Centre for Forensic & Family Psychology

The University of Nottingham
UNITED KINGDOM • CHINA • MALAYSIA

Module code: C84FRP

Student no: 4278568

Year 1 Doctorate in Forensic Psychology
MSc Forensic and Criminological Psychology

2017

Do members of staff in a medium secure unit recognise the signs of dementia and know how to manage it accordingly?

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Journal the paper is written for: The Journal of Forensic Psychiatry and Psychology

Research Portfolio Contents

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Do members of staff in a medium secure unit recognise the signs of dementia and know how to manage it accordingly?

Abstract

The aims of this study were to explore the experiences, awareness and attitudes of members of staff working within a Medium Secure Unit (MSU) regarding older patients, specifically whether they recognise and manage signs of dementia and other age-associated risks. An initial scoping exercise was conducted to substantiate the rationale for the study then inform the content of two focus groups. Each focus group was representative of a staffing group: the first of nursing staff and the second of allied health professionals. The focus groups had the same content, but were conducted sequentially. A thematic analysis was conducted after each group to compare and combine the content using an iterative process. An over-arching theme identified through thematic analysis was forensic risk. The other main themes were: vulnerability of older adults, organisational factors, lack of awareness and recognition, interventions and staff attributions. Differences between the staff groups are explored, with observed differences between their use of reflective practice and supervision. Implications regarding risk management, staff training, supervision and the model of care are discussed.

Introduction

Despite an increase in public health priority regarding increased quality of life for those with dementia, promoting early detection alongside psychological and social interventions, this has not extended to those with dementia in forensic contexts.

The population of older adults and those with dementia in forensic services will first be discussed, followed by a brief exploration of their needs and how these are met by current services. There are numerous criticisms of the current provisions, with arguments favouring specialist geriatric forensic units (Yorston 1999, Yorston and Taylor, 2006). Dementia is often unrecognised, unmanaged and untreated (Shah, 2008), perpetuated by forensic organisations with inappropriate models of care, and professionals with minimal awareness of the disorder.

Prevalence of Dementia in Forensic Settings

It is difficult to know the current prevalence of dementia in forensic settings, particularly in prisons where it is often left undetected (Maschi, Kwak, Ko and Morrissey, 2012). Prevalence can be estimated using referral, admission and diagnostic data to draw conclusions. Definitions of older offenders vary, ranging from 45 to 65 years and above (Stojkovic 2007, Yorston and Taylor, 2006). Those in forensic settings are estimated to have a ten-year difference in overall health compared to the general population (Reimer, 2008).

In a sample of seven UK regions, 2% of admissions to forensic psychiatry services were over the age of sixty, with dementia the most prevalent diagnosis. They had fewer previous convictions and first had contact with psychiatric services later in life, mostly in context of their offending behaviour. (Coid, Fazel, Kahtan, 2002). 50% of the sample's offence was homicide, emphasising the severity of crimes committed by the sample. This review found that adults diagnosed with dementia whilst in prison did not have contact with forensic psychiatry services.

Longitudinal prevalence has also been researched. In a sample of referrals over eleven years to forensic psychiatric services in the UK, dementia was the most common diagnosis (19%). However, the referral process was criticised because standardised assessment tools were not used, prevalence of dementia may be higher, but unrecognised, (Curtice, Parker, Schembri, Wismayer and Tomison, 2003).

Needs of Older Forensic Population

Older adults have equal rights to specialist mental health services (Department of Health, 2001). However, their needs are unique in comparison to the wider forensic population (Yorston and Taylor, 2009). These must first be recognised in order to be met. Specific research exploring the needs of the dementia population within forensic settings has not been conducted.

Patients over-sixty in a high-secure hospital in the UK identified unmet needs regarding reduced quality of life and increased vulnerability. They identified a distinction in needs between older and younger patients which could only be

addressed using individualised care, and not assumed based upon age alone, (Yorston and Taylor, 2009).

Furthermore, older service-users in forensic psychiatric settings in the UK have expressed unmet needs regarding distress, relationships, education, treatment, physical health and memory. Numerous patients appeared to be in the wrong level of security, with the majority requiring lower restrictions, however, adequate provisions were unavailable, (Das, Murray, Driscoll and Nimmagadda, 2011). This further supports the emphasis that services should place upon meeting the needs of older service-users and adapting models of care.

Recognition in Forensic Contexts

Recognising early signs of dementia in the community can be challenging, and can be more difficult within forensic environment. Signs are easily missed due to forensic routines; a potential strategy to improve recognition will be explored.

Dementia can be recognised when 'activities of daily living' (ADL) are disrupted, restrictions of forensic services already interrupt these, with staff requiring specialist training to enhance recognition, (Simmons, Hartmann and Dejoseph, 2011).

General ADLs such as budgeting, cooking, and driving are often irrelevant within forensic contexts, and should be translated to relevant activities such as 'standing for head counts, hearing orders from staff, ambulating to the dining hall for meals', conceptualised as 'prison activities of daily living' (PADL) (Williams et al., 2006). When prisoners aged over-55 were asked about completing PADLs, 28%

self-reported experiencing memory loss. Staff biases regarding offender populations may interfere with recognition and attribution of the behaviour, for example, as defiance, increasing vulnerability of older prisoners to punishment (Maschi et al., 2012).

Current Service Provisions

It appears that in the UK, older people are 'shoehorned' into inappropriate old-age psychiatric services regardless of whether their needs are adequately met (Bullock, 2002). In the UK, independent sector specialist old-age MSUs exist, however, these have historically been criticised as being without clear theoretical underpinnings of service models (Yorston, 2002). If appropriate services remain undeveloped, older mentally-disordered offenders will remain stuck between inappropriate facilities with nowhere to go, (Yorston and Taylor, 2006). This is a wider issue than in the UK alone; those with dementia in American prisons have been referred to as a 'forgotten subgroup', within an environment that is not suitable for their needs (Maschi, et al., 2012)

Research reviewing specialist old-age psychiatry services advising forensic units has been conducted. Referrals were mainly made to obtain: diagnostic, placement and treatment advice. Diagnosis of dementia was prioritised due to the potential for treatment, difficult advice to provide was regarding appropriate placement, with nursing homes not always accepting those with forensic histories. This highlights wider issues regarding appropriate placements (Shah, 2006). For example, increased admissions to high-secure forensic services reflect the

absence of appropriate lower security services for elderly patients, (Coid et al., 2002).

Prisons have been reported to lack appropriate care for older adults, creating conditions of neglect, pain and suffering (Stojkovic, 2007). The necessity for a comprehensive model of specialist forensic old-age psychiatry service at regional level has been argued (Yorston and Taylor, 2006). Despite this research being published in 2006, few developments appear to have been made.

Implications of Inadequate Awareness and Recognition

It is clear that dementia is present within forensic settings. Professionals should be equipped to provide appropriate care, protecting from vulnerability, balancing treatment and security. If negative attitudes or biases are held, this may influence the standard of care provided, facilitating an environment that is conducive to deterioration, increasing service-user vulnerability to abuse (Williams et al., 2006; Stojkovic, 2007).

Emphasis should be upon maintaining relational security for older mentally-disordered offenders, concentrating on interpersonal factors as opposed to physical security (Yorston and Taylor, 2006). Relational security can be considered using the 'Boundary Seesaw' model (Hamilton, 2010), understanding relational security as a balance between the competing agendas of care and treatment with control and security.

Older adults in forensic services have been argued as vulnerable to systemic abuse and neglect, with most services having inadequate resources, processes, and staff numbers to manage (Stojkovic, 2007). The older population in prisons and forensic psychiatry are argued to be more susceptible to the onset of dementia due to lifestyle factors of poor health and exposure to psychological distress, compared to the general population, (Trotter and Baidawi, 2015).

General hospital nurses have reported insufficient training when caring for dementia (Gandesha, 2012). Training that improves staff awareness and recognition of dementia in residential care settings has been associated with reduced incidences of violence; cues of impending aggression that were previously ignored by staff were responded to accordingly (Chrzescijanski, Moyle, Creedy, 2007). Similar research does not appear to have been conducted within forensic organisations, where recognising risk increasing signs is crucial.

The purpose of this paper is to draw attention to the current provisions of care, staff awareness, recognition and perspectives regarding dementia of professionals within an MSU. Risk assessment tools such as the HCR-20 have not been validated upon older adults (Yorston and Taylor, 2006). Risk assessments that rely upon judgements by staff may be compromised due to lack of insight regarding their attributions and biases.

As suggested by the outlined research, if professionals are unprepared to manage dementia within forensic settings, it will influence the treatment provided but also compromise safety, security, safeguarding adults and quality of life of patients.

Method

Design

This study was a single site study, using members of staff in a Medium Secure Unit (MSU). The aim was to explore perspectives of staff regarding older adults with dementia, and their preparedness to meet their needs. The research was an iterative process, starting with a scoping exercise substantiating the rationale for the research and informing the content of the first semi-structured focus group, which was transcribed and analysed before the second focus group was conducted, *See Figure 1.*

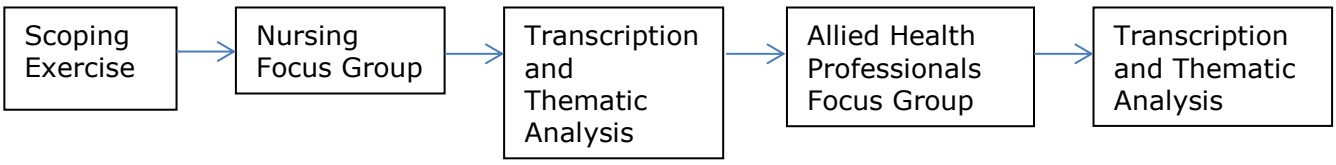


Figure 1: The research design iterative process.

Participants

Participants were current members of staff in an MSU with current patient contact. All participants were over the age of 18. Participants were included from all three care streams; Women's Service, Male Mental Illness and Personality Disorder.

The pre-study scoping exercise was distributed by email to over 300 members of staff across all disciplines, *See Table 1*. 60 participants (20%) completed the survey. Participants were given the option to provide demographic information. See *Table 1,* and their length of employment, see *Table 2.*

Professional Discipline	Number	Percentage
Nursing Staff- Support staff	24	42.1%
Nursing Staff – Qualified	17	29.8%
Occupational Therapy	7	12.3%
Psychology	5	8.8%
Medical	2	3.5%
Other	2	3.5%

Table 1. Demographic information of professional discipline of scoping exercise population.

Length of Employment	Number	Percentage
Less than a year	6	10.3%
1-5 years	24	41.4%
5-10 years	11	19%
10+ years	17	29.3%

Table 2. Length of employment of scoping exercise population.

Two focus groups were conducted the first consisted of 6 participants from the Nursing directorate (Registered Mental Health Nurses and Healthcare Support Workers). The second group, referred to as Allied Health Professionals (AHP) group, with 5 professionals from the Psychology and Occupational Therapy departments. With 11 participants in total, and due to the qualitative nature of the research, a priori power analyses were not required, with widely accepted standardised focus group sizes of 5 or 6 per group.

Procedure

Scoping Exercise

The scoping exercise was distributed by email and explored current training, interventions, policies and procedures within the MSU (*Appendix A*). The survey was completed online using Bristol Online Survey, open for one month, with a second email prompting further responses.

Participants were given the option to volunteer their contact details if willing to participate in focus groups, and were later invited to attend.

Focus Group

Participants were provided with a Participant Information Sheet (*Appendix B*) and Participant Consent Form (*Appendix C*). Confirmation was obtained that they had understood and written consent was witnessed by the researcher. To maintain consistency, both focus groups were conducted in the same room, at the same time of day, with the same facilitator. The content of the first focus group topic guide (*Appendix D*) was based upon the results of the scoping exercise; following a semi-structured approach.

The first focus group consisted of staff from the nursing directorate; proportionately the largest staffing group, with the most patient contact. After the nursing focus group was conducted, the discussion was transcribed and thematic analysis conducted. The findings were combined with the scoping exercise results to inform the second focus group topic guide (Appendix E), forming an iterative process. The second focus group was then transcribed and thematic analysis conducted.

Analysis

Information obtained through the scoping exercise is reported using descriptive statistics. The focus groups were transcribed and analysed using thematic analysis following the methods described by Braun and Clarke, (2006).

Ethical Approval and Confidentiality

The research project was approved by the University of Nottingham School of Medicine Faculty of Medicine Research Ethics Committee (*Appendix F*). It was approved on site by the Research and Development Committee, chaired by Clinical Director (*Appendix G*). The research received University of Nottingham Sponsorship Approval (*Appendix H*). The scoping exercise was approved by Nottinghamshire Healthcare NHS Foundation Trust Research and Development (R&D) as a scoping exercise, and therefore did not require further ethical permissions (*Appendix I*). The research did not require approval by the NHS Research Ethics Committee or Health Research Authority due to being a single site, staff only project. The research was reviewed by the R&D Department Lead and Manager (*Appendix J*).

Participants were recruited by virtue of their professional role, volunteered and were under no obligation to participate. Confidentiality and anonymity were assured. To protect patient confidentiality, no identifiable information was used. Participants were not exposed to any further distress than currently experienced within their employment. In recognition of potential distress, a qualified forensic psychologist was available on the premises whilst the focus groups were

conducted to provide support. Contact details for a clinical psychologist were also provided for any subsequent dementia related issues. These were not required.

Results

Scoping Exercise

Respondents were permitted to complete the survey after confirming that they met the inclusion criteria. Sixty participants completed the survey. It was clearly stated that the questions being asked were about this MSU only.

Prevalence of Dementia

The responses indicated that within the MSU, a population of patients with dementia exists; supporting the rationale for the research, *see Table 3*.

Response	Frequency
Yes	32 (53.5%)
No	13 (21.7%)
Unsure	15 (25%)

Table 3. Responses to the question: 'To your knowledge, are there currently any patients with a diagnosis or suspected diagnosis of dementia?'

Adequacy of Training

Training informing the treatment of older patients does not appear to be available, *See Figure 2.* Those who answered yes, were asked to provide further details: '*mandatory training warns of dangers of physically managing elderly patients'*, which suggests focus upon physical management.

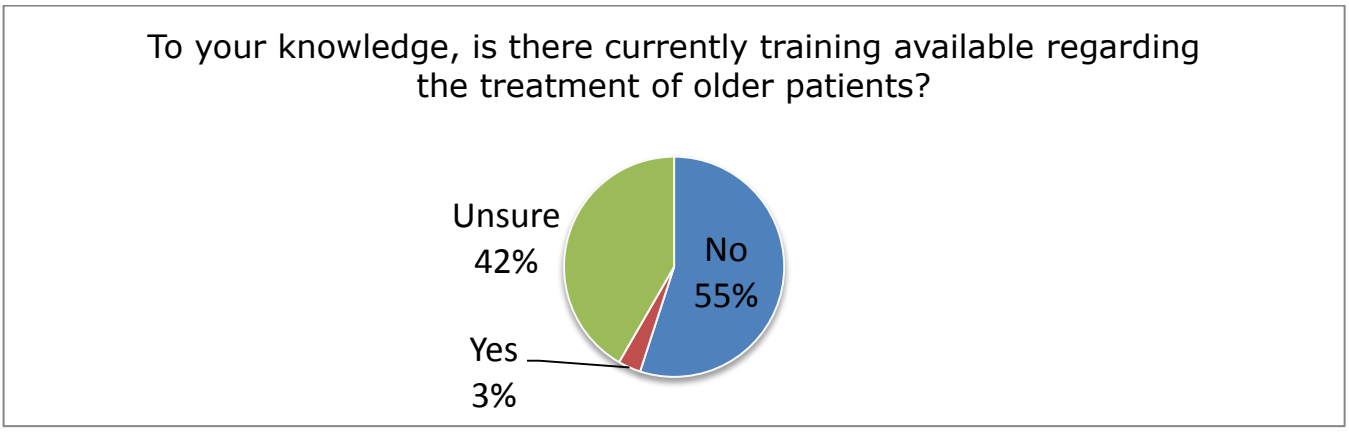


Figure 2. Participant responses regarding current training available concerning the treatment of older patients.

Provision of Cognitive Assessments

Cognitive assessments appear to be conducted in response to concerns raised, *See Figure 3*. Participants seemed unsure regarding when they are carried out, and which assessments are used. The most recognised assessments were Mini-mental State Examination (MMSE) and Wechsler Adult Intelligence Scale (WAIS*), see Table 4*. Two participants responded 'other' reporting '*DKEF*'s' and '*WMS*'.

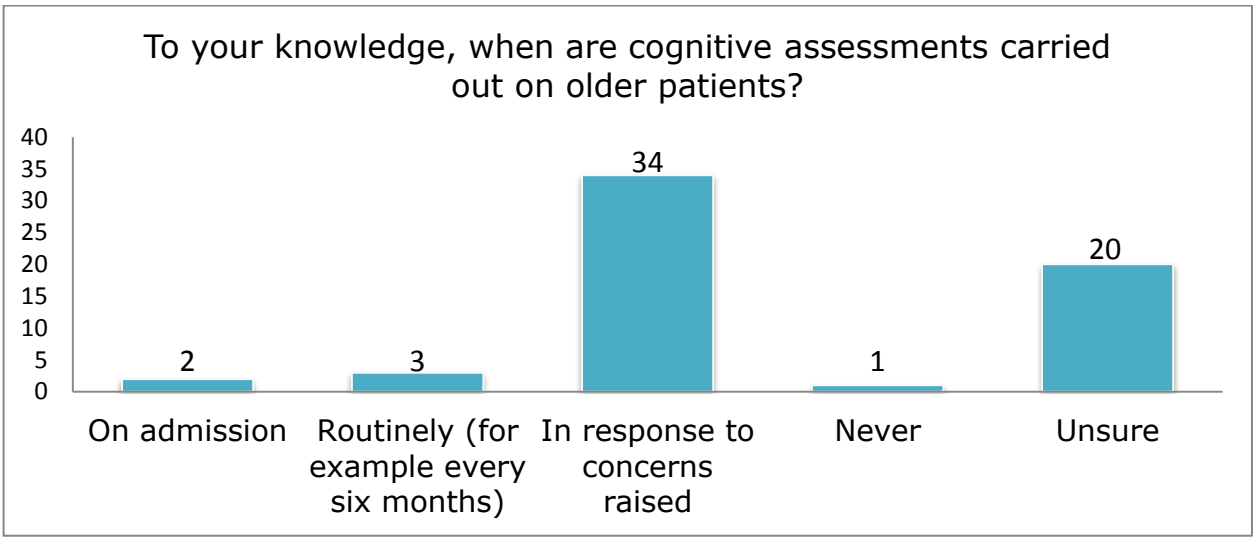


Figure 3. Responses regarding when cognitive assessments are conducted upon older patients.

Cognitive Assessment	**Frequency**
Unsure	42 (51.2%)
Mini-mental State Examination (MMSE)	15 (18.3%)
Wechsler Adult Intelligence Scale (WAIS)	13 (15.9%)
Repeatable Battery for the Assessment of Neuropsychological Status Update (RBANS)	6 (7.3%)

Other	2 (2.4%)

Response	Frequency
Yes	8 (13.3%)
No	4 (6.7%)
Unsure	48 (80%)

to the question: 'To your knowledge, which cognitive

out on older patients?'

External Consultation with Specialist Services

When asked whether the hospital liaises with external specialists in older-age mental health, most responses answered 'Unsure', see *Table 5,* highlighting the lack of awareness of processes and resources available. Responses providing further details considered '*case specific basis', 'colleagues within the trust'* and '*if the patient in question is not likely to fully benefit from the service provided, then the team may refer them to another suitable placement venue*.'

ion 'Does the hospital currently liaise with external

ealth?'

Awareness of Policies and Procedures

Most respondents were 'unsure' when asked about local and trust wide age-related policies and procedures regarding older patients *See Table 6*. Indicating that there may not be specific policies or respondents are unfamiliar with them, suggesting that should age-related issues arise, staff would be uncertain where to source guidance.

Response	Hospital	NHS Trust

Yes	5 (8.3%)	17 (28.3%)
No	14 (23.3%)	3 (5%)
Unsure	41 (68.3%)	40 (66.7%)

Table 6. Responses to the question: 'Does the hospital currently liaise with external specialists in older-age mental health?'

