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# Training healthcare assistants working in adult acute inpatient wards in Psychological First Aid: An implementation and evaluation study

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## Abstract

**What is known on the subject**

- Healthcare assistants are untrained and unregistered frontline staff but are expected to be proactive in preventing and responding to 'untoward' incidents quickly and efficiently when working within adult acute inpatient psychiatric settings.
- Healthcare assistants should be trained to provide enhanced care to service users residing in acute psychiatric settings. To date, a training programme in Psychological First Aid has not been expended in such a setting with nonregistered staff.

**What the paper adds to existing knowledge**

- The study demonstrates that training healthcare assistants in Psychological First Aid is useful in improving their confidence in caring for service users, therapeutic engagement with service users and ward culture in general.

**What are the implications for practice**

- A training programme in Psychological First Aid for healthcare assistants to enhance ward culture can be implemented in different practice environments.
- Psychological First Aid is harmonious with nursing values and provides healthcare assistants with a relevant, useful and easily understood toolkit to apply in acute psychiatric settings.

## Abstract

**Introduction:** Healthcare assistants working within adult acute inpatient psychiatric settings are untrained and unregistered, however, they can contribute to quality service if they receive some training. Psychological First Aid training has never been

expended in these settings, so this study intends to fill this gap in the existing evidence with this category of healthcare personnel.

**Aim:** The aim of this study was to introduce and evaluate first aid training for healthcare assistants.

**Method:** A pre/post design was adopted to gather data using questionnaires and interviews. The groups of participants included 16 healthcare assistants trained in Psychological First Aid, a sample of service users and four ward managers.

**Results:** Post-training, (a) healthcare assistants and service users ranked the therapeutic milieu of the ward more favourably, (b) the self-efficacy of the healthcare assistants increased, and the number of 'untoward' incidents decreased, and (c) health care assistants' confidence in their skills was high. The ward manager interviews post-training revealed four themes: (a) staff utilization of new skills and renewed enthusiasm, (b) calmer atmosphere on the ward and staff togetherness, (c) confidence and reflection on practice and (d) therapeutic engagement.

**Discussion:** Training healthcare assistants is useful in improving staff confidence, therapeutic engagement with service users and ward culture in general.

**Implications for practice:** Techniques and skills learnt are relevant and useful to healthcare assistants and provide an easily understood toolkit that is harmonious with nursing values. If executed correctly, the training can enhance practice and care outcomes and the overall service user experience.

**KEYWORDS**

evidence-based practice, nursing education, patient experience, professional development

## 1 | INTRODUCTION

Healthcare assistants (HCAs) working in the NHS make-up around a third of the caring workforce in hospitals (Cavendish Review, 2013). There are now over 1.3 million, dedicated, frontline staff like HCAs who are not registered nurses yet deliver the bulk of hands-on health and social care (Health and Social Care Information Centre and National Minimum Dataset – Social Care 2011–2012; University of Oxford, 2012). This critical and strategic resource is somewhat undervalued, underappreciated and overlooked (UNISON, 2016). Health Care Assistant (HCA) training is neither sufficiently consistent nor well-supervised to guarantee the safety of patients and users (Cavendish Review, 2013). As the landscape of health and social care becomes more complex and challenging so too have the tasks carried out by HCAs working with vulnerable service users residing in these settings.

The issue of responding to and managing distress and disturbance is one of the major challenges of modern mental health services (Chambers, Kantaris, Guise, & Välimäki, 2015). To enhance care quality and prevent and/or reduce untoward incidents on psychiatric wards better communication and interaction with service users is vital. Untrained and nonregistered, frontline staff like HCAs should have the opportunity to undertake

