenced the type of psychological care they delivered to patients</th>
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</thead>
<tbody>
<tr>
<td>Sub-theme 1</td>
<td>The emotional impact on staff</td>
<td>The impact of participants’ training paths on their levels of experience</td>
<td>N/A</td>
</tr>
<tr>
<td>Sub-theme 2</td>
<td>Having difficult conversations</td>
<td>Learning from others</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Theme 1: Challenges in providing psychological care related to particular points on the patient’s post stroke journey

- **Emotional impact on staff**
  - “sometimes we can be the first people they open up to” (Tanya)
  - “it’s the horrible, horrible thing”
  - “woah, this is, you know, not my area” (Phillipa)
    - Difficulties managing emotional responses of patients
    - Clinical Implications?
  - Differences between inpatient and community staff
    - Reflect the different stage of patient’s journey? (Shock and how this presents)
    - Clinical implications?
  - Feeling attached to patients?
    - “you do get attached, even though you try not to” (Ben)
    - Worries about emotional engagement? Why? Fear? Burnout?
    - Clinical Implications?

- **Difficult conversations**
  - Differences observed between the two teams. Types of conversations
  - Clinical implications
Theme 2: Experience helped staff feel more able to understand and consider the psychological complexities of stroke

- The impact of participants’ training paths on their levels of experience
  - “as a physio you do arms and legs and you’re very much about arms and legs” (Tanya)
  - “I don’t think we did much about mood at university at all’ (Rosemary)
  - “after working on the stroke ward..more...it’s become sort of more important to me to sort of get a holistic view” (Ben)
  - Differences between OT and physio training pathways
  - Clinical implications?

- Learning from others
  - Supervision with psychology (difference between two teams)
  - Peer supervision
  - Learning from colleagues- “I worked with an OT who was very skilled and I remember learning a lot from her”
  - Clinical Implications?
Theme 3: The perceived professional roles of the participants influenced the type of psychological care they delivered to patients.

- What did participants consider to be their role in delivering psychological care?
  - “if it was highlighted that something was off we would flag it up to the OTs” (Ben)

- What did they consider to be the role of other disciplines?
  - Mood and cognition “very much their [OT] role” (Tanya)

- Difficulties?
  - “I think if someone has mildish problems that I feel I can deal with myself and I can work through with that person...that’s ok...if someone has quite severe problems that I can refer to psychology that’s ok, but it’s the bit in the middle” (Fiona)

- Clinical implications?
Clinical Implications

- Further training and psycho-education on the types of psychological difficulties patients can face following stroke and how this can present, may help MDT staff feel more prepared for the types of difficulties they encounter with patients, and feel more confident to respond to this.

- Newly qualified staff, and staff who have had more biologically focused training, would benefit from extra training opportunities.

- Those in a supervisory or managerial role need to recognise the differences in staff training pathways and subsequently, the different learning needs they may have.

- MDT staff will benefit from improving their emotional resilience and reflective skills to help them cope with the sometimes emotionally demanding nature of their work.
Regular supervision, one-to-one and peer supervision, is recommended by the CQC (2013) and it is a positive finding that this was already in place and being used effectively by both the inpatient and community teams.

One service suggestion is the option of a drop-in forum with psychology. The community team participants recognised that they would benefit from further supervision and training with psychology but previous more regular opportunities had been experienced as inflexible and time consuming by some. Perhaps a monthly drop-in, in which particular clinical issues could be brought and discussed confidentially with psychology, would be useful.

It is recommended that MDT staff in stroke services develop an understanding of each other’s roles and learn to accept overlap between professional roles, rather than try to enforce rigid structures. Where there is conflict, for example between OT and psychology roles, it is suggested that they work towards accepting the existence of this grey area and think about how they can work together to ensure patients in this gap get the psychological care they need.

Further research may be useful to explore the how the social identities of staff working in an MDT are informed, with reference to social identity theory.
Reflections

- Study specific
  - Reflexivity is important and was a strength of this study. Helped me to recognise my own assumptions and challenge these.
    - Why was I interested in this area?
    - What was I expecting to find?
  - Not able to recruit nursing staff.
    - Did I try hard enough? (Demonstrate resilience)
    - Do anything differently?

- More generally
  - As I’m sure everyone will be saying…start ethics early! More time consuming than I anticipated.
  - Leave lots of time for redacting ethics materials…work out the best way for doing so. Paint is time consuming!
  - Give yourself at least a whole day for getting the two files ready for submission.
Ethical considerations

- Small team– how to write up findings so they are anonymous?
- Field supervisor worked in the team
- Use of language


That’s all!

Ta!

Any questions??