Access to Specialist Services

Results indicated an awareness of specific services for older patients for physical healthcare, suggesting an emphasis upon physical needs. Access for cognitive needs was much lower*, see Table 7*. Potentially due to lack of awareness they exist, or lack of recognition that they are required.

Service	**Frequency**
Physical healthcare (internal)	56 (25.7%)
Physical healthcare (external)	47 (21.6%)
Psychology (internal)	49 (22.5%)
Psychiatrist (internal)	41 (18.8%)
Geriatrician	5 (2.3%)
Memory Assessment Service	10 (4.6%)
External Older Mental Health Services	7 (3.2%).

Table 7. Responses to the question: 'Which age-related services can patient's access?'

Primary Needs of Older Patients

Psychological factors were considered the most important primary need for older adults, followed by risk management factors, suggesting that psychological wellbeing and safety are prioritised, see *Table 8*.

Factor	**Rank**
Psychological Factors	1 (23, 38.3%)
Risk Management	2 (17, 28.3%)
Physical Health Factors	3 (21, 35%)
Vulnerability Factors	4 (17, 28.3%)
Environmental Factors	5 (21, 35%)

Table 8 Ranked scores of primary needs of older patients.

Age-Specific Interventions Available

Interventions are offered, however are likely to be generic activities that are offered to all patients, as opposed to age-specific. Those who responded 'other' were invited to provide further details in free text format; three responded '*none*', another response was '*Sensory Integratio*n'. *See Table 9.*

Intervention	**Frequency**
Meaningful activities	52
Exercise	51
Self-Care	40
Outdoor space	41
Age specific groups	39
Other	5

Table 9. Frequency to the question 'What interventions are currently available specifically for older patients? Multiple responses were accepted.

Results

Focus Group Thematic Analysis

This section will explore the over-arching and main themes of the research. The thematic analysis is diagrammatically represented by thematic maps. As each theme is explored, the map for that theme will be displayed, followed by the items within the theme in further depth, supported by quotes from the focus groups. The themes will be discussed in order of their elicitation during the thematic analysis. The full maps will then be presented. The second map is the final map, based upon the iterative process. The themes were identified using thematic analysis, as described by Braun and Clarke, (2006).

First, the over-arching theme of forensic risk will be discussed, as this was the most prominent theme throughout the research. Consistent with the findings of the scoping exercise, safety and forensic risk were considered a priority.

The themes will be discussed in the following order:

- **Staff Attributions**: the influences of individual biases upon perceptions of risk, recognition and management.
- **Organisational Factors**: communication and processes at all levels, particularly the model of care and supervision.
- **Lack of Awareness**: recognition of signs and symptoms, adequacy of reporting and documentation.
- **Interventions**: the appropriateness and adaptation of treatment options.
- **Vulnerability**: susceptibility to abuse and neglect, influencing forensic risk.

Items that are within more than one theme have dashed line borders on the thematic maps. During the written explanation, quotes will be used to demonstrate the content. The source of the quote will be in the format: (P1, G1), Participant 1, Group 1.

1. Forensic Risk

The over-arching theme of forensic risk is consistent throughout. Items within the cluster of forensic risk include perceptions regarding risk of violence, being unable to reduce risk, frustration increasing risk and relevance of age to risk. Forensic risk was considered a priority, consistent with the scoping exercise. Some issues cross themes, and will be explored further within other themes.

*'Safety comes first, it's not always mental state it's always safety' (*P3, G1)

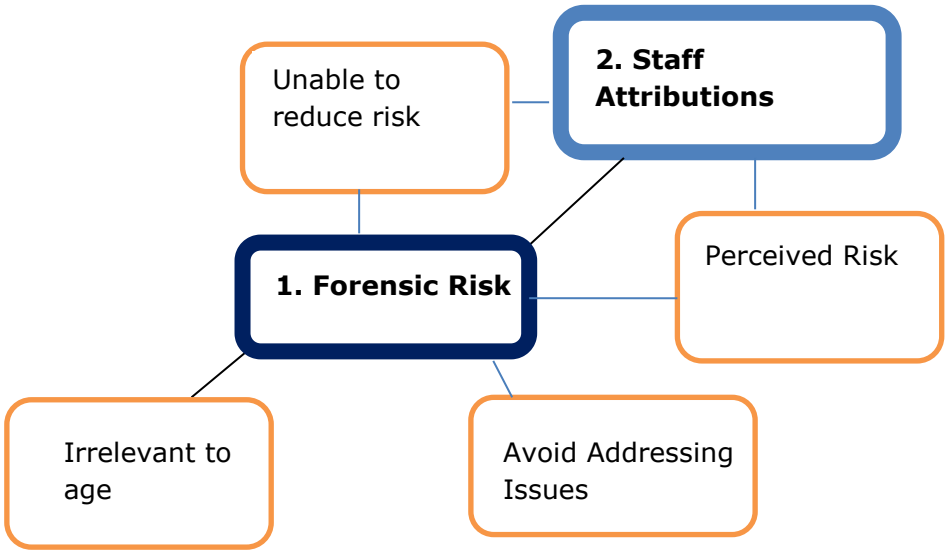


Figure 4. Thematic analysis map of Forensic Risk in nursing group

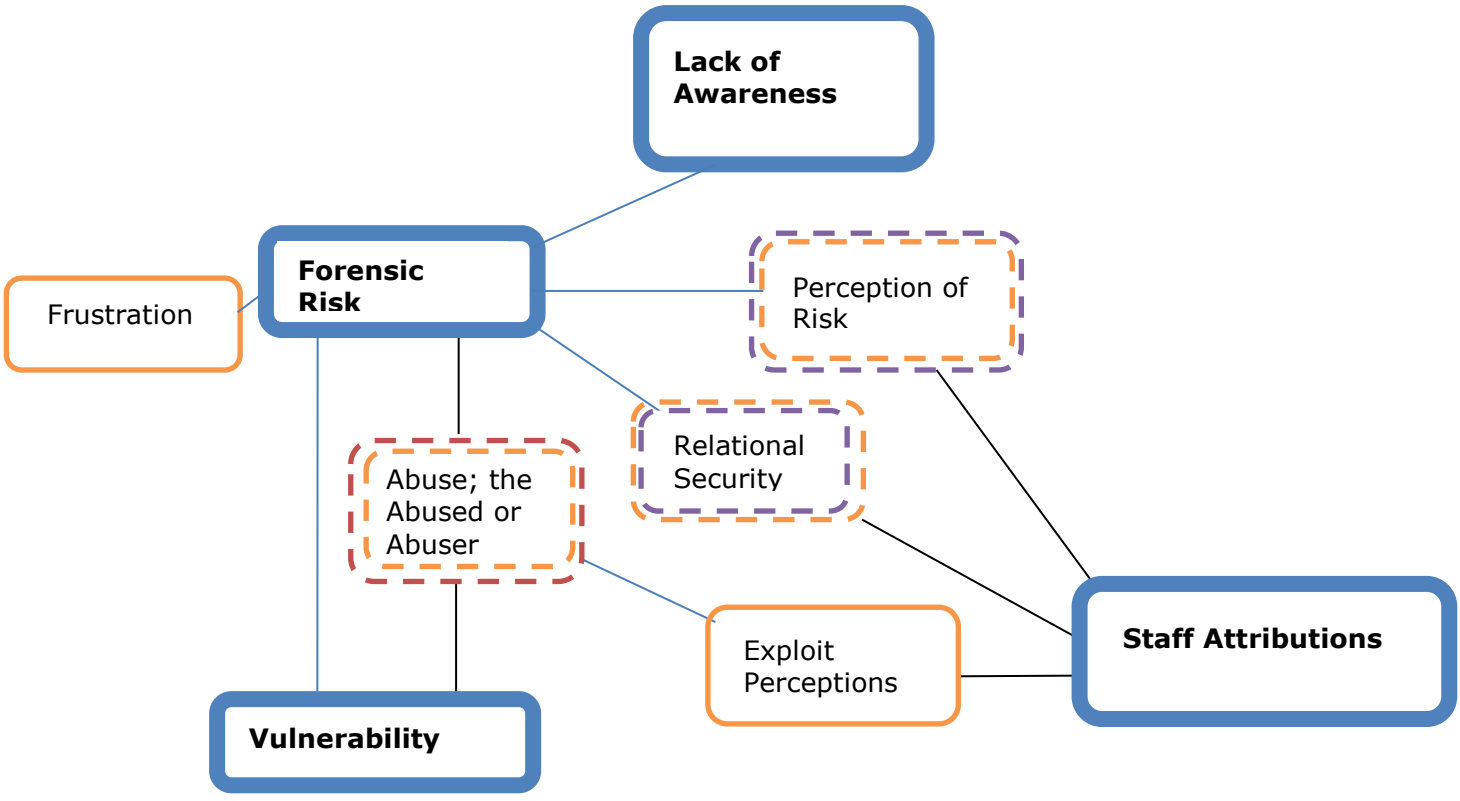


Figure 5. Thematic analysis map of Forensic Risk in Allied Health Professionals group

Frustration Increasing Risk

Frustration was perceived a contributing factor to forensic risk, exacerbated by factors of confusion, memory loss and dementia.

'There's a lot of frustration if he forgets something…if he can't articulate something then that frustration… Really he gets like angry, not with like you yourself, but with himself' (P3, G2).

'Become impulsive as they become confused, as they become frustrated,' (P1, G2)

Risk Irrelevant to Age

Participants disagreed whether forensic risk changes with age, with some participants acknowledging staff attributions influencing risk assessments, and others stating that age is irrelevant to risk, further explored within Staff Attributions.

'In a forensic setting they're dangerous, don't matter if your eighteen years old or ninety years old' (P3, G1)

2. Staff Attributions

The nursing group raised staff attributions in context of perceived risk and ability to reduce risk. The AHP group were reflective of the processes that inform attributions, discussing influencing mechanisms. This was developed as a main theme upon the final thematic analysis map.

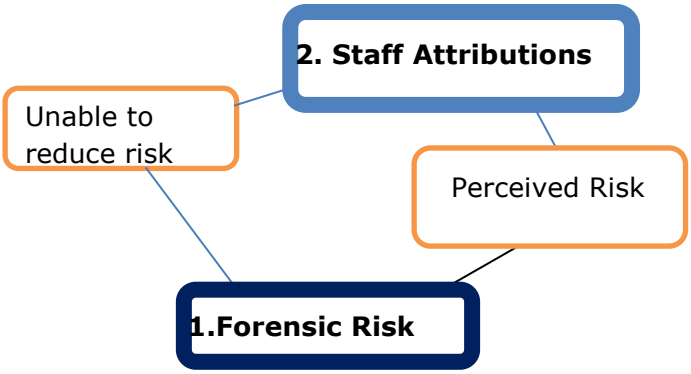


Figure 6. Nursing group thematic analysis map of staff attributions

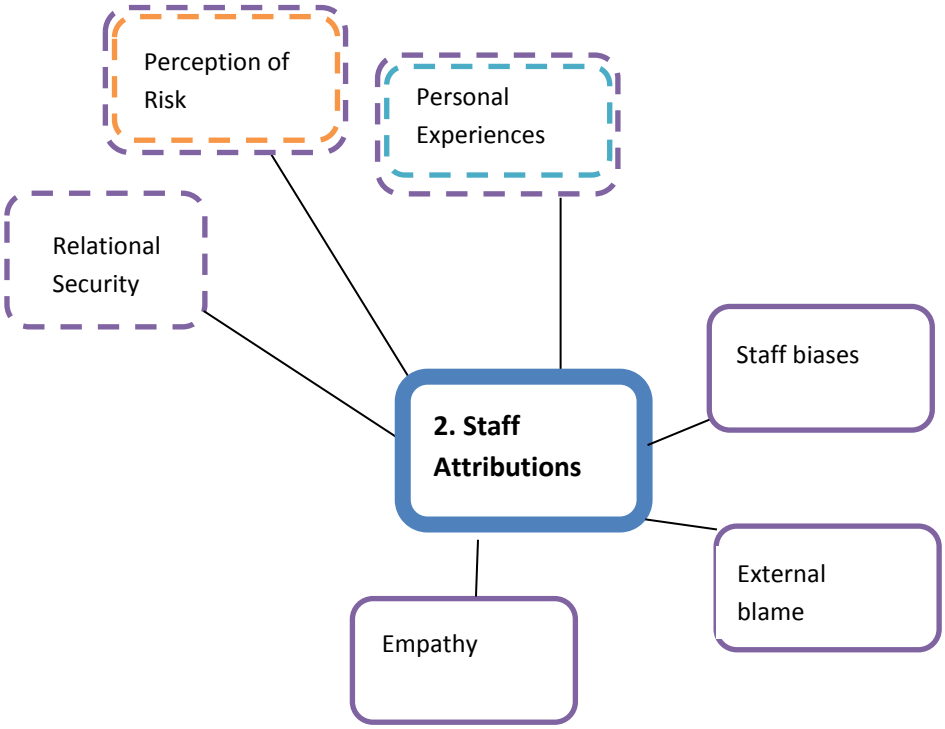


Figure 7. Allied health professionals thematic analysis map of staff attributions

Personal Experiences Influencing Recognition, Management and Treatment

Some staff members were perceived to change their approach when caring for older adults, potentially as a consequence of personal experiences influencing biases, as opposed to information gained within professional roles.

*'Staff changes behaviour, when they're with like a, ninety year old, to a twenty year old, they have a more caring approach to the older person than with the younger person' (*P3, G1)

'People you know, in your life, you're not basing that on professional, kind of, competencies' (P3, G2)

Symptoms were not routinely attributed to cognitive decline.

'Hard to get people to break away from that, because if we're looking at mental state deterioration, that's a completely different ball game, and so we're going into the unknown, and people are a bit like "I don't quite know where are we going with that", it's

safe for them to say 'behavioural', they know where that's… where they stand with that'. (P2, G1)

Perceived Inability to Reduce Risk

Nursing staff alluded to the belief that risk cannot reduce, and some patients may be beyond rehabilitation; influencing effort exerted into risk-reducing interventions.

*'To manage their dangerousness, when they go into the community, there's less time for that with older patients, they may already have a long history' (*P2, G1)

*'To reduce their dangerousness, they may not have as much scope to actually make those actual changes, erm, because it's so ingrained in them' (*P2, G1)

Attributions Influencing Perception of Risk

Nursing staff were believed to often unconsciously perceive risk to be reduced.

*'You're off your guard more' (*P3, G1)

*'Probably not a conscious thing' (*P1, G1)

*'People go more easy on older people, than they do younger, even though they're just as dangerous' (*P3, G1)

Within the AHP group, a more reflective perspective was portrayed, suggesting awareness of risk being under-estimated, potentially altered by external influences.

*'Nursing staff might underestimate that kind of risk, especially if that person is a likeable person' (*P1, G2)

*'Because they are a small population, people's biases often come from externally' (*P1, G2).

Relaxed Relational Security

Biases were perceived to influence the enforcement of rules. Compromised relational security and relaxed boundaries were justified, suggesting that deterioration is inevitable and quality of life outweighs reinforcing boundaries.

*'Tempted to bend those rules'. (*P1, G1)

'If you're looking at, like, how much are you going to be able to change, in the back of your mind, like how much is us, enforcing certain things going to actually get you better'. *(*P2, G1)

*'A lot of staff hold real biases, and will be flexible with stuff like boundaries, to accommodate, because, personal experience of dementia, like a family member' (*P1, G2)

Empathy Influencing Treatment

The AHP group discussed the influence of empathy. Dementia was perceived to activate more emotional connotations than other diagnoses, potentially due to personal experiences. This was associated with reflective practice and remaining aware.

*'People are generally more sympathetic about a person's risk, if they know that they have a diagnosis of dementia as opposed to, for example personality disorder'… 'It's a bit external, it's a demon it's dementia' (*P3, G2)

*'It takes over a person' (*P1, G2)

*' It's something that happens to you… one means bad risk and one means risk that you can't help, rather than, as you said, it's actually much more complex than that' (*P3, G2)

3. Organisational Factors

Issues within the organisation were perceived to be influential in the treatment of older adults, particularly with dementia. The model of care, the need for an appropriate care pathway and adapted treatment goals were emphasised. Both groups valued individualised care, and felt improvements could be made to communication and formal processes.

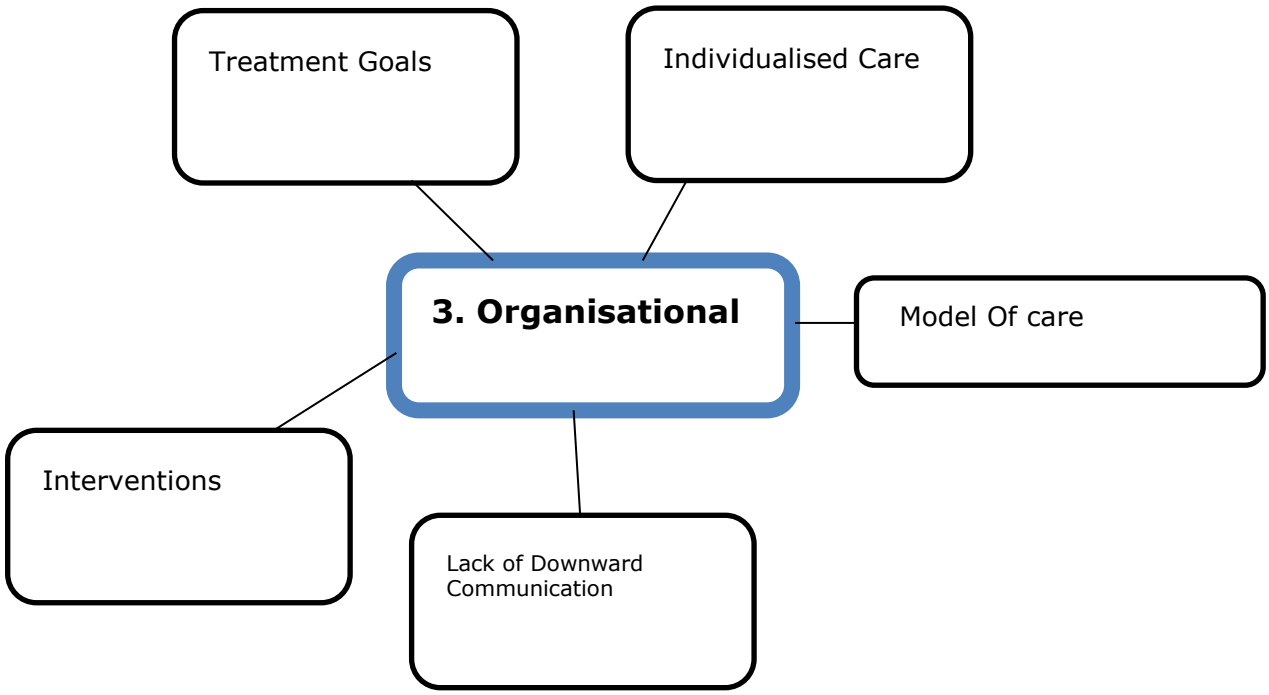


Figure 8. Nursing staff thematic analysis map of organisational subtheme

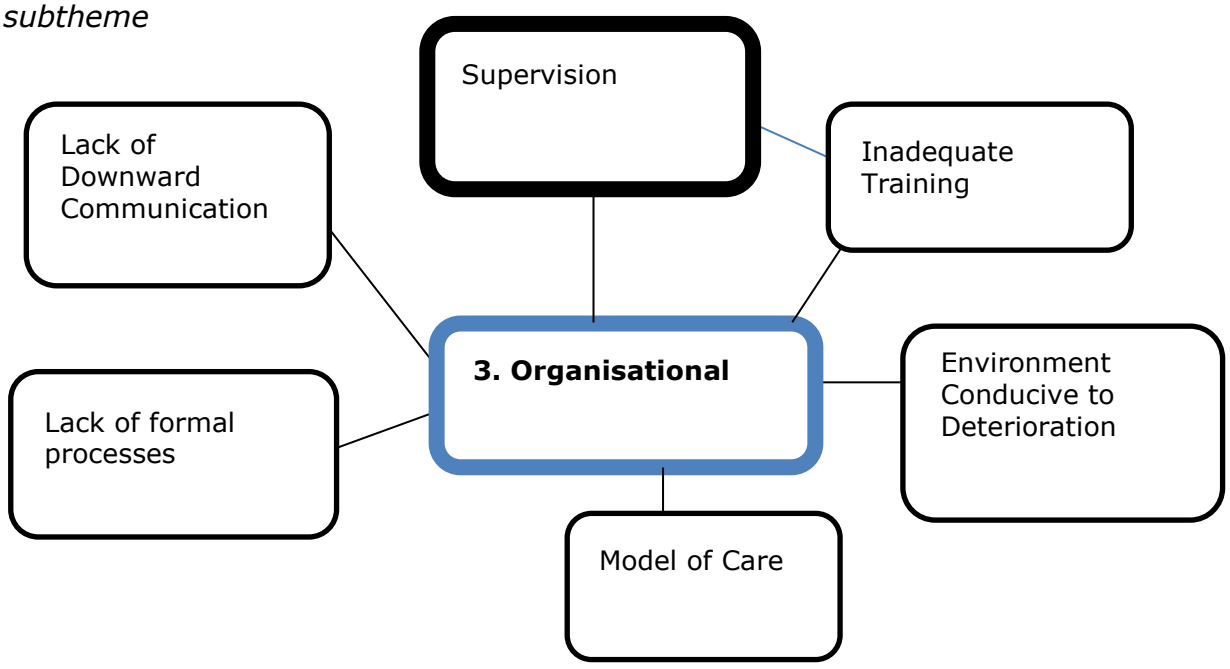


Figure 9. Allied Health Professionals thematic analysis map of organisational subthemes

Model of Care

The way that treatment is delivered, including the best practice during progress through treatment was discussed. Due to the emphasis on recovery and rehabilitation, older adults and those with dementia were not perceived to fit the current model.