training and education. This will enable them to be proactive in preventing and/or responding to untoward incidents quickly and efficiently. Working on a psychiatric ward requires many proficiencies including excellent communication and listening skills, an understanding and empathic manner, being warm and caring and having the ability to stay calm and in control in difficult situations (NHS Health Education England, 2018). The Mental Health Foundation (2013) recognizes that good listening skills and the ability to respond to complex needs are important skills needed by HCAs. Healthcare assistants (HCAs) working within psychiatric settings, where there are high levels of acute distress, disturbance, aggression and/or violence among those experiencing acute mental illness, need to be capable of acting independently and making the right judgements in what can be challenging and stressful situations (Bowers, 2011; Whittington & Richter, 2006). Research by McAndrew, Chambers, Nolan, Thomas, and Watts (2014) found that staff on psychiatric wards considered it unfair that nonregistered staff get minimal training and are not trained in how to de-escalate challenging situations and how to talk to service users. There are no mandatory courses on improving such communication. The Royal College of Nursing (2011) stated that the NHS HCAs' training is "unacceptable". "The psychiatric ward is a pretty frantic place a lot of the time and the people who have

most contact with the patients are the people with the least qualifications" (Bowers, 2011, p. 66).

Psychological first aid (PFA) is a technique designed and developed by the National Center for Post Traumatic Stress Disorder (NC-PTSD), a section of the United States Department of Veterans Affairs (2006), to reduce the occurrence of post-traumatic stress disorder (PTSD), an anxiety disorder caused by stressful, frightening or distressing events (American Psychiatric Association, 2013). According to the NC-PTSD (2006), PFA is a 'needs led' assessment for assisting people in the immediate aftermath of adversity to reduce initial distress and to foster short and long-term adaptive functioning. Psychological first aid (PFA) is meant to be humane, nonintrusive, supportive and involves practical assistance given to those who have recently suffered exposure to 'stressors'. It deals with practical issues which can create stress and aims to improve self-efficacy (one's belief in one's own ability to complete tasks and reach goals; Ormrod, 2006), to enable the client to develop their own coping skills. The components of PFA include having the opportunity to talk without pressure (it does not necessarily involve discussion of the traumatic/distressing event nor are people asked to analyse what has happened or put time and events in order), active listening on the part of the 'first aider' (not to pressurize people to talk about their feelings and/or reaction to an event) and compassion. Steps in the training include contact, engagement and stabilization. The danger of violence and/or aggression is often associated with the branch of psychiatric nursing (Care Quality Commission, 2010). One of the special skills required in this field of nursing is to spot a build-up of tension and be able to defuse it, take charge of stressful, untoward incidents and/or their aftermath. These skills are all essential in performing PFA according to the technique's components and steps (NC-PTSD, 2006). Frontline nonregistered staff such as HCAs who work within psychiatric settings are perfectly placed to benefit from this training. Using PFA is not something that only qualified professionals can do as it is not seen as professional counselling; when crises occur HCA practitioners are expected to guide service users.

The mainstay of current PFA work comes from the World Health Organisation (WHO) World vision War Trauma Foundation (2011–2019) but despite its popularity there is little empirical testing and evidence surrounding the efficacy of PFA. As far as the authors are aware, this is the first time that PFA has been expended in an acute, inpatient, psychiatric setting with nonregistered staff i.e., HCAs. This research complies with the innovation for global health to be applicable to the NHS (NHS Institute for Innovation & Improvement, 2014).

## 2 | THE STUDY

### 2.1 | Aim

The aim of this study was to introduce and evaluate first aid training for healthcare assistants.

## 3 | METHODS

### 3.1 | Design

This was an implementation study (no control used), which adopted a pre/post mixed-methods design. We sought to achieve the following—capture the culture of the ward and the delivery of the 'service' from the perspectives of both HCAs and service users, measure the self-efficacy of the HCAs; measure the therapeutic milieu of the ward from the perspectives of service users and HCAs; identify the number of observations, level of observations and number of 'untoward' incidents; assess the daily 'real-time' feedback from the service users to determine the impact of PFA training on the HCA response to 'untoward' incidents on the ward (as observed by the ward managers) after the PFA training; to assess the 'confidence in skills' of the HCAs post training and to review how the HCAs evaluated the training itself. An alternative hypothesis (2-tailed), 'There will be a difference in the rankings of HCAs in Therapeutic Engagement Questionnaire (TEQ) and General Self-Efficacy Scale (GSE) scores pre and post PFA training', was tested for the possibility of a relationship. This was based on paired data collected from the HCAs pre- and post training.

The impact of the short training programme was evaluated. In addition, the HCAs evaluated how they 'cared for' service users.

### 3.2 | Participants

A sample of HCAs participated in the training. Participants who volunteered shared characteristics and provided pertinent data (Carpenter, 2007). Eligible HCAs were identified and approached by their line managers to undertake the training. The study participants included 16 HCAs (10 males, [three of whom were working in the Psychiatric Intensive Care Unit], and six females), working in the adult acute inpatient psychiatric wards within the Trust. These HCAs were working day or night shifts, part-time or full-time, aged between 20–60 (the majority 38%, aged between 31 and 40) and were essentially of White British, Asian or Black African ethnicity. Although the HCAs were untrained to work within these settings, half of the participants were educated to degree level.

A convenience sample of service users also participated in the study. This group of participants were identified and approached by the ward managers. The inclusion criteria for the service user sample included residing for more than one week on the ward in question within the identified Trust, and up to two weeks after the PFA training of HCAs. Service users needed to have mental capacity as determined by the ward manager. A good command of English language was needed by all participants as the study documentation was only available in English. Both voluntary and detained service users were included (N = 29 pre; N = 31, post). Interested and willing participants were approached by the nurse researchers. As a courtesy, the responsible psychiatrist for the service users was informed of their

participation. The service user sample was recruited from four wards and the ward manager from each of these wards was included in the study.

## 3.3 | Psychological First Aid training (pre- and post training tasks)

Psychological First Aid (PFA) training included a 5-hr interactive, free flowing, face-to-face training course that puts participants in the role of a provider in a post-disaster/stressful scene. The training course is for individuals new to disaster/stressful events response who want to learn the core goals of PFA. It featured innovative activities and demonstrations and provided participants without former mental health education with the concepts and skills associated with PFA. Elements of PFA are to promote safety, calmness, connectedness, self-efficacy (and group efficacy) and hope for its recipients (WHO World vision War Trauma Foundation, 2011–2019). The principles and actions of PFA are the three 'Ls': *Look*—check for safety, check for people with obvious urgent basic needs, check for people with serious distress reactions; *Listen*—approach people who may need support, ask about people's needs and concerns, listen to people and help them to feel calm; *Link*—help people address basic needs and access services, help people cope with problems, give information, connect people with loved ones and social support. 'Link' stresses that it is important to adapt communication with people so we can be respectful to their culture.

Training began with a mindfulness exercise and then a background to PFA and how it might be relevant to busy inpatient wards. Participants were invited to discuss 'bad' things that had happened on the ward and 'difficult' service users. The theme was to self-reflect and validate skills. Communication exercises ensued with bad examples leading the way for what 'good' communication should involve e.g., not to force someone to talk about something that they do not feel comfortable talking about. Breathing exercises and stress management was then covered. Participants worked out the local resources and how they could prepare for events on the wards. The three 'Ls' were put into this context. Problem solving role play was included in the training which saw the HCAs cognitively place themselves in the problem that they were trying to solve. Social mobilization based on local circumstances was also included in the programme. The aim here was for participants to think beyond the inpatient as a collective and to think of the wider community including things, they would not have thought of before such as community resources, religion and culture. The psychoeducation that followed included problem solving, relaxation, breathing and mindfulness techniques, sleep hygiene education, stress management, self-care, social mobilisations, behavioural activation, and self-coping strategies (for the HCAs).

Throughout the session the HCAs attempted to validate their role as they are not always given credit for what they do as nonregistered staff. Their frontline role and its importance in psychosocial care and facilitating the care pathway for service users was emphasized.

As this was the first time PFA was expended in an adult acute in-patient psychiatric setting with nonregistered staff, the HCAs were asked to complete questionnaires to assess their confidence in doing the PFA activities and to comment on the quality of the PFA activities and to provide further feedback about the training.