'You would be looking at a different model of care, which we don't offer' (P2, G1)

*'The treatment, the groups and the system would be more of a, more of a moving down and moving on' (*P2, G*1)*

*'The recovery model approach of care or something, where you're looking at them, defining, like, how they see their mental illness in order to like progress forward, and how to manage it, and to manage their dangerousness, when they go into the community,'… 'they may not have as much scope to actually make those actual changes, erm, because it's so ingrained in them' (*P2, G1)

*'Elderly care isn't the focus of … our kind of care pathway' (*P2, G2)

*'It does make you question whether we do recovery, with older adults' (*P3, G2)

*'We just sort of write them off' (*P5, G2)

Emphasis on Individualised Care

Individualised care was valued, identifying and meeting needs informally. However, they felt constrained by low staffing numbers and not knowing where to prioritise interventions due to inadequate training.

*'We've implemented our own structures haven't we… like, when we get the patients up in the morning, you make sure he gets up, you knock him up, and say "are you getting up", whereas before, you'd leave him like everyone else and you'd be waiting for him for meds and he would still be in the shower, so we've sort of just done it ourselves haven't we, we've discussed it and implemented actions.' (*P6, G1)

*'If you've got five young people wanting to play a certain game, and one old person wanting to do this, and it's only you, you have to give your time to the majority' (*P3, G1)

Inadequacy of Training

Within both groups there was emphasis upon the inadequacy of training, leading to reliance upon personal experiences. Training regarding physical management was recognised, correlating with the scoping exercise.

'getting them up and moved on a daily basis, we do, we do it safely, erm but it probably takes a bit more thinking' (P2, G1)

'Cause there's no formal training it's just off our own backs really isn't it' (P6, G1)

'There's a definite need for more information' (P4, G1)

Organisational factors were given further consideration by the AHP group, and the following subthemes were also apparent.

Environment Conducive to Cognitive Deterioration

Patients were perceived to decline faster than in the community. Factors within the environment were associated with numerous items identified within the vulnerability theme, particularly lack of stimulation.

'I often think that some of our patients are almost ten years older than they actually are, to look at them sometimes, that just I think because of lifestyle, or whatever it is, they do seem to be more impacted upon by the ageing process'

*'We spoon feed our patients everything' (*P4, G2)

*'They don't do anything for themselves, they don't have to cook for themselves, they don't have to clean for themselves, so you're brains going to decline, so if someone sort of says, oh he's forgotten his keys, it's because we've all got a key on our belts, I'd leave my key in my room' (*P4, G2)

Lack of Formal Organisational Processes

There were no policies or procedures referred to within either of the groups. Both groups sought to clarify amongst themselves whether the hospital currently has an age threshold or admission criteria. Informal discussions were referred to.

*'Who are the older adults?' (*P3, G2)

*'Informal discussions with someone, it's not through the formalised process' (*P1, G2)

Lack of Downward Communication

Despite not being familiar with all organisational processes, the AHP showed awareness that they exist. It was raised that these are not sufficiently communicated across the organisation. Nursing staff did not acknowledge these.

'*There's loads of processes that happen above us, there's like the male mental illness forum, there's loads of other places where they are more aware of it, but I don't think that's filtered down to us' (*P1, G2)

Need For Specialised Supervision

The AHP participants recognised that inadequate training not only affects their knowledge, but also their ability to manage their emotions when dealing with complex patients. The desire for specific supervision was highlighted, particularly when linked to personal experiences of family members with dementia. Furthermore, care which is not focused around recovery may require a different model of supervision.

*'We don't really have anything, like we said before, training, on what to look out for, but also training on how to cope with … I mean like managing how you cope as a person … With working with someone who is long term care' (*P1, G2)

*'Feeling quite like, oh well that's not why I came to work here' (*P2, G2)

Organisational Processes Reactive Not Preventative

Information and training is delivered to staff when a need arises, correlating with the findings of the scoping exercise.

*'It's come up when it's needed it's never been put in place first' (*P5, G2)

4. Lack of Awareness

Recognition of the cognitive signs of dementia appeared to be poor amongst the sample, with emphasis upon the physical signs. Most knowledge appeared to be based upon personal experiences. Other challenges include the routine masking symptoms and symptoms being co-morbid with mental illness. Due to crossing themes, personal experiences have been discussed within the Staff Attributions theme.

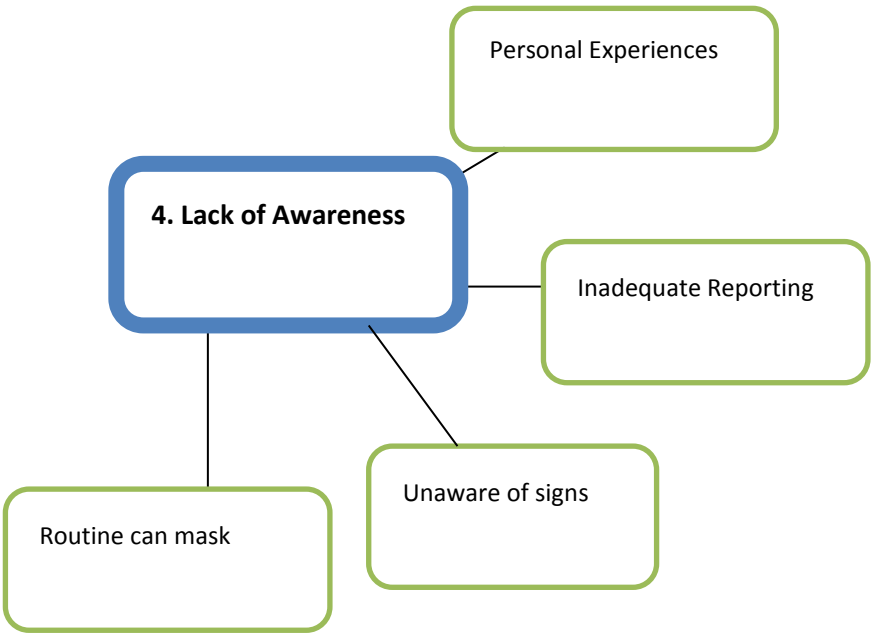


Figure 10. Nursing staff thematic analysis map of Lack of Awareness subthemes

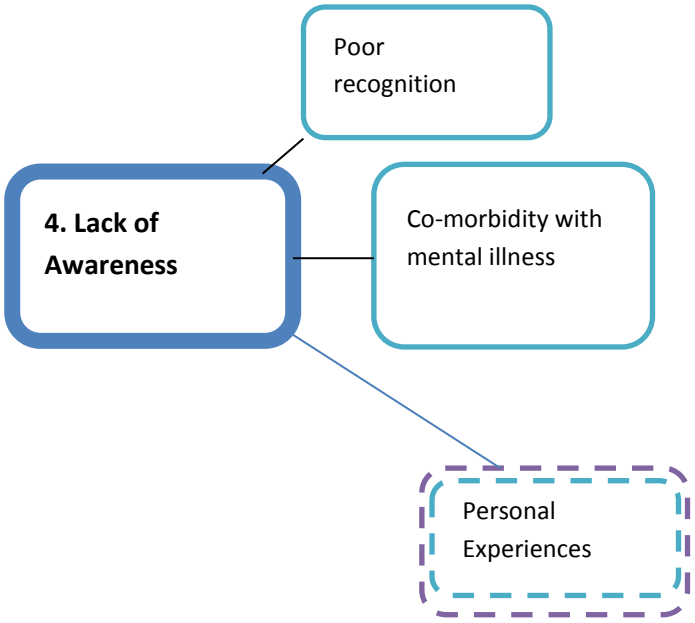


Figure 11. Allied Health Professionals thematic analysis map of Lack of Awareness subthemes

Unaware of Signs of Dementia

Neither group listed specific cognitive signs or symptoms of dementia. Overt physical signs were discussed, which supports the organisational factor of inadequate training.

'Unless there was something really obvious, like coming out of their room having wet themselves and not realised… Until it's something big like that, that's when you start taking it seriously' (P3, G1)

'That makes it come down to the training, if staff knew what older needs might be and what early signs might look like, you know' (P2, G2)

Inadequacy of Reporting

Due to a lack of awareness and recognition of symptoms, reporting them is often inadequate, preventing discussion within the multidisciplinary team and early interventions. An organisational drive to raise awareness was suggested.

'You pick up on it, but it's the fine line between when do you start actually implementing things' (P2, G1)

*'Does it get documented? That might be a thing it might be in handover a passing comment, like oh they're a bit forgetful today, during handover but does it get documented enough to be passed on' (*P5, G1)

*'I need to record that today, because that training, tells me that this is important' (*P2, G2)

Routine 'Masks' Signs, Preventing Recognition

The forensic environment is structured with routines, with minimal control over the environment. Recognition is therefore harder because symptoms can be masked by routines.

'*Got set routines, so, within that, there are, you can sort of, they may be able to mask it better' (*P2, G1)

'*If they are starting to forget things, they're given a knock on the door in the morning, told to get in the shower, have a towel put in their hand, you have* meals at certain times of the day it's very easy to just go where you're told to go' (P2, G2)

*'One of the first signs that you might be getting dementia is that you get lost in places, that you should know, erm, and you're thinking well, you wouldn't notice signs like that' (*P2, G2)

*'You're not gonna see that unless you take the structure away' (*P5, G2)

Professionals Avoid Addressing Concerns

Some members of staff appear to avoid discussing concerns regarding symptoms of dementia with patients in order to avoid negative interactions. However this prevents meaningful engagement.

*'Not focusing too much on it as well because I think that would upset him, to think oh I've forgotten' (*P4, G1)

*'Giving prompts, and reminding, without focusing very much that, "you are forgetting", or 'we've already told you that', it's just generally sort of sweeping over it and just sort of, just reminders.' (*P4, G1)

Poor Recognition

Recognition was not reported to be sufficient, with limited awareness of the signs to identify. The AHP group felt that they were more likely to notice changes than nursing staff, due to longer time between sessions, and emphasis upon recall during psycho-education sessions

'*Lower in the cognitive functioning than what we would expect, the decline either isn't as dramatic as it would be in the community, or by the time the dementia becomes visible, the decline is so strong' (*P1, G2)

*'you're more likely to pick up on those kinds of things if that session is about "let's recap what we did last week" and think about that and "can you remember that" you do pick up on those kinds of things' (*P3, G2)

*'I think it's quite different, from sort of, our perspectives, to nursing staff, because we don't see them every day, it's not like we've got that constant drip feed of not noticing change, when it happens, if you see them so regularly, but when we see them only once a week, or once every couple of weeks, there's suddenly the difference, which can be quite, dramatic' (*P1, G2)

Co-Morbidity with Mental Illness

It is difficult to recognise and diagnose dementia when also present with symptoms of another mental disorder.

'*Difficult to distinguish, actually what's dementia, and what's the mental health difficulty' (*P3, G2)

5. Interventions

Within the first group, interventions were referred to, however, not focused upon, and thematically were perceived within the organisational theme. Within the AHP group, developing and delivering interventions is a more prominent aspect of their role. There were numerous crossed items with the vulnerability theme.

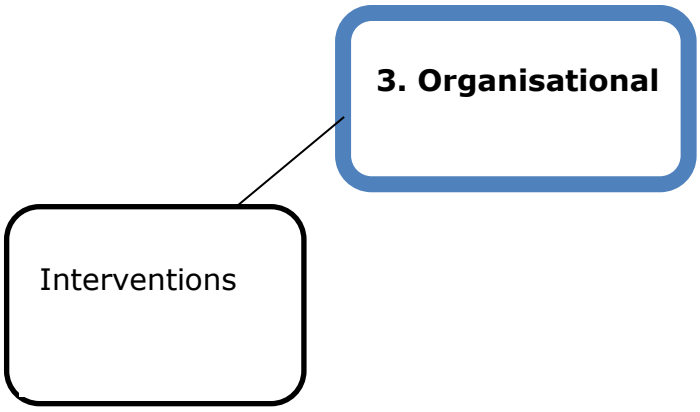


Figure 12 Nursing group interventions as a subtheme of organisational theme

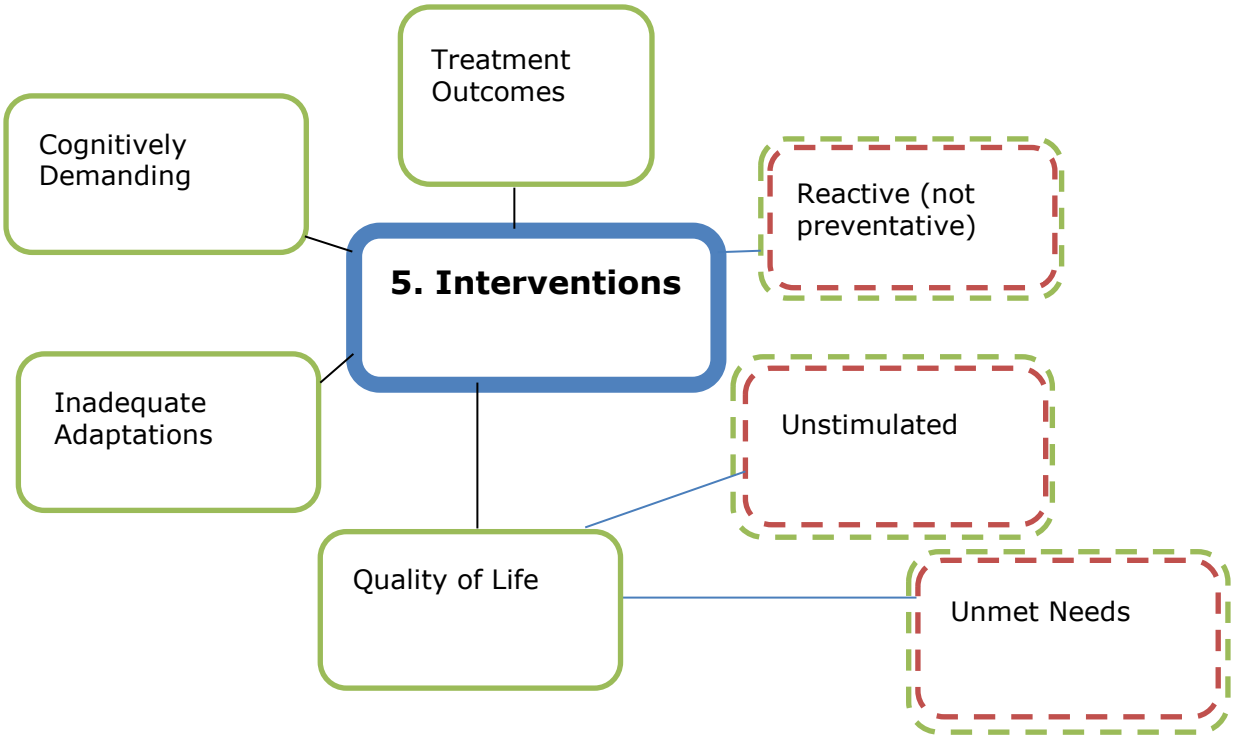


Figure 13 Allied Health Professionals map of thematic analysis of interventions theme

Inadequate Adaptation of Interventions

Within the AHP group interventions are not adapted to make them more accessible specifically for older patients or those with dementia. Adaptations have been made for physical needs, but not cognitive decline.

*'It's made me really aware of is that I make no differentiation I make no allowance of anything that I deliver, that did actually make me stop and think, that's something that I've not even considered, in my materials or in anything that I offer', (*P5, G2)

*'I've done a few sessions, designed for people who can't move as quickly, who can't erm operate (machinery)' (*P4, G2)

However, the group did feel that their approach adapts and addresses issues sensitively, whereas nursing staff can avoid addressing issues.

'*A culture where you can have those basic but sometimes uncomfortable conversations, of we know that you're struggling with your memory sometimes, you sometimes forget things, how would you like us to remind you*' (P3, G2).

Interventions Overly Cognitively Demanding

Current interventions were perceived to be cognitively demanding, excluding those with cognitive decline, with emphasis upon psycho-education and Cognitive-Behavioural models, requiring memory and recall.

*'Our interventions kind of naturally exclude people with dementia as well, just in the sense that a lot of it is kind of psycho educational, building on knowledge, retaining knowledge, practicing and I guess the fact that if somebody lacks the capacity to do that, more so you know than that average person on the ward, I think it kind of makes it very difficult to do work with them' (*P3, G2)

Increasing Quality of Life

Some interventions are delivered exclusively to increase quality of life, which was valued amongst the group, addressing vulnerability factors.

'*Quality of life sessions, and or aim is to sort of do what they used to do, like woodwork and stuff' (*P4, G2)

*'We have to kind of balance those "ok well you're here for active treatment, that person's here for quality of life"' (*P2, G2)

Both groups discussed the 'SAGE' group, a collaborative social group between nursing staff and the OT department for patients over 50, meeting monthly to watch old films. The groups did not explain the abbreviation, upon further enquiries after the groups were conducted the abbreviation is: '*Support Advocacy Group Elderly'*. The AHP group highlighted the opportunity for this group to be developed as a peer support group in which experiences are shared, as opposed to for quality of life only.

> *'On a monthly basis, but even to say like, one in a quarter, we won't put a movie on, we'll just discuss your experiences of, as someone who reaches the age for the group, what's your experience within the hospital'* (P2, G2)

Inappropriate Treatment Outcomes

The purpose of treatment within the model of care is to move on and progress, however, older adults and those with dementia do not have the same treatment goals. Individualised care was discussed, and separate outcomes identified to meet their specific needs.

'*How can we still improve their functioning or maintain the level they're at' (*P1, G2)

'*Slip off the radar, cause we've not got that focus for them, for their future, we're not planning for their future beyond from here', (*P5, G2)

6. Vulnerability

Within the vulnerability theme, prominent items included social isolation, being forgotten, unstimulated, neglected and targeted by others. The nursing group did not appear to acknowledge the links between vulnerability and forensic risk. The AHP group made links between vulnerability and the forensic risk and intervention themes, particularly how the interventions could address the vulnerability factors.