## 3.4 | Data collection

The data collection took place in four adult acute psychiatric care units in England in a single mental health Trust. The number of beds in each unit ranged from 16 to 22. Acute psychiatric services in England take care of service users aged from 18 to 65 years and include persons with dual diagnosis, i.e., substance user disorders and mental health problems. Service users residing in the four units were a combination of detained and informal service users.

### 3.4.1 | Pretraining

On the day of the PFA training, the HCAs completed a questionnaire in relation to the therapeutic milieu of the ward as well as self-efficacy. Prior to the training, service users also completed a questionnaire in relation to the therapeutic milieu of the ward.

## 3.5 | Questionnaires

The Therapeutic Engagement Questionnaire (TEQ; Chambers & Kantaris, 2017) is a 20-item tool that is designed to assess therapeutic engagement from both the perspectives of registered mental health nurses and service users within adult acute inpatient psychiatric settings. The questionnaire is an opportunity for both staff and service users to express their opinions about therapeutic engagement within two contexts, the general clinical environment and atmosphere of their ward/unit i.e., the therapeutic milieu and one-to-one sessions. This study only asked for opinions on the former whose Cronbach Alpha is 0.97. The scale is self-administered and has a completion time of 5–10 min. Responses are made on a 4-point Likert scale that range from strongly disagree-strongly agree. Responses to the items are summed on two subscales (care delivery and care interactions) to yield the final composite score. The TEQ has been validated in England. Psychometric evaluation of the TEQ has shown high inter-scale correlations (0.66–0.95 SU; 0.57–0.90 RMHN), sound subscale internal consistency (>0.95), concurrent validity (>0.60) and adequate score variability. The TEQ behaves well as a measurement tool.

The General Self-Efficacy Scale (GSE) (Schwarzer & Jerusalem, 1995) is a 10-item scale that is designed to assess optimistic self-beliefs to cope with a variety of difficult demands in life. In contrast with other scales that were designed to assess optimism, this one explicitly refers to personal agency, i.e., the belief that one's actions are responsible for successful outcomes. The scale is self-administered and has a completion time of 5 min. Responses are made on a 4-point Likert scale

ranging from 'not at all true-exactly true'. Responses to all 10 items are summed to yield the final composite score. The internal reliability for the GSE has Cronbach's alphas between 0.76 and 0.90. With regard to validity, the scale is correlated with emotion, optimism and work satisfaction. Negative coefficients were found for depression, stress, health complaints, burnout and anxiety.

The service users may have asked someone of their choosing to assist them to complete the study documentation i.e., consent form, questionnaires; it may have been another user or staff members (not from the ward) however, this information was not collected. Missing data was not reported.

## 3.6 | 'Real-time' feedback

Service user 'real-time' feedback data (a quality indicator developed in the participating Trust based upon the NHS Patient Feedback Challenge, 2006), and ward data i.e., number of observations, level of observations, number of untoward incidents, was collected from the ward managers by the researchers prior to the PFA training of the HCAs. Collected data covered ward activity over the preceding 6 weeks.

## 3.7 | Post-training questionnaires and ward manager interviews

Two weeks after the PFA training service users were invited to complete the TEQ again. Service users who took part in the study prior to the PFA training of the HCAs were also invited to take part in the post study. Due to the transient nature of service users, paired data collection was not possible.

Four to six weeks after the PFA training the HCAs were invited to complete the TEQ and GSE questionnaires again. Whilst the research team understand that it takes time before the 'true' impact of the training can show, we anticipated that this timeframe would be enough for the PFA training to be embedded in the work of HCAs. At this point, the nurse researchers collected the 'real-time' feedback and ward data from the ward managers. In addition to this, a brief one-to-one interview took place between the nurse researchers and each ward manager. These interviews focused on ward activity over the preceding two weeks and the impact, if any, of training HCAs in PFA e.g., reduction of untoward incidents on the ward (this will be an indicator of change); interviews were audio-recorded.