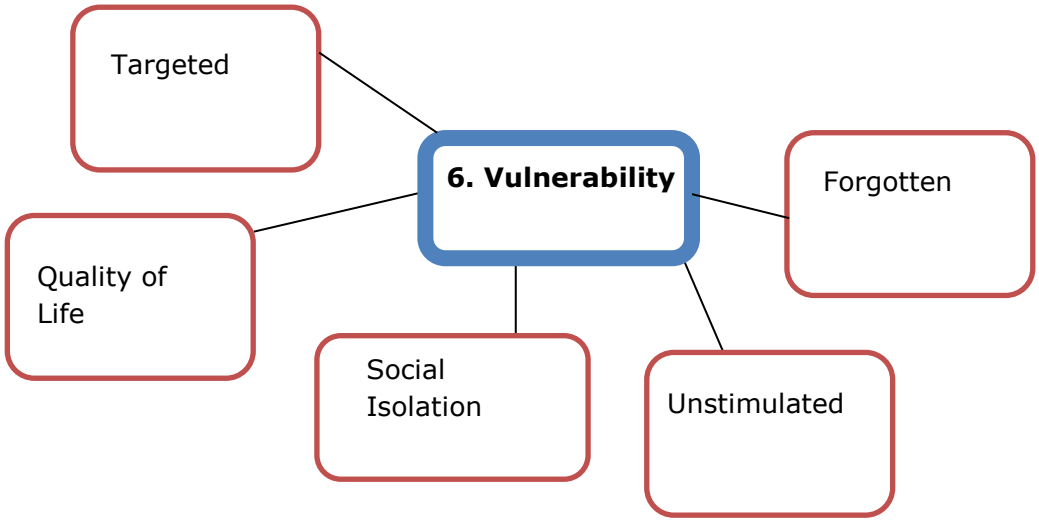


Figure 14. Nursing Group thematic analysis map of vulnerability theme

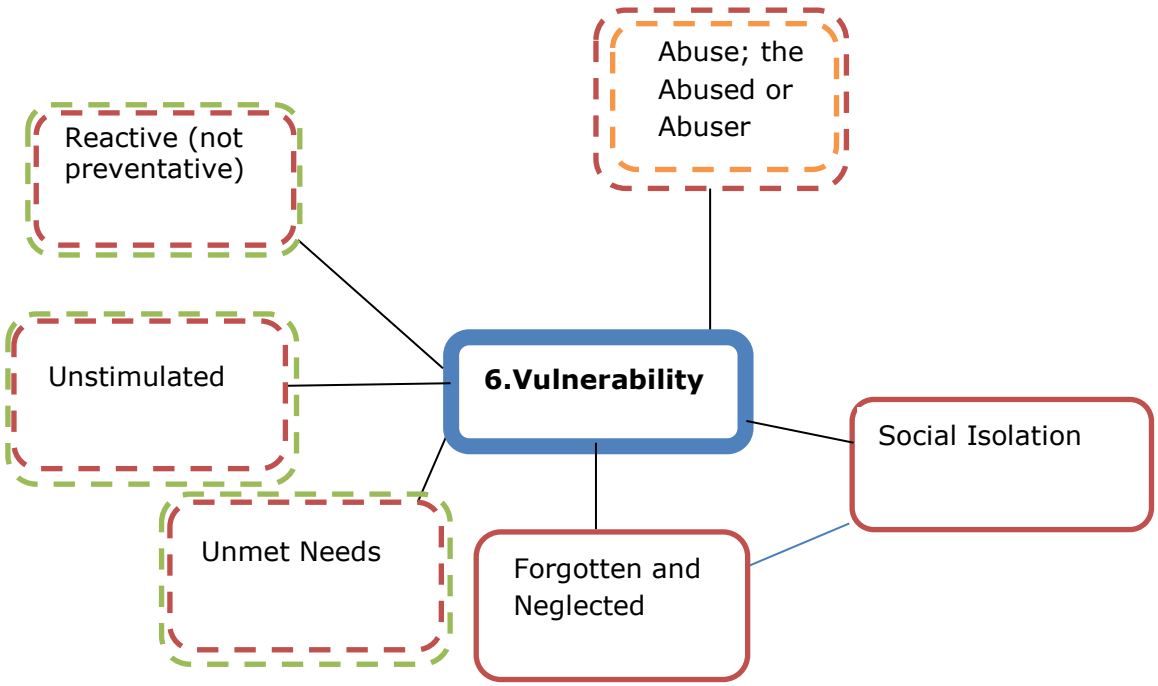


Figure 15. Allied Health Professionals Group thematic analysis map of vulnerability theme

Lack of Cognitive Stimulation

Older adults were perceived to be susceptible to decline due to lack of stimulation, which could be addressed through adapted interventions if awareness increased.

*'They can just end up sleeping in the chair if there's not someone there to encourage to do otherwise, they're quiet cause they aren't causing any trouble, so you could tend to leave him, just to sit there, and he would just sleep all day, which I suppose wouldn't help him improve would it really, only decline, rather than just sat there like a zombie in a chair' (*P6, G1).

*'Very few, certainly in male mental illness, will you see them sit there reading a book' (*P4, G2).

Forgotten and Neglected

Patients may not only be unstimulated but forgotten, ignored and neglected; interacting with the subtheme of social isolation. This issue was particularly pertinent when discussing prioritising staff time due to other patients presenting management issues, neglecting quieter patients.

*'They're more at risk of just being left. Left alone and not interacting with as much' (*P4, G1)

*'Creating even the time to use the resources that you might have, that we have on other wards, it becomes more difficult, because erm, you're firefighting, and as we said it just gets left, if someone's asleep it's harder to have to create time for someone who's not a management problem. Because you're spending time dealing with someone who has an obvious management problem for the sake of safety' (*P2, G1)

Socially Isolated

Social isolation was discussed in context of the MSU environment with peers, with older adults as the minority, with different interests and life experiences.

*'More vulnerable, make them less sort of integrated into the ward' (*P2, G1)

Social isolation was also considered from a wider forensic perspective, with deprivation of physical relationships and separation, but also some families ending communication as a consequence of offending.

*'Restricted access to those family and friends… social support from the outside, that then is more restricted being a secure hospital, so in that respect, all the family may not want to be involved, based on what they've done' (*P2, G1)

Vulnerability to exploitation was discussed in context of social isolation, suggesting that older adults may allow themselves to be exploited to maintain relationships with others.

'*The idea that well "I'm not gonna grass on him, because he's the only person that actually speaks to me or pays any attention to me"' (*P2, G2)

Targeted by Peers

Older adults were acknowledged as at increased risk of being targeted and exploited within both groups.

'*They can target that patient. And sort of get something out of them, whether it be trading or something like that, so in terms of vulnerability, I think I've seen that' (*P1, G1)

Decreased Quality of Life

The population were perceived to be vulnerable to reduced quality of life in comparison to the wider inpatient population. It was emphasised that interventions should meet individual needs. Quality of life was sometimes perceived to outweigh enforcement of rules where deterioration appears inevitable.

*'It's about giving them the better quality of life, and er, probably not about rehabilitation if they're not likely to be moving down to low secure' (*P6, G1)

'Better quality of life, trying to keep them mentally and physically well' (P6, G1)

Unmet Needs

Older adults were perceived to have unidentified and unmet needs. Due to being a minority population, specialist older interventions are not prioritised. Patients are rarely asked what interventions they would like.

*'Older people have different, they'll have different, erm, medication needs, and physical needs, but actually I don't think that's emphasised massively' (*P2, G1)

'*No-one asks them what they want from the group' (*P5, G2)

'We've got to put more onus on patients to do that' (P4, G2)

Further developing the main themes commenced by the nursing group, the AHP group discussed the associations between the forensic risk and vulnerability themes.

Staff Attributions Exploited

Some older adults deliberately exploit staff biases in order to meet their needs or facilitate offending behaviour.

'*We had a lady on there who purposely presented herself as a lot older and a lot more vulnerable, and she, looking at her and talking to her, you would think she was in her late sixties, really frail and old when she was actually in her mid-forties, because she presented herself that way' (*P1, G2)

Patient as Abused or Abuser

Some patients may take advantage of residing within a vulnerable population, increasing their risk of offending. The AHP group showed awareness of the dangers of progressing from forensic conditions to general old-age care, with potential vulnerability factors such as decreased mobility. Older adults were also discussed in terms of their vulnerability to abuse.

*`Putting someone with that risk, erm, spectrum, in a place, with vulnerable(older) adults, that aren't very mobile... that person is really really quite risky in an elderly service' (*P2, G2)

*'So it almost goes both ways, he was very vulnerable, to kind of the psychological and financial exploitation of a peer of a similar age but then… he's almost er posing a risk, well a voyeuristic type risk, to younger males on the ward' (*P2, G2)

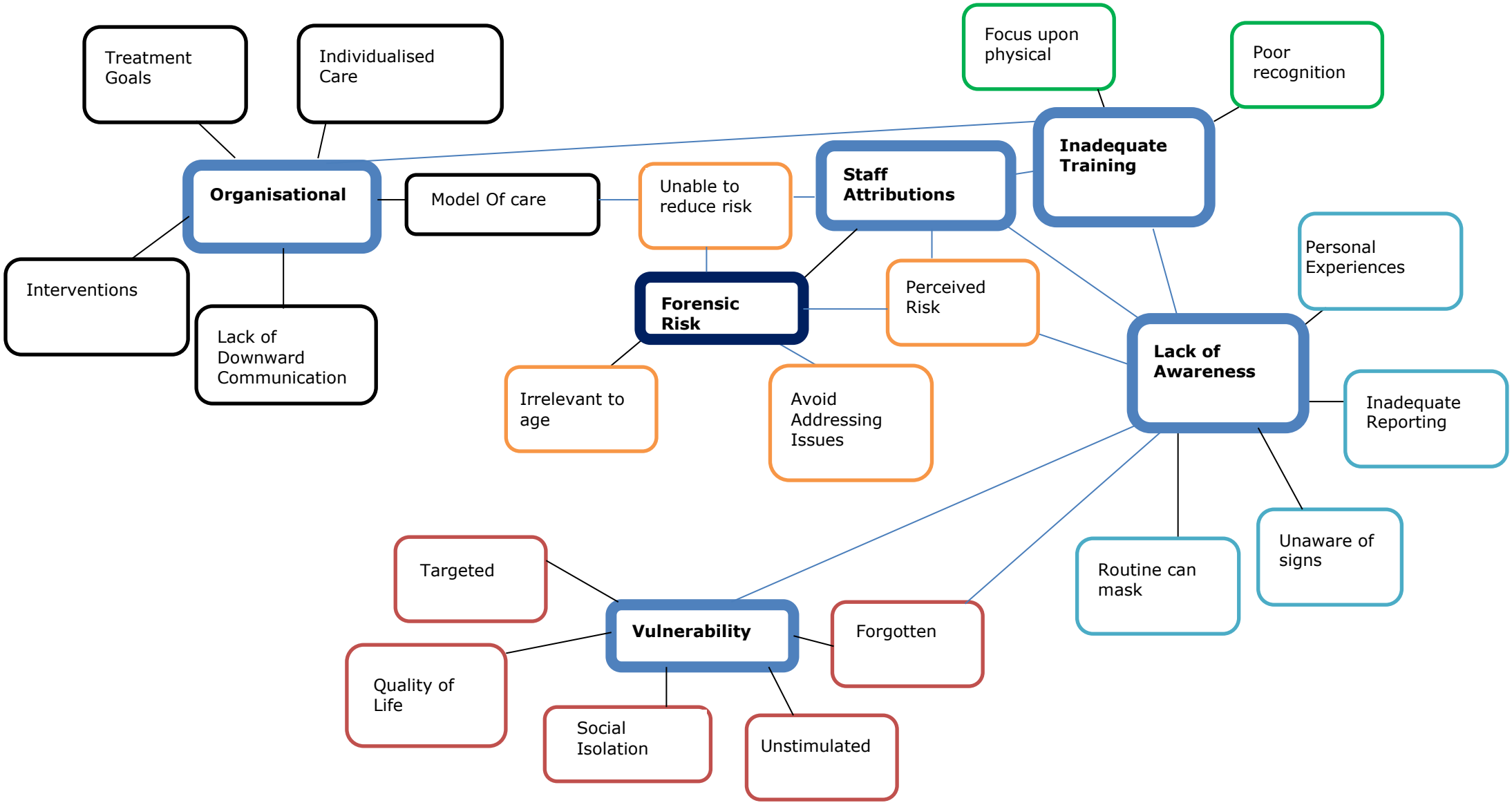


Figure 16. Full thematic analysis map of Nursing Group

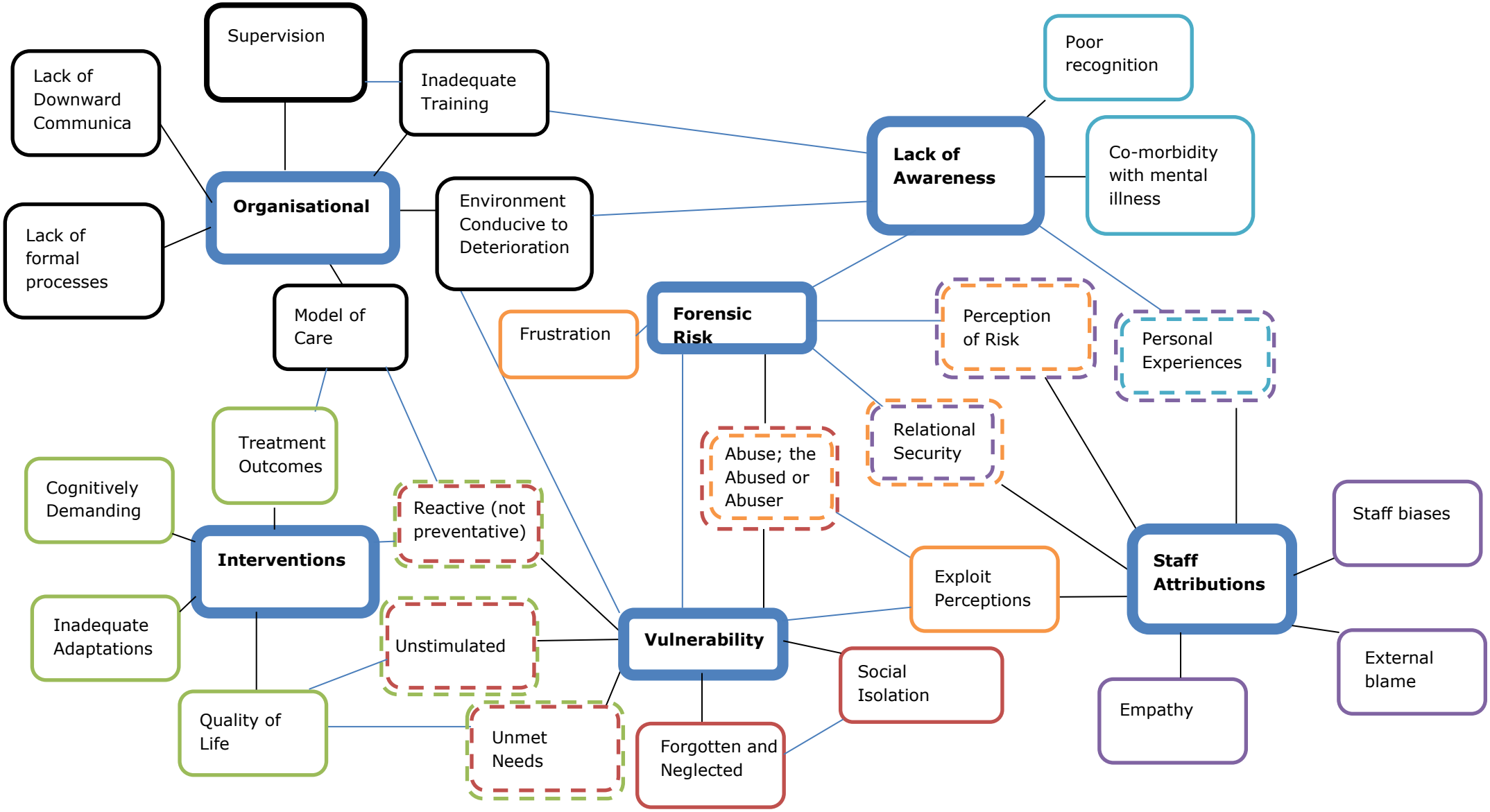


Figure 17. Full thematic analysis map of Allied Health Professionals Group

Discussion

The aim of this research was to explore the experiences, awareness and attitudes of members of staff working within an MSU regarding older patients; specifically whether they recognise and manage signs of dementia and other age-associated risks. The themes identified through thematic analysis highlight the current challenges when recognising dementia within a forensic context, particularly the vulnerability of this population, the influence of staff attributions and the constraints of the organisation. These will be discussed in context of current research. Implications regarding risk management, training, supervision, the model of care, vulnerability and the environment are discussed.

In answer to the research question 'Do members of staff in a medium secure unit recognise the signs of dementia and know how to manage it accordingly?' both the scoping exercise and the focus groups indicated that within the MSU there is a lack of awareness of the cognitive signs of dementia, leading to professionals allowing their attributions to influence their management of older adults. This causes missed opportunities at individual and organisational levels in recognising and providing appropriate treatment and interventions. Furthermore, in context of the MSU as an organisation, the current model of care may require adaptations with regard to treatment pathways and goals.

The over-arching theme of forensic risk was to be expected within an MSU. The interactions between forensic risk, staff attributions and vulnerability are of particular interest, perceived patient vulnerability and biases leading to compromised relational security. Relaxed boundaries therefore increase forensic risk, due to 'over-caring', an imbalance within Hamilton's (2010) boundary seesaw model.

Risk Management and Training

Compromised relational security, perception of risk and leniency with boundaries are particularly important when considered in context of previous research arguing the importance of procedural and relational security with older adults in forensic settings, (Yorston and Taylor, 2006). The implementation of staff education programmes has previously been found to reduce dementia-related aggressive incidents within dementia care settings (Chrzescijanski et al., 2007). The findings support adapting training and supervision to prevent individual biases and attributions skewing risk assessment and the management of older adults with dementia.

Supervision and Organisational Factors

The perceived lack of downward communication within the organisation should be addressed through clear information sharing platforms, including increasing awareness of relevant policies and procedures.

With regard to the environment 'masking' symptoms, routines are a feature of forensic settings that will not change. However, staff perspectives can be adapted through training to recognise signs and symptoms at the earliest opportunity.

Based upon the experiences of the sample, supervision and reflective practice do not currently appear to address external biases influencing their delivery of care. Reflection regarding personal attributions influencing relational security and boundaries should be encouraged, as should individual coping with delivering care to a population using a different model of care.

Model of care

When considering the appropriateness of the model of care and forensic placements for older adults with dementia, it does not appear feasible to create a new service due to small population numbers. Current models could be adapted with emphasis upon quality of life. Measures that are necessary from old-age psychiatry and dementia legislation should be implemented, however, this would be difficult when patient population has a mixture of ages, but would work with individual care planning.

The thematic analysis demonstrated the emphasis placed upon individualised care, meeting specific needs, identifying vulnerability factors and targeting interventions accordingly. This correlates with

previous findings regarding the 'uniqueness' of the older patient population and their need for individualised care, needs cannot be assumed based upon age alone (Yorston and Taylor, 2009).

Vulnerability

Both groups considered the population to be vulnerable, recognising their susceptibility to being forgotten and unstimulated. This corresponds with previous research regarding systemic abuse and neglect experienced by elderly prisoners, (Stojkovic, 2007). It has also been suggested that there is too much emphasis upon security over vulnerability, with poor recognition of dementia causing the signs to be punished when attributed to defiance, (Maschi et al., 2012). Considerations regarding being targeted by others and the interaction between the roles of 'the abused' and 'the abuser' were made; exploiting perceived vulnerability to offend against other vulnerable patients, highlighting the need for emphasis upon safeguarding older adults.

Strengths and Limitations

Qualitative methods are subject to interpretation. The aims of this research were to explore the area and generate ideas, as opposed to supporting hypotheses. This research cannot be perceived as fully representative of the full workforce population, but provides insight into some current perspectives held.

The differences between care-streams were highlighted; considering the differing models of care, however still appeared inadequate for older adults, particularly with dementia. Gender differences were also identified, with social relationships perceived to be of higher importance to female patients; therefore vulnerability factors such as social isolation may be more significant, which should be considered when adapting interventions and treatment.

Future Recommendations

This study met the aim of exploring the current awareness, preparedness and recognition amongst staff regarding older adults with dementia within a single MSU. However, despite including a number of disciplines in the scoping exercise, this study only included participants from the nursing, psychology and occupational therapy departments in the focus groups. Future research should be conducted on larger scales across other services and all levels of the organisation, including medical professionals, those who influence policies and procedures, and at strategic levels within the trust.