## 3.8 | Training evaluation feedback

After the PFA training the HCAs were invited to give feedback about the training and their experience using a feedback sheet developed specifically for the course by the research team. Questions included: *what did you expect the training to include? Did the training meet your expectations? On a scale of 1–10,* (1 being the least and 10 being the most), *how helpful/relevant do you think the training will be in aiding you in your daily work?*

## 3.9 | Data analysis

Paired data collected from the HCAs (TEQ and GSE questionnaires) pre and post-PFA training were analysed by (a) simply comparing descriptive data i.e., mean, median, standard deviation and variance and (b) utilizing the Wilcoxon matched pairs signed ranks test for nonparametric related sample data to determine whether there was a difference in the ranking of pre- and post PFA training TEQ and GSE scores by the HCAs. The alternative hypothesis (2-tailed), 'There will be a difference in the rankings of HCAs in TEQ and GSE scores pre and post PFA training', was tested.

The service user data (TEQ) were analysed as pre- and post data by simply comparing descriptive data i.e., mean, median, standard deviation and variance but not as paired data.

Pre- and post 'real-life' feedback data (qualitative) was summarized and reviewed and 'verbatim' quotes extracted to support 'observations'. A comparison was made of positive and negative feedback.

A pre- and post review of the descriptive ward data supplied by the ward manager i.e., the number of observations, level of observations and number of 'untoward' incidents, was undertaken.

The interviews with the ward managers' post PFA training were transcribed verbatim and a 'mini' inductive content analysis (Elo & Kyngas, 2018) was undertaken to identify any themes to support the findings with specific emphasis on post training outcomes. All the authors were involved in the analysis of the data. The data were compared for agreement and were finally reviewed by an independent researcher for verification. Illustrative verbatim quotes from the recorded interviews were extracted to support the themes.

Training evaluation forms were also reviewed.

# 4 | RESULTS

## 4.1 | Questionnaire findings

A Wilcoxon matched pairs signed rank test was conducted to determine whether there was a difference in the ranking of pre- and post PFA training TEQ and GSE scores by the HCAs. Results of that analysis indicated that there was a significant increase in the HCA TEQ scores post training, $z = -1.99$, $p < .05$, therefore ranking the therapeutic milieu of the ward more favourably. Results of that analysis also indicated that there was a significant increase in how the HCAs ranked their self-esteem pre- and post training, $z = -0.32$, $p < .05$.

Table 1 shows the descriptive characteristics of the paired data for HCAs regarding their TEQ and GSE questionnaire scores pre- and post PFA training. The mean HCA TEQ and GSE scores increased post training and the variance decreased. Table 2 shows the descriptive characteristics of the service user group data regarding

their TEQ questionnaire scores pre- and post PFA training. The mean SU TEQ scores increased post training.

The data presented in the tables show the comparison between pre- and post training.

Observations within these kinds of settings are defined as "Regarding the patient attentively while minimising the extent to which they feel that they are under surveillance. Encouraging communication, listening and conveying to the patient that they are valued and cared for are important components of skilled nursing observations" (Standing Nursing & Midwifery Advisory Committee, 1999). There are four levels of observation Level 1: General, Level 2: Intermittent, Level 3: Continuous within eyesight and Level 4: Continuous within arms-length.

The following ward data were reported pre- and post training for only two of the four wards participating in the study (PICU and one adult ward) due to time pressures and staff shortage on the other two wards.

Pretraining, 36 service users in total had been on level 3 'Intermittent' observations. Pretraining, one service user per week for 6 weeks was on a level 4 'Within Arm's Length/Close observation', or level 2 observation. The number on level 3 observations fluctuated hugely from week to week but on average 5 service users per week for 6 weeks. Records showed 51 incidents pretraining including two around incidents involving aggression and/or violence.

Post-training, 40 service users had been on level 3 observations and one on a level 3 Within-Eyesight' observation. Serious incidents of violence and aggression recorded on the ward Incident Reporting system was as follows, 18 pretraining and 25 post training (incidents increased). The ward manager indicated that during the study period the ward was busier than usual with many service users having high acuity. Post-training also saw a mean of 5 people per week on level 3 observation and one service user on level 2 observations. Records showed 39 incidents post-training.