It may be beneficial to deliver staff training regarding recognising and managing dementia and older patients within secure care. In order to measure the effectiveness of such training, a similar survey to that of the scoping exercise could be conducted before and after the training is received. Changes to current supervision practices would encourage

reflection regarding personal experiences and biases influencing care, particularly relational security and forensic risk.

In conclusion, staff awareness and recognition of dementia require improvement in order to protect against the identified vulnerability factors, manage personal attributions and improve relational security thus preventing aggressive and violent dementia related-incidents.

Word count: 7995 (8000 max)

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Appendices

A. **Scoping Exercise Survey**

B. **Participant Information Sheet**

C. **Participant Consent Form**

D. **First Focus Group Topic Guide**

E. **Second Focus Group Topic Guide**

F. **University of Nottingham Faculty of Medicine Research Ethics Committee Approval**

G. **Clinical Director Approval letter**

H. **University of Nottingham Sponsorship Approval**

I. **Nottinghamshire Healthcare NHS Foundation Trust Research and Development Approval – Scoping exercise**

J. **Nottinghamshire Healthcare NHS Foundation Trust Research and Development Approval – Full Project**

Arnold Lodge Staff Survey

I am currently studying for a Masters in Forensic and Criminological Psychology at the University of Nottingham.

Data Protection
The information you provide will remain confidential, adhering to Nottinghamshire Healthcare NHS Foundation Trust policies and procedures regarding data protection.

Withdrawal
You have the right to withdraw at any time, and do not have to give a reason for withdrawal.

Questions
If you have any queries regarding this research, please contact Alicyja Uczniak on Alicyja.uczniak@nottshc.nhs.uk or Dr Shihning Chou at the University of Nottingham on shihning.chou@nottingham.ac.uk
Do you currently have patient contact at Arnold Lodge?
☐Yes
☐No

If no, thank you for your participation, you can now close the survey, no further answers are required.

Current practice at Arnold Lodge

To your knowledge, are there currently any patients at Arnold Lodge with a diagnosis or suspected diagnosis of dementia?

- ☐ Yes
- ☐ No

- ☐ Unsure

To your knowledge, are there currently any patients at Arnold Lodge with age-related cognitive decline?

- ☐ Yes
- ☐ No
- ☐ Unsure

Is there training available at Arnold Lodge regarding the treatment of older-age patients?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes please give further details

……..
……..

Is there training available at Arnold Lodge regarding dementia?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes please give further details

……..
……..

<u>Current practice at Arnold Lodge</u>

To your knowledge, at Arnold Lodge, when are cognitive assessments carried out on older patients?

- ☐ On admission
- ☐ Routinely (for example every six months)
- ☐ In response to concerns raised
- ☐ Never
- ☐ Unsure

To your knowledge, at Arnold Lodge, which cognitive assessments are conducted on older patients?

- ☐ Mini-mental state examination (MMSE)
- ☐ Montreal Cognitive assessment (MoCa)

- ☐ Cambridge cognition examination (CAM-COG)
- ☐ Wechsler Adult Intelligence Scale (WAIS)
- ☐ Repeatable Battery for the Assessment of Neuropsychological Status Update (RBANS)
- ☐ Unsure
- ☐ Other

If other, please give further details:
……..

Does Arnold Lodge currently liaise with external specialists in older-age mental health?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes please give further details
……..
……..

Within Arnold Lodge, are there age-related policies and procedures?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes please give further details
……..
……..

Within Nottinghamshire Healthcare Foundation NHS Trust, are there age-related policies and procedures?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes please give further details
……..
……..

Whilst at Arnold Lodge, which age related services can patient's access?
Please tick all that apply

- ☐ Physical healthcare (internal at Arnold Lodge)
- ☐ Physical healthcare (external hospital)
- ☐ Psychology (internal at Arnold Lodge)
- ☐ Psychiatrist (internal at Arnold Lodge)
- ☐ Geriatrician
- ☐ Memory Assessment Service (MAS)
- ☐ External Older mental health services
- ☐ Other

If other, please give further details
……..
……..

What are the primary needs of older patients at Arnold Lodge? Please rank 1-5, 1 being the most important, 5 being the least
(Please only select one factor per ranking)

- ☐ Psychological Factors (Mental illness, Personality Disorder,)
- ☐ Risk Management Factors (violence, aggression)
- ☐ Physical Health Factors (Pain, infection, injuries)
- ☐ Vulnerability Factors (unable to identify needs, declining intervention)
- ☐ Environmental Factors (physical safety, access to interventions)

What interventions are currently available specifically for older patients?
Please tick all that apply.

- ☐ Meaningful activities
- ☐ Exercise
- ☐ Self-care
- ☐ Outdoor space
- ☐ Age-specific groups
- ☐ Other

If you have selected other, please give further details.
……
……

This section of the survey is optional.

By which discipline are you employed?

- ☐ Nursing – Support Staff
- ☐ Nursing – Qualified
- ☐ Occupational Therapy
- ☐ Psychology
- ☐ Medical

Number of years at Arnold Lodge

- ☐ Less than a year
- ☐ 1-5 years
- ☐ 5-10 years
- ☐ 10 years +

Would you be happy to be contacted again for further research?

- ☐ Yes
- ☐ No

If yes please provide your email address

……@nottshc.nhs.uk

Thank you for participating in this survey. Your input is very much appreciated.

If you require further support or information regarding the topics covered in this survey, please contact Alicyja.uczniak@nottshc.nhs.uk or Alicyja.uczniak@nottingham.ac.uk

Participant Information Sheet

Do members of staff in a medium secure unit recognize signs of dementia and know how to manage it accordingly?

1. Invitation paragraph

You have been invited to participate in a research project which aims to explore the perspectives of, and knowledge of, dementia amongst staff that work in medium security forensic services.

Before you agree to take part, it is essential for you to understand the purpose of the research and what it involves. It is therefore important that you read and understand this information sheet, taking care to ensure you understand it fully.

If you have any questions or require any further information, please contact the researcher, Alicyja Uczniak, via email at alicyja.uczniak@nottshc.nhs.uk, or research supervisor Dr Donna Maria Coleston-Shields at Dons.Coleston-shields@nottshc.nhs.uk or Dr Shihning Chou at shihning.chou@nottingham.ac.uk.

Participation is entirely voluntary. Thank you for your time.

2. What is the purpose of the project?

The aim of the project is to explore staff awareness of dementia within forensic psychiatric settings and their confidence in delivering appropriate care, whilst also meeting the risks of the individual. The findings of the study will be used to identify ways in which care can be improved. The final report will be completed by August 2017.

3. Why have I been invited to participate?

You have been approached to participate in this study as you are a member of staff at Arnold Lodge forensic medium secure unit.

4. Do I have to take part?

Taking part in the research is entirely voluntary, and deciding not to participate will not have any effect upon your employment. Should you decide to participate, you have the right to decline to answer any questions, and you may withdraw at any time. It is not necessary that you provide a reason for your withdrawal. Data collected will be completely anonymous.

5. What will happen to me if I agree to take part?

Should you choose to participate in this study you will be asked to participate in a focus group of up to six people, which will involve discussing your awareness, experiences and perspectives of dementia at Arnold Lodge. The focus group will last one hour.

When participating in the focus group, it is asked that you do not name any patients of Arnold Lodge by name, or any other identifying information, in order to protect their confidentiality.

Participation is voluntary, and you will not receive any payment for taking part in this research project. The study will be conducted on the non-secure side of Arnold Lodge. The focus group discussion will be recorded using an audio recording device, so that it can be analysed at a later date.

6. What are the possible benefits, disadvantages and risks of taking part?

There are no explicit benefits for participants in taking part in this study. Whilst it is not anticipated that you will experience any adverse effects from participating in this study, there is always the possibility that participants will experience distress when participating in psychological research. If you choose to take part in the study, you will be debriefed upon completion, and in the unlikely event that you experience a distressed state, please contact the researcher for further support.

7. What happens when the research study ends?

The information that you and other participants provide will only be used for the purpose of this study, and will be statistically analysed and written into a report. The findings will be made available to all staff at Arnold Lodge via a brief findings feedback leaflet. All information provided by participants will be anonymised so that no one individual can be identified. The report will add to the existing psychological literature on dementia within forensic psychiatric settings, and it is hoped that findings will inform future care available to the older population within forensic psychiatric services.

8. What if something goes wrong?

Should you have any concerns, please contact in the first instance the researcher, Alicyja Uczniak. A Qualified Psychologist will be available on the premises for the duration of the focus group and immediately afterwards.

9. Will my taking part in this project be kept confidential?

Participant information will be treated in a strictly confidential manner. All participants' data will be anonymised so that it is non-identifiable to anyone. Direct quotations from the focus group may be used in the final write up, however there will be no personal identifiable information reported.

The data will be stored as follows: sound file will be kept on the property of Arnold Lodge, electronically transcribed to a word document on a computer at Arnold Lodge. No names will be used in this document; each participant will be given a unique non-identifying number.

All data will be anonymised. All data will be held in accordance with Nottinghamshire Healthcare NHS Foundation Trust and University of Nottingham research policy.

10. What if I want to withdraw from the study?

You have the right to withdraw from the study at any time, with all of your data collected removed from the analysis, and with no effect on your employment. In order to do this, make a note of your unique participant identification number found on your consent form, as this will allow your data to be removed.

Should you lose capacity to consent to participating in the research during the study, t~~hen~~ you and your data will be withdrawn from the study.

11. What will happen to the results of the research project?

The results of the research will be used in a written report that will be submitted to the University of Nottingham as part of the student researcher's Masters in Forensic and Criminological Psychology. The findings of the research will also be shared with the research committee at Arnold Lodge. The findings will be made available to all staff at Arnold Lodge via a brief findings feedback leaflet. There will be no identifiable participant information.

12. Who is organising and funding the research?

The research is being sponsored by the University of Nottingham

13. Who has reviewed the project?

The University of Nottingham Faculty of Medicine Ethics committee have reviewed the research, as have the Nottinghamshire Healthcare Research and Development Lead, Academic Supervisors at the University of Nottingham, Arnold Lodge Research and Development Committee and Arnold Lodge Clinical Director.

14. Contact for further information

If you wish to talk to someone further about the project, or wish to raise any concerns, please contact the Primary Investigator at alicyja.uczniak@nottshc.nhs.uk , or the main contact for the Masters programme; Dr Shihning Chou, shihning.chou@nottingham.ac.uk

Participants can also seek general advice about taking part in research at Arnold Lodge from Lucy McCarthy (Research Fellow) at Lucy.McCarthy@nottshc.nhs.uk

CONSENT FORM

Title of Study: Do members of staff in a medium secure unit recognize signs of dementia and know how to manage it accordingly?

Name of Researcher: Alicyja Uczniak

Name of Participant:

Unique Participant Identifying Number:

Please initial box

1. I confirm that I have read and understand the Participant Information sheet for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my employment being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of my data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the focus group will be recorded and that anonymous direct quotes from the focus group may be used in the study reports. ☐

5. I understand that data will be stored in accordance with Nottinghamshire Healthcare NHS Foundation Trust and the University of Nottingham policies. ☐

6. I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Medicine, University of Nottingham, if I wish to make a complaint relating to my involvement in the research. ☐

7. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Witnessed by Researcher	Date	

First Focus Group Topic Guide

- Introduction
- Current Training available
- Awareness of signs/ symptoms
- Needs of older patients (what are they, are they different, do we meet them?)
- Attitudes towards older patients behaviour (and where they come from)
- Perception of risk in older patients
- Vulnerability
- Recognition
- Priorities of care - safety, physical, psychological factors
- Assessments – (awareness, when? By who?)
- Provisions in place for aging population (policies, procedures, facilities)
- Interventions available
- Summary

Second Focus Group Topic Guide

- Introduction
- Initial thoughts regarding older patients in the MSU
- Current Training available
- Model of Care
- Awareness of signs/ symptoms
- Needs of older patients (what are they, are they different, do we meet them?)
- Recognition
- Forensic routines and recognition
- Interventions available (AHP adaptations, reducing risk)
- Attitudes towards older patients behaviour (and where they come from, biases and attributions)
- Perception of risk in older patients
- Vulnerability (particularly social isolation)
- Assessments – (awareness, when? By who?)
- Differences with nursing group
- Provisions in place for aging population (policies, procedures, facilities)
- Summary

E-mail: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine and Health Sciences

Research Ethics Committee
C/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

31st March 2017

Dr Donna Maria Coleston-Shields
Division of Psychiatry & Applied Psychology
Institute of Mental Health
School of Medicine
Jubilee Campus
University of Nottingham
Triumph Road
Nottingham
NG7 2TU

Dear Dr Coleston-Shields

Ethics Reference No: E200317 17018– **please always quote** **IRAS ID:** 221240 **Sponsor ref:** RGS 17018	
Study Title: Do members of staff in a medium secure unit recognize signs of dementia and know how to manage it accordingly?	
Chief Investigator/Supervisor: Dr Donna Maria Coleston-Shields, Principal Research Fellow/Consultant Clinical Psychologist & Neuropsychologist, Division of Psychiatry and Applied Psychology.	
Lead Investigators/student: Alicyja Uczniak, Masters in Forensic and Criminological Psychology	
Other Key Investigators: Dr Shining Chou, Assistant Professor & Forensic Psychologist Director of MSc in Forensic & Criminological Psychology & Year 1 D.Foren.Psy, Division of Psychiatry and Applied Psychology.	
Type of Study: Masters student project.	
Proposed Start Date: 01/04 /2017	**Proposed End Date:** 31/08/2017 5mths
No of Subjects: 312	**Age:** 18+years
School: Medicine	

Thank you for submitting the above application which was considered by the Committee at its meeting on 20th March 2017 and the following documents were received:

- FMHS Research Ethics Application form dated 6 March 2017
- Sponsor Letter dated 15th March 2017
- UoN Evidence of Insurance 20 July 2016
- Confirmation letter from Nottinghamshire Healthcare NHS Trusts R&I to conduct study at Arnold Lodge, Medium Secure Forensic Psychiatric Unit dated 13/01/2017
- Letter of permission from Dr S Geelen, Clinical Director Nottinghamshire Healthcare NHS Foundation Trust dated 6 February 2017.
- Protocol final version 1.0 dated 6 March 2017
- Short Research protocol version 1.0 dated 6 March 2017
- Participant Information Sheet version 1.0 06 March 2017
- Consent form Focus Group
- Scoping Survey dated 06 March 2017

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

The University of Nottingham

A favourable opinion I is given on the understanding that the conditions set out below are followed:

1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

2. You must notify the Chair of any serious or unexpected event.

3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Alicyja Uczniak

Nottinghamshire Healthcare NHS
NHS Foundation Trust

The East Midlands Centre for Forensic Mental Health
Arnold Lodge
Cordelia Close
Leicester
LE5 0LE

Tel: 0116 207 7700
Fax: 0116 207 7777

Our Ref: SG/LCF

6 February 2017

TO WHOM IT MAY CONCERN

Dear Sirs

Re: Alicyja Uczniak – Masters Research

I confirm that Ms Uczniak's Research Project entitled 'Do members of staff in a medium security forensic unit recognise signs of dementia and know how to manage it accordingly?' has been approved by myself as Clinical Director at Arnold Lodge.

Yours faithfully

Dr Steve Geelan
Clinical Director

positive about integrated healthcare

Alicyia Uczniak

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Research, Enterprise and Graduate Services
University of Nottingham
King's Meadow Campus
Lenton Lane Nottingham
NG7 2NR

Our reference: RGS 17018
IRAS Project ID: 221240

0115 8467906
sponsor@nottingham.ac.uk

Health Research Authority
Research Ethics Committee

Dr Donna Maria Coleston-Shields
Division of Psychiatry & Applied Psychology
Institute of Mental Health
University of Nottingham
Triumph Road
Nottingham
NG7 2TU

15th March 2017

Dear Sir or Madam,

Sponsorship Statement

Re: Do members of staff in a medium security forensic unit recognize the signs of dementia and know how to manage it accordingly?

I can confirm that this research proposal has been discussed with the Chief Investigator and agreement to sponsor the research is in place.

An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.*

Any necessary indemnity or insurance arrangements will be in place before this research starts. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

The duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.**

* Not applicable to student research (except doctoral research).
** Not applicable to research outside the scope of the Research Governance Framework.

Yours faithfully

Angela Shone
Head of Research Governance
University of Nottingham

positive

Nottinghamshire Healthcare NHS
NHS Trust
Positive about integrated healthcare

Research Support Services
Institute of Mental Health
University of Nottingham Innovation Park
Triumph Road
Nottingham
NG7 2TU

E-mail: Shirley.mitchell@nottshc.nhs.uk
Direct Line: 0115 748 4321

Date of letter: 13/01/2017

Alicyja Uczniak
Division of Psychiatry & Applied Psychology,
School of Medicine,
University of Nottingham
B Floor, Yang Fujia Building,
Wollaton Road,
Nottingham,
NG8 1BB,

Dear Alicyja,

Study Title: Arnold Lodge Staff Survey

Nottinghamshire Healthcare NHS Trusts Research and Innovation team have reviewed the documentation associated with the project listed above. I can confirm that the survey is classed as a scoping exercise, and as such does not require any additional ethical or governance approvals.

Yours sincerely

Shirley Mitchell
Head of Research Management and Governance
CC: Dons Coleston-Shields

positive

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Research and Development
Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

E-mail: shirley.mitchell@nottshc.nhs.uk

Date of NHS Permission: 05/04/2017

Alicyja Uczniak
Division of Psychiatry & Applied Psychology,
School of Medicine,
University of Nottingham
B Floor, Yang Fujia Building,
Wollaton Road,
Nottingham,
NG8 1BB,

Dear Alicyja,

Study title: Do members of Staff in a Medium Security Forensic Unit Recognize the Signs of Dementia and Know How to Manage it Accordingly?
Sponsor: University of Nottingham
Edge ID: 94628
Principal Investigator: Alicyja Uczniak
Chief Investigator: Dr Dons Coleston-Shields
Site: Arnold Lodge

Thank you for submitting your project to the Nottinghamshire Healthcare NHS Foundation Trust's R&D Department. The project has now been given NHS permission by:

Dr Julie Hankin: R & D Director, on behalf of Nottinghamshire Healthcare NHS Foundation Trust

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. As this project is a single site, student project involving NHS staff only, Health Research Authority approval is not required (as per HRA guidance).

The following documents were reviewed:

Document	Version	Date
Participant Information Sheet	1.0	06/03/2017
Consent Form Focus Group	N/A	N/A
Short Research Protocol	1.0	06/03/2017
Protocol	1.0	06/03/2017
Letter of Permission – S Geelan	N/A	06/02/2017
Sponsor Letter	N/A	15/03/2017

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UoN Evidence of Insurance	N/A	20/07/2016
Scoping Confirmation Letter	N/A	13/01/2017

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available http://www.nottinghamshirehealthcare.nhs.uk/contact-us/freedom-of-information/policies-and-procedures/

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

Shirley Mitchell
Head of Research and Innovation

cc.

Chief Investigator

Sponsor

Do members of staff in a medium security forensic unit recognize the signs of dementia and know how to manage it accordingly?

Final Version 1.0
17/03/2017

Short title: *Recognising and managing dementia in a forensic service*

IRAS Project ID: 221240

Study Sponsor: University of Nottingham

Sponsor reference: *17018*

Funding Source: Student own

STUDY PERSONNEL AND CONTACT DETAILS

Sponsor:
Contact name

University of Nottingham
Ms Angela Shone
Head of Research Governance
Research and Graduate Services
King's Meadow Campus
Lenton Lane
Nottingham
NG7 2NR

Chief investigator:

Dr Donna Maria Coleston-Shields
Division of Psychiatry & Applied Psychology
Institute of Mental Health
University of Nottingham
Triumph Road
Nottingham NG7 2TU

UoN job title: Principal Research Fellow and Consultant Clinical Psychologist & Neuropsychologist

Email Dons.Coleston-Shields@nottshc.nhs.uk

Co-investigators:

Alicyja Uczniak (student)
Masters in Criminological and forensic psychology.