## 4.2 | 'Real-time' feedback findings

The 'Real-time' feedback was reviewed and on the whole, there was no difference between the service user comments pre- and post training on either ward. Pretraining comments included, "the level of stress on the ward was well-managed for all; I am happy with my

experience on the ward; thank you very much for helping me; good support and care; I am always listened to when I have problems or difficulties; staff are very supportive and understanding". However, one service user made this comment, "service could be improved; should be able to access staff more often". Post-training comments included, "the staff are all good and took good care of me; staff were relaxed, and professional atmosphere is good; being afraid at first…. Lead to me actually feeling safe and understood; they (staff) listening to me". One service user from one of the wards commented, "staff should talk more with service users". Service users were assured complete anonymity with regards to their feedback and no demographic data were collected.

## 4.3 | Ward manager interview themes

The ward manager interviews post-training were positive and informative in nature, "I think the training has had a positive effect and I would like to see more people do it; the staff who did the training were really positive about it and they really enjoyed it and came back talking about it; they were really enthusiastic and they wanted to tell everyone (colleagues on the ward) what they learnt". Ward manager (WM)1.

Post training outcomes were encompassed by the following four broad themes that are illustrated below with verbatim examples from the interview transcripts.

### 4.3.1 | Theme 1: Staff utilization of new skills and renewed enthusiasm

It appeared that staff members were enthused and keen to show what they had learnt, "The member of staff is keen…. already started using the approach she has acquired" (WM1), "The HCAs have taken on a more leadership role as they seem to have more confidence and they don't rely so much on the nurses in psychiatric emergencies"(WM4). Staff members were also dealing with emergencies, "…using knowledge of patient to deal with them" (WM2). There was a language/attitude shift by staff members such as "Let me go and talk to (patient name) first" (WM3), and "Can I try my thing first?" (WM1) One of the ward managers reported that "…there was a very distressed patient on the ward that the

**TABLE 1** Descriptive characteristics of HCAs pre- and post-TEQ and GSE scores

|  | Pre-TEQ | Post-TEQ | Pre-GSE | Post-GSE |
|---|---|---|---|---|
| N = 16 |  |  |  |  |
| Mean | 68.5 | 72[a] | 310 | 316[a] |
| Median | 70.5 | 76 | 3.3 | 3.3 |
| SD | 11.19 | 8.3 | 6.78 | 3.39 |
| Variance | 125.14 | 68.84[b] | 46 | 11.48[b] |

[a]Increase in mean score.
[b]Decrease in variance.

**TABLE 2** Descriptive characteristics of SU groups pre- and post TEQ scores

|  | Pre TEQ | Post TEQ |
|---|---|---|
| N | 29 | 31 |
| Mean | 57.8 | 59.6[a] |
| Median | 58.50 | 55.50 |
| SD | 15.03 | 16.08 |
| Variance | 225.96 | 258.61 |

[a]Increase in mean score.

Registered Mental Health Nurse said needed to go to Psychiatric Intensive Care Unit; one of the HCAs who undertook the training said that we need to manage the patient on the ward – this approach is very different to what he would have done before" (WM3).

### 4.3.2 | Theme 2: Calmer atmosphere on the ward and staff togetherness

Service users appeared calmer on the ward and wanted to take time speaking with staff, "(Staff) spending less time fire-fighting; more about dealing with incidents now" (WM4). In addition, a feeling of team support and 'togetherness' was reported by ward managers, "The ward is busy and we have a lot of disturbed patients at the moment; I see the team working together quite closely and de-briefing each other and supporting each other; good to see that" (WM1), "There's a togetherness within the team and a lot more support for each other" (WM2).

### 4.3.3 | Theme 3: Confidence and reflection on practice

Ward managers reported an increase in confidence from the HCAs who undertook the training when dealing with challenging situations and have been taking on a more 'leadership' role in such circumstances, "HCAs dealing with difficult patients and are more confident talking to patients when they are being challenging and aggressive. I don't know how confident they would have been a couple of months ago. It was nice to see these members of staff taking on a leadership role in these kind of emergencies; there's a change from before" (WM3), "Increase in confidence of HCAs; the ward culture can be about the RMN dealing with psychiatric emergencies but chaps who have undertaken the training have taken on more of a leadership role" (WM4).

After the training, the HCAs fed-back that they were most confident about doing the following: communication and problem solving, showing understanding when providing support and encouraging the use of coping strategies when under distress, "I learnt better coping strategies to deal with stressful situations on the ward. The pace of the training was really good" (WM1). "I learnt that the time you spend with them (service users) is equally as important as the convo itself" (WM2).

Ward managers have seen a shift in HCA staff members practice, "There's a change from before, a lot more reflecting amongst peers and looking outside the box" (WM1). Staff members have become more reflective in practice, "some impact on the way they de-escalate situations" (WM4). The HCAs seem to have embraced the training and becoming more forthright, "Let me go and talk to him first and see if I can encourage him to take his medication" (WM2). "The HCAs say things like, can I try my thing first" (WM3), I haven't seen this dynamic before" (WM3).

Post-training, the HCAs were asked to rate their confidence in the skills learnt during the training; 75% of trainees rated themselves as quite confident to very confident; two trainees rated themselves as 'a little bit confident' when 'giving special attention in a crisis situation'. The activities that the trainees were confident in doing were providing support with dignity, asking service users about their concern, empathizing with service users, breathing exercises and generally the 3 L's.

### 4.3.4 | Theme 4: Therapeutic engagement

Considering that therapeutic engagement is at the core of quality mental health nursing and has been recognized as being of significant clinical importance (Peplau, 1952) it is important that more therapeutic engagement with service users was reported by a ward manager, "Increase over the last few weeks in therapeutic one-to-one time" (WM2). This resulted in more positive feedback from the service users, "The last 2 weeks have seen much more positive feedback. A few weeks ago, it was chaotic and noisy experiences" (WM4). Feedback about ward staff in general, for example "I like it here; I like the staff here; I feel confident here". A ward manager reported, "the patients have had a more positive experience over the past four weeks" (WM1).

### 4.4 | Training evaluation feedback findings

Post-training, the quality of the PFA activities was rated as moderate to high quality by all trainees. All the trainees strongly agreed that the training was satisfactory, clinically important, simple to understand, that the role play activities were helpful, "Role playing allowed us to see things from the patient's viewpoint", the reading materials were informative and the training programme was helpful in general—"Every frontline nurse should take part in the training", "Very interesting and informative, with directly relevant methods". Trainees stated that they would use PFA when a patient is newly admitted to the ward. Managers reported that "more HCAs wanted to do the training, but they were unable to due to timetabling issues". "I would like to send more people to do the training. The staff came back from the training and were telling the other staff members what they learnt".

## 5 | DISCUSSION

Ward manager feedback has shown that the HCAs were able to more effectively manage aggression and violence on the wards in question and in a more confident manner (McAndrew et al., 2014). They found the training to be motivating and valuable and ensured renewed enthusiasm when interacting with service users (Chambers, Gillard, Turner, & Borschmann, 2013). Feedback from the trainees reflected a high degree of skill acquisition and enhancement and a

noticeable change in ward culture after completing the PFA training. The concern raised by Bowers (2011, p. 54), "…….. there is more time for chatting with patients on acute psychiatric wards than is overall utilised in my estimation", has been addressed here and the results shows that self-efficacy and therapeutic engagement can go hand in hand. The study objectives were met, and the training deemed successful.

Healthcare assistants (HCAs) do a remarkable job on psychiatric wards but they have no professional recognition. By training this nonregistered, frontline group of staff members they become more confident and learn to take on 'leadership' roles that help to de-escalate and defuse stressful incidents for the 'good' of the service users and other staff members. More one-to one time with service users enabled extra engagement with them which seemed to add to a calmer ward atmosphere. As previously mentioned, this research complies with the innovation for global health to be applicable to the NHS (NHS Institute for Innovation & Improvement, 2014). The results of research by others e.g., Marinopoulos et al. (2007); Chambers et al. (2010); Chambers et al. (2013) and Forsetlund et al. (2012) corroborate that education and training are key to changing staff attitudes, improving professional clinical practice and advancing healthcare outcomes for service users.