Email Alicyja.uczniak@nottingham.ac.uk

Dr Shihning Chou
Division of Psychiatry & Applied Psychology,
School of Medicine,
University of Nottingham
B Floor, Yang Fujia Building,
Wollaton Road,
Nottingham,
NG8 1BB,
UK

Email Shihning.chou@nottingham.ac.uk

Study Coordinating Centre: University of Nottingham School of Medicine

SYNOPSIS

Title	Do members of staff in a medium security forensic unit recognize signs of dementia and know how to manage it accordingly?
Short title	Recognising and managing dementia in a medium secure forensic service
Chief Investigator	Dr Donna Maria Coleston-Shields
Objectives	To investigate whether staff members are aware of the different types and stages of dementia, and whether they feel confident recognising them within a forensic setting. It will be explored whether the organisation is currently prepared to meet the demands of forensic patients with dementia.
Study Configuration	Single Centre
Setting	Arnold Lodge Medium Secure Forensic Unit, Nottinghamshire Healthcare NHS Foundation Trust.
Sample size estimate	The pre-study scoping survey will be distributed to in excess of 300 members of staff, it is estimated that the response rate will be 30%. The focus groups will consist of 6 participants per focus group, 12 in total. Due to the qualitative nature of the data, a priori power analysis are not required, and an accepted standardised focus group size is 6 per group.
Number of participants	Participant numbers for the survey are estimated to be 20% of the whole of the sample, around 60 responses. Within each focus group, there will be a maximum of 6 participants per focus group, 12 focus group participants in total
Eligibility criteria	All current members of staff at Arnold Lodge Medium Secure forensic hospital, that have patient contact, over the age of 18.
Description of interventions	Scoping survey distributed to whole sample. Two focus groups will be conducted, each lasting one hour, containing up to six members of staff recruited from all departments.
Duration of study	Scoping survey will be open for participants for one month. Focus groups will be conducted within close succession, lasting for one hour. Focus groups are planned to take place in April 2017.
Methods of analysis	The nominal data from the scoping survey will be analysed using univariate chi square, in order to inform research questions for focus group. The focus group will be anonymised when transcribed, and analysed using thematic analysis.

ABBREVIATIONS

CI	Chief Investigator overall
CRF	Case Report Form
GCP	Good Clinical Practice
NHS	National Health Service
PI	Principal Investigator at a local centre
PIS	Participant Information Sheet
REC	Research Ethics Committee
R&D	Research and Development department
UoN	University of Nottingham

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STUDY BACKGROUND INFORMATION AND RATIONALE

Through content analyses of the literature, it has been suggested that there is currently limited research focusing upon the mental health of older individuals within forensic services (Maschi, Sutfin, & O'Connell, 2012). Furthermore, it has been concluded that healthcare services for older psychiatric patients with a forensic history are inadequate (Nnatu et. al 2005). Current practice has mainly been measured through 'audit' research, cross-sectional studies and research content analysis.

There is current literature exploring dementia awareness in front line nursing staff from a general hospital setting, which has found that those in acute general wards felt they did not receive sufficient training to care for those with dementia (Gandesha, 2012). However, similar research has not been conducted using staff perspectives within forensic psychiatric services.

It has been suggested that forensic older patients have more unmet needs than those of other age groups (Fazel et. al 2004). Das, Murray, Driscoll,& Nimmagadda, (2011) found that older service users in forensic psychiatric settings have expressed unmet needs in a number of areas; healthcare, psychological distress, company, sexual expression, basic education, treatment, physical health needs, memory and personal security. It was found that those in low/medium security had significantly more 'met needs' than those in high secure. It was found that numerous patients were currently placed in the wrong level of security, with the majority requiring lower restrictions. It was emphasised that staff should receive training in meeting the needs of older forensic patients.

Although research has suggested that staff in healthcare settings undertake dementia and older patient specific training, Timmons et. al (2015) conducted a review on dementia services in acute hospital settings and found that dementia training was offered in only 2 of 35 hospitals.

STUDY OBJECTIVES AND PURPOSE

PURPOSE

The aim of the project is to explore staff awareness of dementia within a forensic psychiatric setting, their confidence in recognising early signs of dementia, and managing those with the disorder. There is currently limited research into the ageing population within forensic psychiatric services in the UK, and limited evidence that staff receive adequate training in the management of older service users. The research will explore overall management of the condition within the service, and the organisational preparedness to manage those with dementia.

The following questions demonstrate the kind of knowledge that is hoped to be found during this exploratory research;

- Are staff members aware of the different types and stages of dementia, and do they feel confident recognising the signs and symptoms, and delivering appropriate interventions?
- Do staff underestimate the risk of violence and aggression within forensic services in those with dementia?
- What training is available for staff regarding dementia? Do staff identify a need for further training?
- At ward level, what assessments, treatments and interventions are currently in place?

- Is the organisation (Arnold Lodge) currently prepared to meet the demands of forensic patients with dementia? Are there policies and interventions in place?
- Is the wider organisation (Nottinghamshire Healthcare NHS Foundation Trust) prepared to meet the demands of the ageing population? Trust wide policy?

PRIMARY OBJECTIVE

The study is exploratory in nature, and it is hoped that knowledge will be gained regarding staff member's training in recognising the signs, symptoms and different types of dementia. Staff perception of risk of violence and aggression within those with dementia will be explored. Do members of staff feel confident managing the forensic risks posed by those with dementia?

SECONDARY OBJECTIVES

To explore whether the organisation is currently prepared to meet the demands of forensic patients with dementia, including current policies, procedures and interventions that are in place. To explore at ward level, what assessments, treatments and interventions are currently in place

STUDY DESIGN

STUDY CONFIGURATION

The study will be conducted at a single centre location, Arnold Lodge Medium Secure Psychiatric hospital. Participants will voluntarily participate.

Participants will receive an email inviting them to complete a short survey, which addresses the secondary aims of the project, establishing the current training, interventions, policies and procedures currently in place. This will be open for one month, prior to the focus groups being conducted, in order to inform the contents of the focus groups.

The scoping survey has been approved by R&D Lead Ms Shirley Mitchell, Nottinghamshire Healthcare NHS Foundation Trust as a scoping exercise, and therefore not subject to further ethics or governance

Participants that provide written consent to participating in the focus groups will not be randomly allocated to a focus group, as the groups will be selected to ensure that the groups are representative of all members of staff and there will be no conflicts of interests between the participants. Participants will be assigned to their study arm by Student Researcher Alicyja Uczniak, currently employed at Arnold Lodge.

STUDY MANAGEMENT

The study will be managed by student researcher Alicyja Uczniak, currently employed at Arnold Lodge, and currently undertaking the Msc in Forensic and Criminological Psychology. The student researcher will be responsible for the recruitment of participants, allocation to

focus groups, distribution of participant information sheets, facilitation of the focus group, transcription of the focus group, data analysis and final write up.

The Chief Investigator has overall responsibility for the study and shall oversee all study management. The data custodian will be the Chief Investigator. (Dr Donna Maria Coleston-Shields)

DURATION OF THE STUDY AND PARTICIPANT INVOLVEMENT

Study Duration:

Participants will be invited to complete the survey via NHS staff email, this is anonymous and can be completed in isolation, it is not a prerequisite for participating in the focus groups. The survey should take no longer than 10 minutes to complete, and will be open for completion for one month.

The focus groups will last one hour each, and will be completed before May 2017 to allow time for analysis and write up for masters deadline on 1st August 2017.

Participant Duration:

Participants will have the time between the recruitment email and the focus group to take decide whether they will take part, during this time they will have access to the participant information sheet.

The survey component of the research is being conducted prior to focus groups. The survey will take no longer than ten minutes for each participant to complete. The survey will be open for completion for one month. Participants who volunteer to complete the survey are under no obligation to participate in a focus group.

Prior to the focus groups, participants will also have approximately 15 minutes to read the consent form and participant information sheet immediately prior to the focus group.

The Focus group will last for approximately one hour. A debrief will be given, and further support available by a qualified psychologist on the premises. There will not be research follow-up.

End of the Study

The end of the study will be when the two focus groups have been completed. Data analysis and write up will occur after this.

SELECTION AND WITHDRAWAL OF PARTICIPANTS

Recruitment

The study will be conducted at Arnold Lodge Medium Secure Forensic Psychiatric hospital. This setting is appropriate as it will capture a staff population currently working within NHS psychiatric services.

The initial approach will be by NHS internal email by the student researcher Alicyja Uczniak, (currently also employed at Arnold Lodge) inviting them to participate in the research.

Participants will first be invited to complete the survey via NHS staff email, participants will then volunteer to complete the survey. The survey will be anonymous. Paper copies of the survey will also be made available in ward offices, with envelopes addressed to the researcher (Alicyja Uczniak) through the internal mail.

Following the completion of the survey data collection, an email will be sent inviting participants to participate in focus groups.

Following this, ward managers will be approached to invite participants through staff support meetings.

Participants will remain in contact with the researcher informing them of the date, time and location of the focus group that they have been allocated to. Each participant will attend one focus group, individual participants will not attend both focus groups

Participants will be recruited from nursing staff, both qualified and unqualified, on all seven wards (three care streams; Male Personality Disorder, Male Mental Illness and Women's service). Participants will be recruited from the occupational therapy, psychology and medical departments.

Translator services are not expected to be used as all participants are members of staff at Arnold Lodge, who must be speak English for their employment. If needed, the usual hospital interpreter and translator services will be available to assist, however consent forms and information sheets will not be available printed in other languages.

It will be explained to the potential participants that entry into the study is entirely voluntary and that their employment will not be affected by their decision. It will also be explained that they can withdraw at any time but attempts will be made to avoid this occurrence. In the event of their withdrawal it will be explained that their data collected will be removed.

Once data has been analysed within the final analysis and entered onto the UoN secure network, data cannot be erased as UoN backups cannot be tampered with. This is covered within the withdrawal section of the participant information sheet.

Eligibility criteria

Participants are all current staff members at Arnold Lodge hospital and are considered capable to give informed consent. All members of staff with patient contact have the potential to benefit from the outcomes of the study.

Inclusion criteria

- Current member of staff at Arnold Lodge Medium Secure Unit, Nottinghamshire Healthcare NHS Foundation Trust.
- Have current patient contact
- Aged over 18

Exclusion criteria

- Not current member of staff at Arnold Lodge Medium Secure Unit, Nottinghamshire Healthcare NHS Foundation Trust.
- Does not have current patient contact
- Aged under 18.

Expected duration of participant participation

The survey is expected to take no more than ten minutes to complete. The survey will be open for responses for one month prior to the focus groups being conducted. Participants do not have to complete both the survey and the focus group. The focus group is expected to last one hour. If a person was to complete the survey and the focus group, they will be involved in the study for no longer than two months.

Participant Withdrawal

Participants will be given a participant information sheet prior to completing the focus group, at which point they may choose to withdraw from the study.

Participants may be withdrawn from the study either at their own request or at the discretion of the Investigator. The participants will be made aware that this will not affect their future care or employment. Participants will be made aware (via the information sheet and consent form) that should they withdraw the data collected to date cannot be erased and may still be used in the final analysis.

Informed consent

Participants will provide consent through written consent forms. The consent forms will be kept in a locked drawer at Arnold Lodge for the duration of the study. Consent forms will be distributed immediately before the focus group, and thus amendments to the study regime will not be made between obtaining consent and participation in the research.

Participants will be informed that the focus group is being recorded prior to informed consent.

Consent will be explicit, for both the participation in the research and the use and retention of study data.

All participants will provide written informed consent. The Consent Form will be signed and dated by the participant before they enter the study. The Student Investigator Alicyja Uczniak will explain the details of the study and provide a Participant Information Sheet, ensuring that the participant has sufficient time to consider participating or not. The Student Investigator will answer any questions that the participant has concerning study participation.

Informed consent will be collected from each participant before they undergo any interventions related to the study. One copy of this will be kept by the participant and one will be kept by the Investigator. The written consent will be witnessed by the Student Investigator Alicyja Uczniak, who will also sign the consent form.

Should there be any subsequent amendment to the final protocol, which might affect a participant's participation in the study, continuing consent will be obtained using an amended Consent Form which will be signed by the participant.

Participants will be made aware (via the information sheet and consent form) that should they withdraw from the study, their data collected will be removed from the analysis.

Should a participant lose capacity to consent during the study, their data will be withdrawn from the study.

Completion and subsequent return of the scoping survey will be taken as informed consent and separate written informed consent will not be sought.

STUDY REGIMEN

Pre-study Scoping Exercise

A brief scoping survey has been developed in order to explore the broader themes identified within the current research, and hone these to inform the questions for the focus group.

This survey has been approved by Nottinghamshire Healthcare NHS Foundation Trust R&D lead Shirley Mitchell as not requiring further approval, and has been approved for distribution.

Approval for the distribution of the scoping survey has been obtained from Arnold Lodge Clinical Director Dr S. Geelan.

The survey contains 13 questions, which are non-identifiable to individual staff members, with the option of providing demographic information through 3 questions at the end of the survey.

The scoping survey explores current practice at Arnold Lodge regarding older patients, including current age specific procedures, interventions, assessment tools and training undertaken staff. The survey also asks staff to rank the priority of primary needs of older patients in their care.

In order to reach the widest variety of staff members, the survey will be conducted via an online survey, (distributed by email) and via paper copies made available in ward offices. The online survey will be conducted via 'Bristol online survey' using the University of Nottingham's licence, these will be answered on computers based on the premises of Arnold Lodge Hospital.

At the end of the scoping survey, there is an optional page for respondents to provide their contact details if interested in receiving information regarding participating in a focus group.

Focus Group

When the questionnaire has been distributed and analysed, an email will be sent to invite participants who provided their contact details at the end of the scoping survey to participate in a focus group. Participants that are interested in participating will be sent a participant information sheet, for them to read prior to the date of the focus group, so that full informed consent can be given.

The focus groups will be facilitated by student researcher Alicyja Uczniak, and will be semi-structured using the content identified through the scoping survey. Staff that consent to participating in the focus groups will not be randomly allocated, as the groups will be selected to ensure that these are representative of all members of staff and there will be no conflict of interests between the participants. Participants will be assigned to their study arm by researcher Alicyja Uczniak.

The focus group will take place on the non-secure side of Arnold Lodge, and will be recorded using a dictaphone. Participants will be informed prior to their participation that the focus group is being recorded. The focus group will then be transcribed and

anonymised by Alicyja Uczniak. The sound file will be kept on trust property for data protection, and will be encrypted and password protected.

The anonymised data from the survey and focus groups will be analysed using SPSS on University of Nottingham property.

Compliance

Compliance will be defined as acceptable contribution to the focus group. Participants that make inappropriate comments may be considered to be demonstrating unacceptable compliance with the study regime and asked to leave the study.

Criteria for terminating the study

The study is being conducted at one centre therefore if it were to be stopped it would stop as a whole. This is unlikely to occur, however may be terminated due to major safety concerns, new information or poor recruitment. If recruitment is poor, the study may be scaled down to one focus group as opposed to two.

Unused study materials, for example participant information sheets, should be returned to the student investigator Alicyja Uczniak, to be destroyed in an appropriate manner. As the research is a focus group, the sound file will be stored in accordance with NHS trust policy and University of Nottingham policy, archived according to the archiving section below.

ANALYSES

Methods

The findings will be analysed by Alicyja Uczniak, student researcher.

The sound file will be anonymised and transcribed on site at Arnold Lodge, according to Nottinghamshire Healthcare NHS Foundation Trust data procedures, it will then be analysed using University of Nottingham computers.

Using SPSS, the main analysis will be thematic analysis of the focus group transcription. Due to the nature of the research, no blinding will be used and no interim analyses will be conducted.

Sample size and justification

The pre-study scoping survey will be distributed to in excess of 300 members of staff, it is estimated that the response rate will be 30%.

The focus groups will consist of maximum 12 participants, 6 per focus group. Due to the qualitative nature of the data, a priori power analysis are not required, and an accepted standardised focus group size is 6 per group. Due to the small nature of the focus groups,

and information provided prior to participation it is not expected that there will be any ‘drop out’ participants.

ADVERSE EVENTS

In the unlikely event that the content of the discussion during the focus group may become distressing for some participants, a qualified psychologist will be on site at Arnold Lodge should participants need support. Due to the nature of the occupation of the participants, being staff at Arnold lodge, they should not be exposed to any more harm than they currently experience in their current roles.

The occurrence of an adverse event as a result of participation within this study is not expected and no adverse event data will be collected.

ETHICAL AND REGULATORY ASPECTS

Participants should not be exposed to any more harm than they experience in their current employment with regards to sensitive topics when completing the survey or participating in the focus group. Participants have been recruited for this study by virtue of their professional role. The main discussion will be regarding their professional preparedness to recognise and manage dementia, in a manner which may be generalizable across medium secure services.

No person-identifiable information will be elicited during the scoping survey. If names are inadvertently used during the focus group, they will be replaced with anonymous items such as ‘participant’, and any identifying statements will not be quoted in the final write up.

In the participant information sheet and at the start of the focus groups, it will be requested that participants do not mention service users of Arnold Lodge by name or identifiable information, for example the ward that they are from, in order to protect their confidentiality. Should any names be given inadvertently, these will be anonymised during transcription and replaced with names such as 'Female1'.

The focus group will be conducted using a dictaphone, and when transcribed will be anonymised. Any identifying information will not be used in the final report, participants will be informed prior to their participation that the focus group is being recorded. The sound file and transcript will be kept on trust property for data protection, and will be encrypted and password protected, data collected will be stored in accordance with trust policy.

The focus groups will contain members of staff from various departments of the hospital, the participant mix will be considered when assigning participants to focus groups.

Discussing dementia may be a sensitive topic for some members of staff. This will be stated in the participant information sheet, and participants will be reminded that they are under no obligation to participate. Whilst the group is being conducted, a qualified psychologist will be available on the premises to offer support. Following participation, a debrief sheet will be offered, signposting participants to agencies with further information and support they may desire.

ETHICS COMMITTEE AND REGULATORY APPROVALS

The study will not be initiated before the protocol, consent forms and participant information sheets have received approval / favourable opinion from the designated ethics board, and the respective National Health Service (NHS) Research & Development (R&D) department.

Should a protocol amendment be made that requires ethical approval, the changes in the protocol will not be instituted until the amendment and revised informed consent forms and participant information sheets have been reviewed and received approval / favourable opinion from the ethics and R&D departments.

A protocol amendment intended to eliminate an apparent immediate hazard to participants may be implemented immediately providing that the ethics are notified as soon as possible and an approval is requested. Minor protocol amendments only for logistical or administrative changes may be implemented immediately; and will be informed.

The study will be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, 1996; the principles of Good Clinical Practice, and the Department of Health Research Governance Framework for Health and Social care, 2005.

INFORMED CONSENT AND PARTICIPANT INFORMATION

The process for obtaining participant informed consent will be in accordance with the REC guidance, and Good Clinical Practice (GCP) and any other regulatory requirements that might be introduced. The investigator or their nominee and the participant or other legally authorised representative shall both sign and date the Consent Form before the person can participate in the study.

As approved by R&D Lead, Ms Shirley Mitchell, completion and subsequent return of scoping exercise survey will be taken as informed consent and separate written informed consent will not be sought.

The participant will receive a copy of the signed and dated informed consent forms and the original will be retained in the records.

The decision regarding participation in the study is entirely voluntary. The investigator or their nominee shall emphasize to them that consent regarding study participation may be withdrawn at any time without penalty or affecting the quality or quantity of their employment, or loss of benefits to which the participant is otherwise entitled. No study-specific interventions will be done before informed consent has been obtained.

The student researcher will inform the participant of any relevant information that becomes available during the course of the study, and will discuss with them, whether they wish to continue with the study. If applicable they will be asked to sign revised consent forms.

RECORDS

Case Report Forms

The case report forms will supply each participant with a unique identifying participant number, which will be used to correlate the participant number with their consent form, whilst maintaining confidentiality. Due to the research being single centre, dates of birth will not be used, nor will initials. The numbers used will allow for sufficient identification to prove a person exists and their contribution within the focus groups can be matched to their consent

form. The forms will be stored in a locked drawer on the non-secure side of Arnold Lodge. The forms will be used to inform the transcription of the focus group data.

Each participant will be assigned a study identity code number, for use on CRFs, other study documents and the electronic database.

Due to each participant only participating in a focus group once, the CRFs are not needed to chase data queries or for further data.

CRFs will be treated as confidential documents and held securely in accordance with regulations. The investigator will make a separate confidential record of the participant's name and Participant Study Number, to permit identification of all participants enrolled in the study, in case additional follow-up is required.

CRFs shall be restricted to those personnel approved by the Chief or Student Investigator and recorded as such in the study records.

All paper forms shall be filled in using black ballpoint pen. Errors shall be lined out but not obliterated by using correction fluid and the correction inserted, initialled and dated.
The Chief or Student Investigator shall sign a declaration ensuring accuracy of data recorded in the CRF.

Source documents

Source documents shall be filed at the investigator's site and may include but are not limited to, consent forms, study records, field notes, interview transcriptions and audio records. A CRF may also completely serve as its own source data. Only study staff shall have access to study documentation other than the regulatory requirements listed below.

Direct access to source data / documents

The CRF and all source documents shall made be available at all times for review by the Chief Investigator, Sponsor's designee and inspection by relevant regulatory authorities.

DATA PROTECTION

All study staff and investigators will endeavour to protect the rights of the study's participants to privacy and informed consent, and will adhere to the Data Protection Act, 1998. The CRF will only collect the minimum required information for the purposes of the study. CRFs will be held securely, in a locked room, or locked cupboard or cabinet. Access to the information will be limited to the study staff and investigators and any relevant regulatory authorities (see above). Computer held data including the study database will be held securely and password protected. All data will be stored on a secure dedicated web server. Access will be restricted by user identifiers and passwords (encrypted using a one way encryption method).

Electronic data will be backed up every 24 hours to both local and remote media in encrypted format.

QUALITY ASSURANCE & AUDIT

INSURANCE AND INDEMNITY

Insurance and indemnity for clinical study participants and study staff is covered within the NHS Indemnity Arrangements for clinical negligence claims in the NHS, issued under cover of HSG (96)48. There are no special compensation arrangements, but study participants may have recourse through the NHS complaints procedures.

The University of Nottingham as research Sponsor indemnifies its staff, research participants and research protocols with both public liability insurance and clinical trials insurance. These policies include provision for indemnity in the event of a successful litigious claim for proven non-negligent harm.

STUDY CONDUCT

Study conduct may be subject to systems audit for inclusion of essential documents; permissions to conduct the study; CVs of study staff and training received; local document control procedures; consent procedures and recruitment logs; adherence to procedures defined in the protocol (e.g. inclusion / exclusion criteria, timeliness of visits); accountability of study materials and equipment calibration logs.

STUDY DATA

Monitoring of study data shall include confirmation of informed consent; source data verification; data storage and data transfer procedures; local quality control checks and procedures, back-up and disaster recovery of any local databases and validation of data manipulation. The Academic Supervisor, or where required, a nominated designee of the Sponsor, shall carry out monitoring of study data as an ongoing activity.

Entries on CRFs will be verified by inspection against the source data. A sample of CRFs (10% or as per the study risk assessment) will be checked on a regular basis for verification of all entries made. In addition the subsequent capture of the data on the study database will be checked. Where corrections are required these will carry a full audit trail and justification.

Study data and evidence of monitoring and systems audits will be made available for inspection by the REC as required.

RECORD RETENTION AND ARCHIVING

In compliance with the ICH/GCP guidelines, regulations and in accordance with the University of Nottingham Code of Research Conduct and Research Ethics, the Chief or local Principal Investigator will maintain all records and documents regarding the conduct of the study. These will be retained for at least 7 years or for longer if required. If the responsible investigator is no longer able to maintain the study records, a second person will be nominated to take over this responsibility.

The study documents held by the Chief Investigator on behalf of the Sponsor shall be finally archived at secure archive facilities at the University of Nottingham. This archive shall include all anonymised audio recordings, study databases and associated meta-data encryption codes.

DISCONTINUATION OF THE STUDY BY THE SPONSOR

The Sponsor reserves the right to discontinue this study at any time for failure to meet expected enrolment goals, for safety or any other administrative reasons. The Sponsor shall take advice as appropriate in making this decision.

STATEMENT OF CONFIDENTIALITY

Individual participant personal information obtained as a result of this study are considered confidential and disclosure to third parties is prohibited with the exceptions noted above.

Participant confidentiality will be further ensured by utilising identification code numbers to correspond to treatment data in the computer files.

If information is disclosed during the study that could pose a risk of harm to the participant or others, the researcher will discuss this with the CI and where appropriate report accordingly.

Data generated as a result of this study will be available for inspection on request by the University of Nottingham representatives, the REC, local R&D Departments and the regulatory authorities.

PUBLICATION AND DISSEMINATION POLICY

The results of the study will be used as part of a Masters in Criminological and Forensic Psychology at the University of Nottingham. The findings will be presented at the Arnold Lodge Academic programme and potentially at the Institute of mental health Nottingham in 2016. Participants will not be identified in any publications.

USER AND PUBLIC INVOLVEMENT

There has not been any user or public involvement in the design of this study.

STUDY FINANCES

Funding source

This study is receiving no funding from an external source, any costs will be covered by the Student Investigator, Alicyja Uczniak.

Participant stipends and payments

Participants will not be paid to participate in the study. Travel expenses will not be offered.

SIGNATURE PAGES

Signatories to Protocol:

Chief Investigator: (name)_____

Signature:_____

Date: _____

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Executive Summary

Do members of staff in a medium secure unit recognise the signs of dementia, and know how to manage it accordingly?

This summary is intended to inform members of staff working in the medium secure unit where the research was carried out, and for wider distribution throughout the NHS trust.

Background

Despite an increase in public health priority research regarding increasing quality of life for those with dementia, alongside promoting early detection and psychological and social interventions; this has not extended to those with dementia in forensic contexts.

Dementia is present within forensic settings however there are numerous difficulties with recognising dementia due to the constraints of the forensic environment (Simmons, Hartmann and Dejoseph, 2011, Williams et al., 2006). The management of older populations is also a challenge; identified as having 'unique' needs that are often not appropriately met (Yorston and Taylor, 2009).

The vulnerability of the population has also been emphasised; dementia is often unrecognised, unmanaged and untreated (Shah, 2008), perpetuated by forensic organisations with inappropriate models of care, and professionals with minimal awareness of the disorder.

The aims of this research were to explore the experiences, awareness and attitudes of members of staff working within a Medium Secure Unit (MSU) regarding older patients. Specifically, whether they recognise and manage signs of dementia and other age-associated risks.

Methods of the current research

In order to explore the aims of the research a scoping exercise was conducted to substantiate the rationale for the study, justifying the presence of dementia within the MSU and the lack of awareness regarding recognition, management and current provisions within the organisation.

The results were then used to inform the content of two focus groups. Each focus group was representative of a staffing group: the first of Nursing Staff and the second of Allied Health Professionals. These were conducted sequentially in order to form an iterative process (*See Figure 1*). A thematic analysis, as described by Braun and Clarke (2006), was conducted after each group.

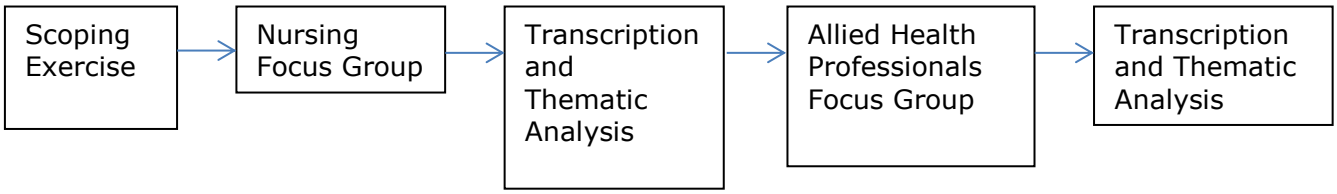


Figure 1: The research design iterative process.

Findings of the research

The over-arching theme identified within the research was forensic risk, which interacted with the main themes of the research.

The main themes identified were as follows:

- Staff Attributions: the influences of individual biases upon perceptions of risk, recognition and management
- Organisational Factors: communication and processes at all levels, particularly the model of care and supervision
- Lack of Awareness: recognition of signs and symptoms, adequacy of reporting and documentation.

- Interventions: the appropriateness and adaptation of treatment options.
- Vulnerability: susceptibility to abuse and neglect, influencing forensic risk

These are also displayed as thematic analysis maps.

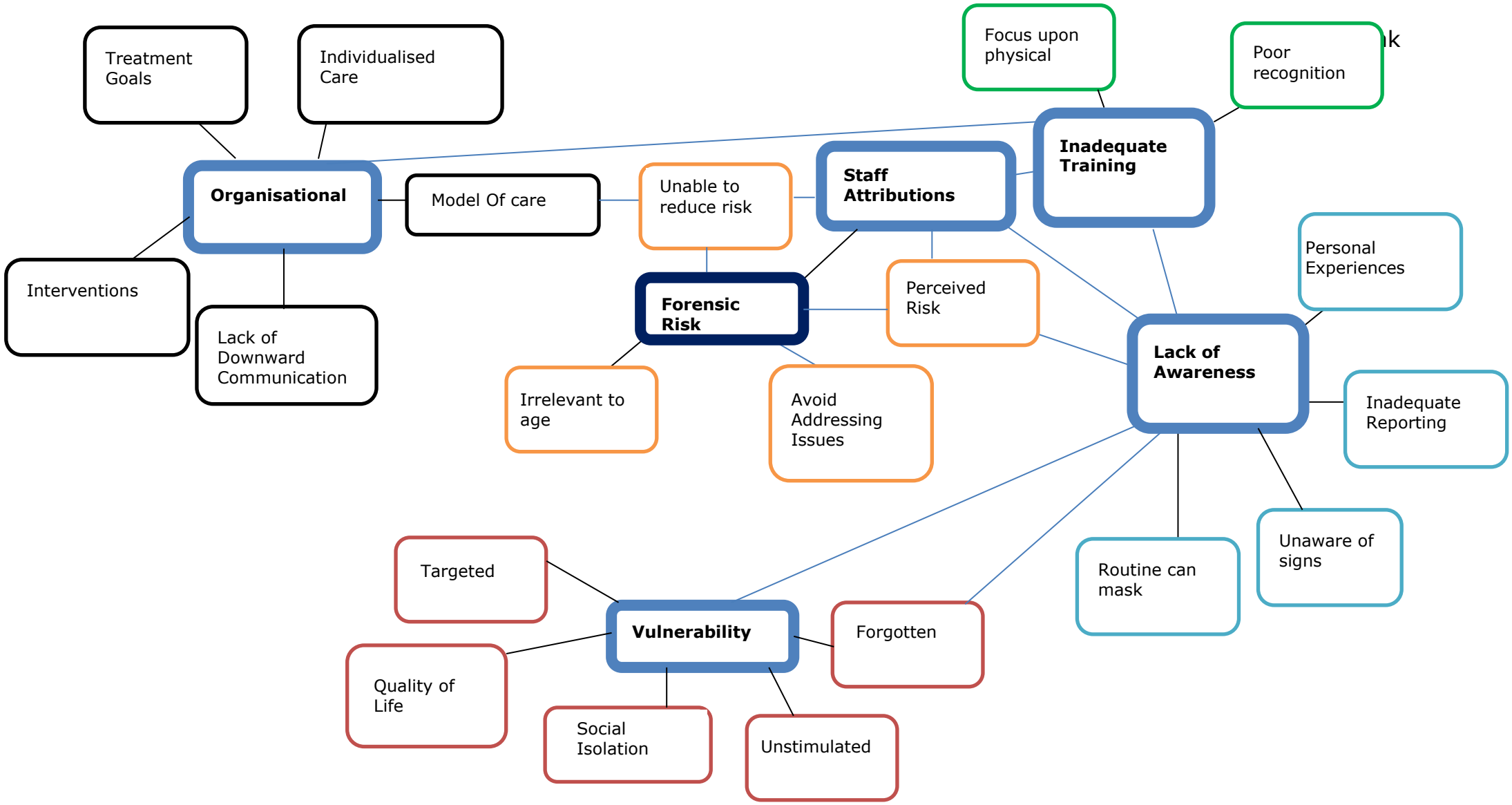


Figure 2. Full thematic analysis map of Nursing Group

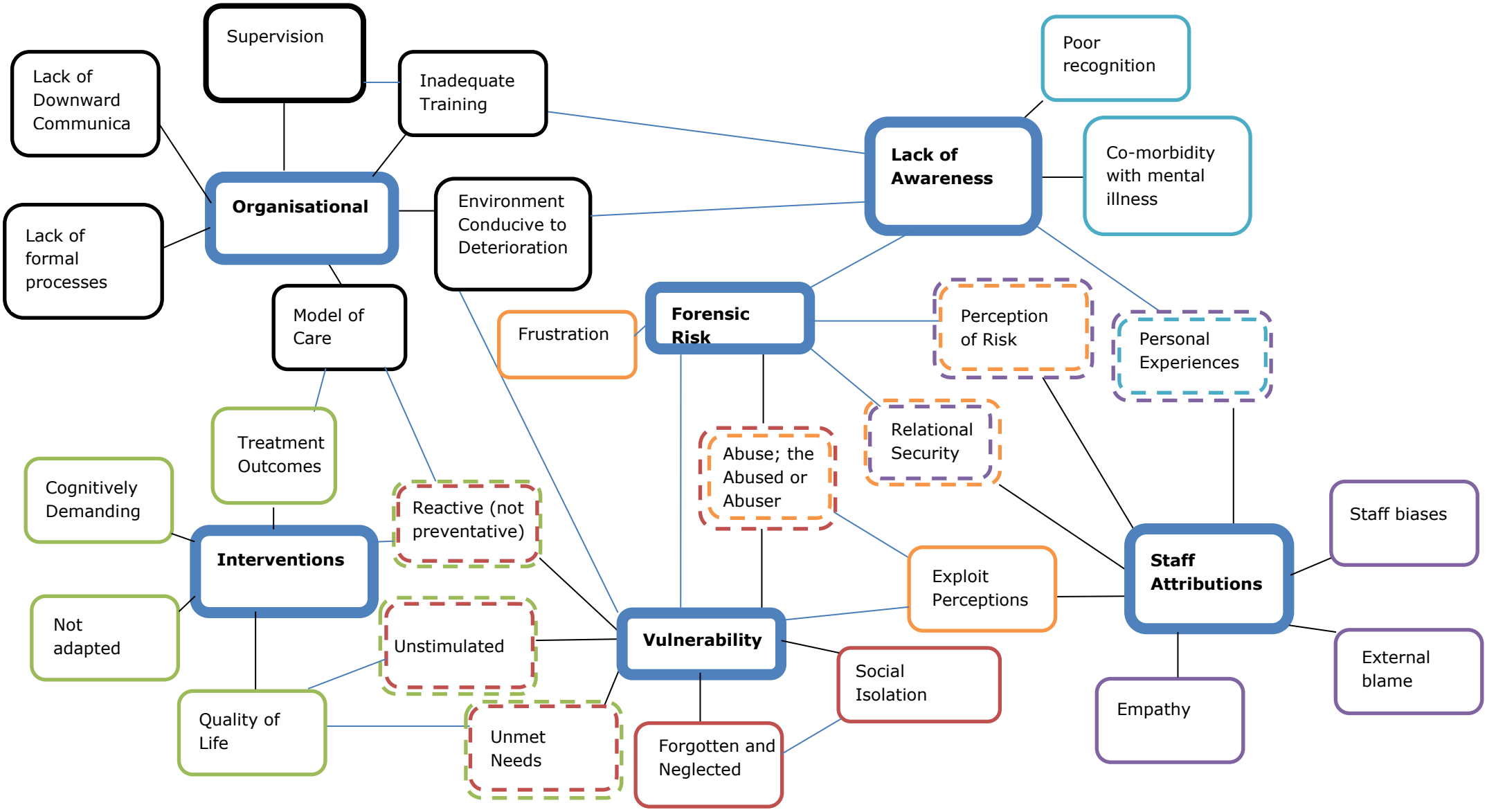


Figure 3. Full thematic analysis map of Allied Health Professionals Group

The themes identified through thematic analysis highlight the current challenges when recognising dementia within a forensic context, particularly the vulnerability of the older patient population, the influence of staff attributions and the constraints of the organisation.

In answer to the question 'Do members of staff in a medium secure unit recognise the signs of dementia and know how to manage it accordingly?' this research indicates that there is a lack of awareness of the cognitive signs of dementia, leading to professionals allowing their attributions to influence their recognition and management of older adults. This leads to missed opportunities at individual and organisational levels to recognise and provide appropriate treatment and interventions. The current model of care does not currently appear to be appropriate for the management of older adults and those with dementia.

This study met the aim of exploring the current awareness, preparedness and recognition amongst staff regarding older adults with dementia within a single MSU. However, despite including a number of disciplines in the scoping exercise, this study only included participants from the nursing, psychology and occupational therapy departments in the focus groups. Future research should be conducted on larger scales across other services and all levels of the organisation, including medical professionals, those who influence policies and procedures, and at strategic levels within the trust.

Staff education programmes have previously been found to reduce dementia-related aggressive incidents within dementia care settings (Chrzescijanski et al., 2007). Training and supervision should therefore be adapted to prevent individual biases and attributions skewing judgement and mediating risk management of older adults with dementia. Training regarding the recognition and management of dementia would also be useful.

The perceived inadequacy of supervision indicates a need for change to current supervision practices, encouraging reflection regarding personal experiences and biases influencing care delivered to older patients, particularly relational security and forensic risk.

When considering the appropriateness of the model of care and placements for older adults with dementia within forensic services, it was concluded that it does not appear feasible to create a new service due to small population numbers. However, current models could be adapted with emphasis upon quality of life.

It may be beneficial to deliver staff training regarding recognising and managing dementia and older patients within secure care. Changes to current supervision practices would encourage reflection regarding personal experiences and biases influencing care, particularly relational security and forensic risk.

In conclusion, staff awareness and recognition of dementia require improvement in order to protect against the identified vulnerability factors, manage personal attributions and improve relational security thus preventing aggressive and violent dementia related-incidents.

Word Count: 833

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Do members of staff in a medium secure unit recognise the signs of dementia and know how to manage it accordingly?

Alicyja Uczniak

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Aims and rationale

- Despite an increase in public health priority regarding increasing quality of life for those with dementia, alongside promoting early detection and psychological and social interventions; this has not extended to those with dementia in forensic contexts.
- The aim of this research was to explore the experiences, awareness and attitudes of members of staff working within an MSU regarding older patients; specifically whether they recognise and manage signs of dementia and other age-associated risks.

Methods

Pre-study Scoping Exercise

In order to explore the aims of the research a scoping exercise was conducted to substantiate the rationale for the study, justifying the presence of dementia within the MSU and the lack of awareness regarding recognition and management. The results were used to inform the focus group topic guides.

Focus Groups

The focus groups were conducted sequentially, and the attitudes of Nursing staff group and Allied Health Professionals were compared and combined, using an iterative process to conduct a thematic analysis.



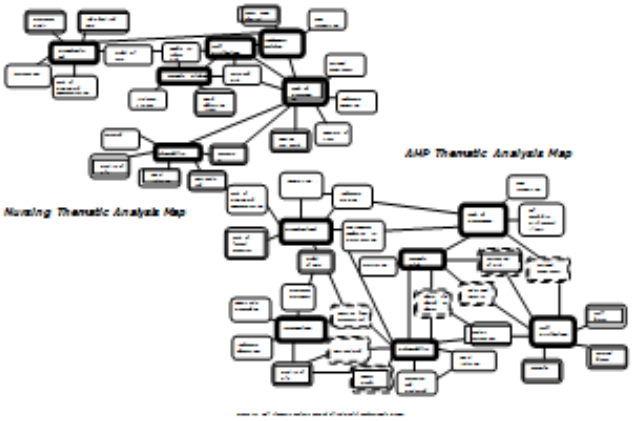
Results

Thematic analysis found an over-arching theme of **Forensic Risk**

- **Staff Attributions**: the influences of individual biases upon perceptions of risk, recognition and management.
- **Organisational Factors**: communication and processes at all levels, particularly the model of care and supervision.
- **Lack of Awareness**: recognition of signs and symptoms, adequacy of reporting and documentation.
- **Interventions**: the appropriateness and adaptation of treatment options.
- **Vulnerability**: susceptibility to abuse and neglect, influencing forensic risk.

Differences between the two staff groups are explored, with focus upon differences in reflective practice and supervision

Thematic Analysis Maps



Implications and Future Research

- Staff awareness and recognition of dementia require improvement in order to protect against the identified vulnerability factors, manage personal attributions and improve relational security thus preventing aggressive and violent dementia related-incidents.
- Implications regarding risk management, staff training, supervision and the model of care
- Changes to supervision practices would encourage reflection regarding personal experiences and biases influencing care, particularly relational security and forensic risk.
- Larger scale research across all levels of the organisation
- Conduct dementia awareness training and measure recognition and confidence in managing before and after

Reflection

Introduction

Whilst completing the Masters in Forensic and Criminological Psychology, I have continued to work at Arnold Lodge Medium Secure Unit (MSU) part-time as an Assistant Psychologist and Senior Healthcare Support Worker within the Male Mental Illness Service. The MSU has three care streams, Male Mental Illness, Male Personality Disorder, and Women's Service. Whilst working within the MSU, I recognised a disparity between the needs of older adults, particularly those with dementia, and the preparedness of the service to meet them. I therefore proposed the research in order to investigate the question; 'Do members of staff in a medium secure unit recognise dementia and know how to manage it accordingly?'

This reflection will explore the process of conducting the research, from conceptualisation, preparation and design, data collection and analysis, through to the write up of the research. The process will be considered using Kolb's (1984) model of experiential learning. The model compliments my learning style, reflecting upon objective experiences. The model consists of four stages:

- Stage 1: 'Concrete experiences', consists of events or experiences that have happened, and are used as the opportunity to learn and reflect.
- Stage 2: 'Reflective observation', involves thinking about and reviewing what has been done and experienced.
- Stage 3: 'Abstract conceptualization', interpreting the previous two stages in order to generate a hypothesis about the meaning of the experience.
- Stage 4: 'Active experimentation', the final stage of the cycle, testing the hypothesis generated within stage 3 and new experiences either support or challenge the hypothesis.

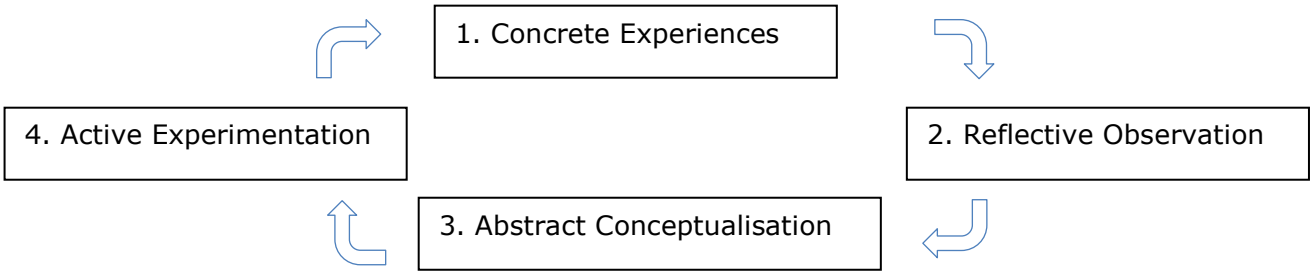


Figure 1: Kolb's reflective cycle

Conceptualisation

Within the process of conceptualisation, I was aware that I felt unprepared to recognise signs of dementia and manage those with the disorder within a forensic environment. After raising these concerns during group supervision, it appeared that other members of staff also felt unequipped to deal with the challenges posed by the older forensic psychiatric population, including those with dementia. It appeared that staff felt frustrated that they could not deliver appropriate care, and were also unsure how to manage their own emotions when unable to facilitate recovery.

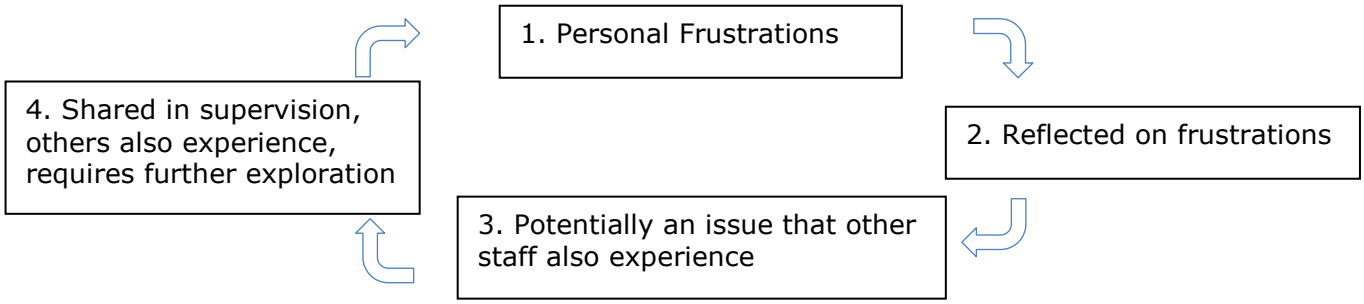


Figure 2 Conceptualising research aims

It appeared that other members of staff also felt that older adult's needs were not being met, and the current model of care may not be adapted to suit their needs. I felt that exploring the attitudes, experiences and preparedness of staff, and the wider organisation would be an appropriate first phase of research in this area, with potential to expand including patients in the future. Due to the short time frame of the Masters, my supervisor agreed that a staff only project would be realistic.

During the conceptualisation process, I attempted to be aware of any personal biases through my professional role to avoid influencing the direction of the research. We agreed that empirical evidence was required to justify the rationale for the research. A scoping exercise was proposed to identify the key issues, define and limit the field of research, as suggested by Ehrich, Freeman, Richards, Robinson and Shepperd, (2002).

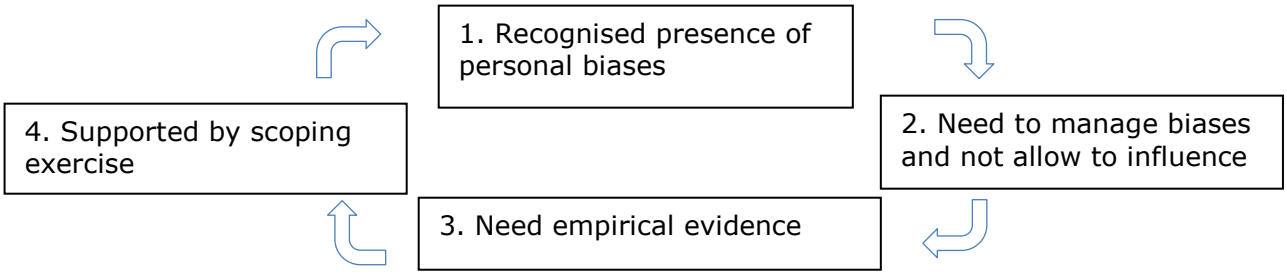


Figure 3 Managing personal biases from influencing the research

Due to the exploratory nature of the research, it was clear that the research would need to be qualitative, I was initially apprehensive as I had never conducted qualitative research before. I learnt that researchers should adapt and use methods suited to the aims of the research, and not force methods to fit with previous experience.

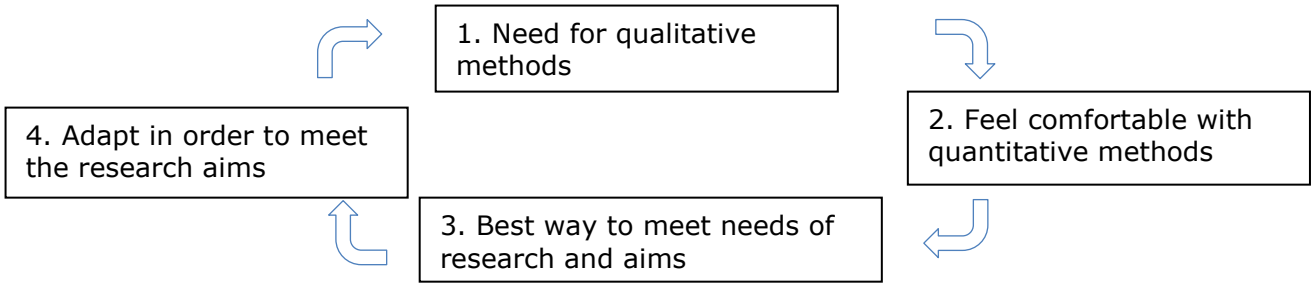


Figure 4 Apprehension completing qualitative research

I initially experienced difficulties finding related articles on the topic, however, upon reflection re-framed this as an advantage as there is currently a gap within the current literature. I then used this experience to begin writing the introduction section, with strong arguments regarding the need for the research. The need was also confirmed during the scoping exercise.

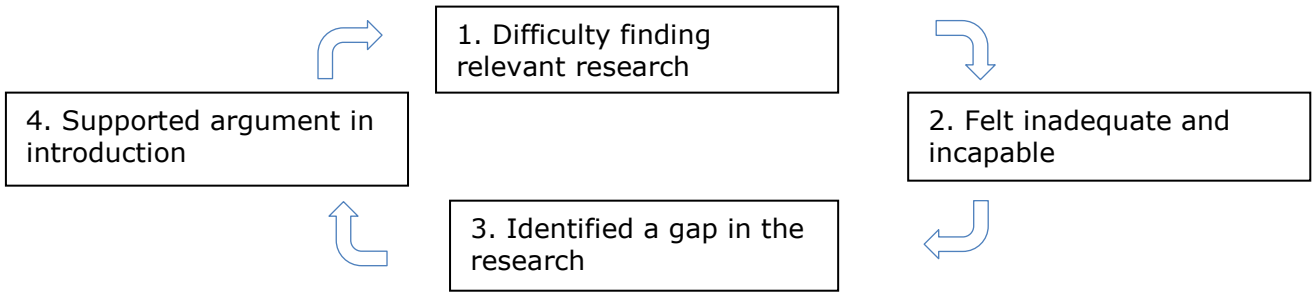


Figure 5 Difficulties finding relevant research

Preparation and Design

Ethics Permission

Due to the research being conducted both within the NHS and as a University project, the permissions required were not clear. I sought advice from numerous professionals, and clarified the necessary approvals. It initially appeared that the research would require NHS Research Ethics Committee (NHS REC) and Health Research Authority (HRA) approval; therefore I completed an Integrated Research Application System (IRAS) form, which covered the research design in depth with specific details.

However, after liaising with Nottinghamshire Healthcare Foundation NHS Trust Research and Development (R&D) Department, the criteria had recently changed, and due to being a single site, staff only research project, the research only required university ethics board approval. Although the IRAS form was no longer needed, the information prepared for the form covered the research in rich detail, and was used to inform the final research protocol.

Following submission and approval by the University of Nottingham Sponsorship Department, an application was submitted to the Division of Applied Psychology Ethics Committee. However, there was also change in acceptance criteria and higher permission from the Faculty of Medicine Ethics Committee was required. This process allowed me to

become familiar with numerous application forms and in-depth knowledge of the design of my research project.

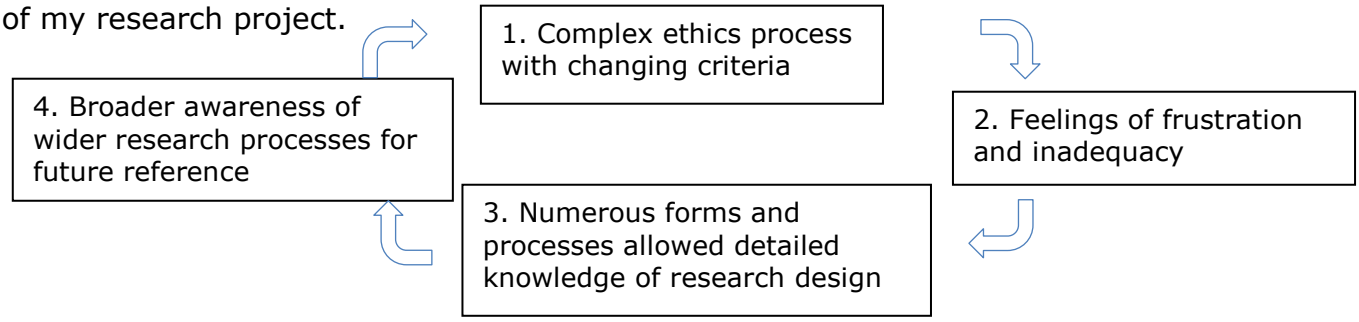


Figure 6 Difficulties with ethics and permissions processes

I found it difficult to manage feeling out of control when waiting for external processes to occur. I reflected upon managing these feelings and associated frustrations, and reframed the experience as an opportunity to use the time productively to start preparations for the next stages of the research.

Research Design

Due to the complex nature of the research, I felt it was best explained in diagram format *(Figure 7)*. At first I found it difficult not having all materials prepared, however, it meant that the research was not constrained to my personal expectations.

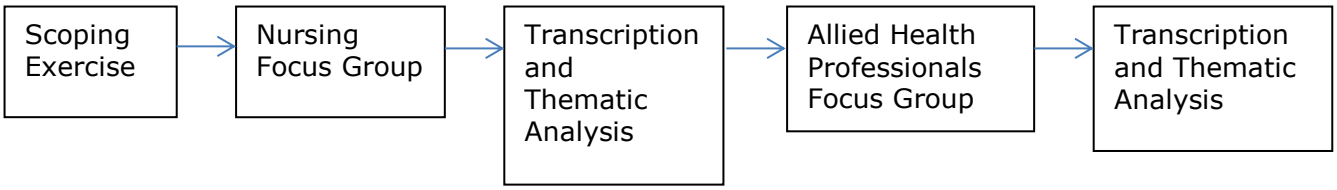


Figure 7: The research design iterative process.

Data Collection and Analysis

Scoping Exercise

I found the process of conducting the scoping exercise straightforward; it received a positive response rate, and Bristol online survey was easy to use.

Focus Groups

I felt it was necessary to rehearse the role of facilitating a focus group, particularly how to interact as the facilitator. I asked a family member questions about a topic, guiding the conversation to remain relevant. I found this useful, particularly because I listened back to the recording and noted the minimal answers received when closed questions were used. This exercise also emphasised the importance of not using technical jargon. Within Kolb's reflective cycle, the hypotheses I formed were tested when I facilitated the focus groups.

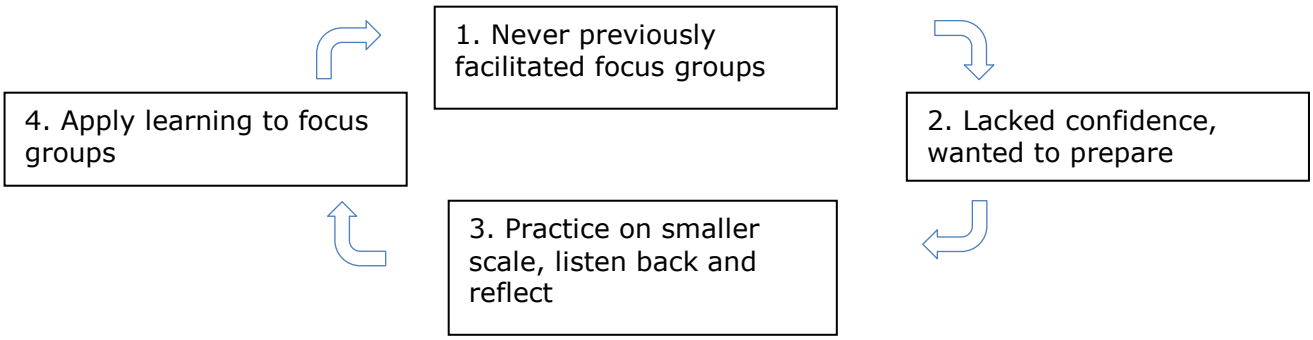


Figure 8 rehearsing role of facilitator

During the focus groups, I ensured that I maintained awareness of my presentation, ensuring that my personal biases and attitudes did not influence participant's responses, as reflected upon during the conceptualisation section. I found facilitating the focus groups enjoyable, participants openly engaged and shared their experiences.

I conducted the thematic analyses as described by Braun and Clarke (2006), transcribing the focus group discussions myself allowed me to get a feel for the content of the discussions.

I found the thematic analysis coding and developing thematic maps difficult at first, possibly because they are creative and abstract, as opposed to right and wrong answers, which I am more familiar with. I hypothesised that I was overcomplicating the task, and

that the codes should be clear and simple. Once applied, the process became much easier. To test the hypothesis, I reviewed my first attempt at coding the transcript in supervision, and following revisions, the codes and maps started to appear coherent.

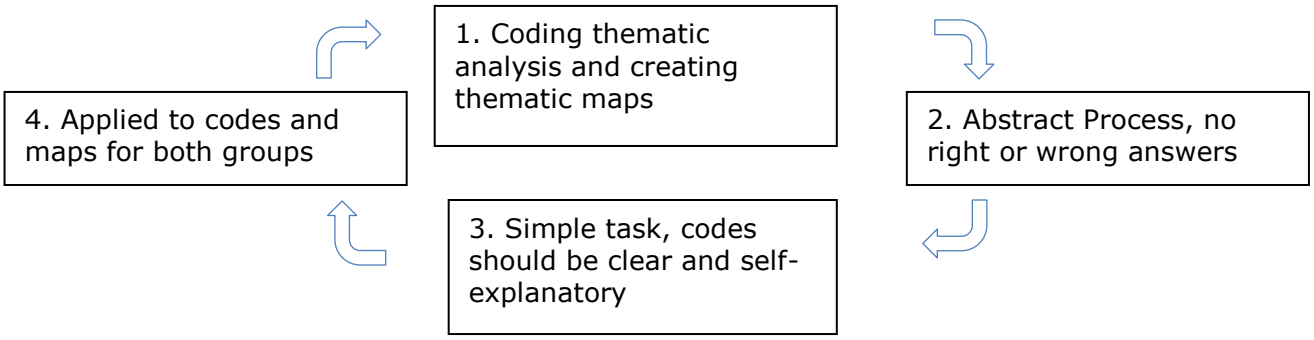


Figure 9 Thematic analysis process

At first I attempted to make too many themes, over time I understood the importance of consolidating the themes. When completing the second map, I was able to build upon the themes identified within the first group and display a wide representation of staff perspectives.

Write up

I started the final write up quite early within the research process, using the information from the research protocol and scoping exercise whilst waiting for other processed to occur. In order to ensure that the style of the paper was appropriate, I developed my understanding of the structure and style for reporting thematic analyses within unrelated journal articles. I also researched appropriate journals that the research would be suitable to submit to, and concluded that the research findings would be of more interest within forensic journals than geriatric journals. I decided upon the Journal of Forensic Psychiatry and Psychology. In order to meet the structural criteria, tables have been used which present new information rather than duplicating the text, and can be interpreted without reading the text.

I found it beneficial to take time away from the research, reading the full write up with a fresh perspective. I particularly was concerned that explanations which made sense to me may not be comprehensible to others, or the article may make sense as individual components but not flow as one narrative. By doing this, I was able to read the full article objectively, and make changes which I may not have noticed when too immersed within the research.

Supervision

Throughout the research process I was supervised by Dr D. Coleston-Shields, Consultant Clinical Psychologist and Neuropsychologist at the Institute of Mental Health. We met regularly to discuss the conceptualisation, design and planning of the research. I found this helpful to understand the numerous processes and procedures that must be followed when applying for ethical approval.

I was also supervised on-site by forensic psychologist R. Lawday, who was able to provide advice regarding local requirements and the current treatment provision within the MSU. The research was approved by the Research and Development Committee, Dr D. Coleston-Shields and I met with them during the planning stages of the research, keeping them informed as the research progressed.

The collaborative supervision between the University and the NHS meant that I was aware of all procedures that must be followed from both sides, and the combination of forensic and clinical supervision allowed me to consider the research from both psychological perspectives.

Conclusion

In conclusion, I found that I learnt the most during the conceptualisation and design components of the research, as I was unfamiliar with numerous processes and

conducting qualitative research. I enjoyed conducting the research, and the whole process has allowed me to reflect upon my professional roles, including awareness of my personal biases influencing care, wider organisational factors and the importance of safeguarding and protecting vulnerability factors.

Word Count: 1662

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