Current mental health policy (Department of Health, 2011) states that therapeutic engagement between service users and healthcare practitioners should be a must. This study demonstrated that training frontline workers can provide a stronger therapeutic milieu and HCAs can rise to the challenge of interacting with service users. Nonregistered staff should be provided with the necessary knowledge and skills to engage with service users (Bee et al., 2006).

## 5.1 | Limitations and strengths

The PFA was expended in an acute, inpatient, psychiatric setting with nonregistered staff like HCAs for the first time to the authors' knowledge. The sample size was small and was volunteer or self-selected therefore restricting the generalization of study findings. The inclusion criteria for the study included that the HCAs be willing participants as motivation to undertake the training and to make changes in practice was necessary. One could ponder that the HCA participants may have wanted the training and therefore more likely to use skills learned. Perhaps different results would have occurred if the training was mandatory for HCAs. In addition, the 'real-time' feedback findings were rather general, not meaningful and unrelated to the training. It appears that the 'real-time' feedback' on the wards is more of a platform for general feedback from service users. Furthermore, missing ward data could have produced biased estimates in 'observations', leading to invalid conclusions.

Despite these limitations, the study draws strength from the data that clearly shows a positive impact of the training on ward culture and increased confidence in HCAs. The findings are valuable for future studies of this kind (with a larger sample) and for the development of mental health education and practice. Training of this kind on other

adult acute inpatient psychiatric wards within other UK Mental Health Trusts and ward types who are interested in training frontline staff such as HCAs could see PFA training being mandatory for all staff. A power calculation has shown that a sample of more than 45 HCAs would be appropriate for such studies. Further and larger scale studies may assess the effects of the programme over time and involve the interviewing of HCAs and service users pre- and post training to evaluate the training, its use and impact upon service user outcomes/experience, and touch-on the impact on HCA work-life experience.

## 5.2 | Implications

The results have shown the difference training can make in healthcare settings. If executed correctly, PFA has the potential to reduce untoward incidents on psychiatric wards, enhance practice and care outcomes and the overall patient experience. For HCAs, their self-efficacy and confidence in delivering therapeutic care will be increased. Other clinicians and researchers can use the results to plan similar training programs. This training could be pre-requisite to brief solution focused therapy (BSFT) training (Hosany, Wellman, & Lowe, 2007) as they have similar principles. Together the two sets of training provide nursing staff with a goal-directed collaborative toolkit that is conducted through direct observation of service user responses (Chambers & Kantaris, 2017).

## 6 | CONCLUSIONS

Clearly, the training of nonregistered, frontline staff working in acute inpatient psychiatric settings can have positive impact for staff on a psychosocial personal level and for the ward culture and atmosphere. Improvement in service user outcomes is essential so training of staff would enhance the service user inpatient experience. Making Directors of Nursing aware that training nonregistered staff like HCAs can bring about positive change within psychiatric settings is necessary. This study has shown that nonregistered frontline staff like HCAs can achieve enhanced interaction and therapeutic skills with a short, focused training programme which not only has a positive impact on clinical practice but on the people that they care for.

## 7 | RELEVANCE STATEMENT

This article describes a training programme for healthcare assistants working in adult acute inpatient psychiatric settings and its evaluation from the perspective of (a) the ward manager, (b) the healthcare assistant and (c) the service user. The programme yielded positive results and it appears that skills learnt are harmonious to nursing values. If executed correctly, the training can enhance practice and care outcomes as well as the overall service user experience across the National Health Service (NHS).

## ETHICAL APPROVAL

Ethical approval was obtained from the NHS National Research Ethics Service (NRES) prior to the study commencing. The study was registered with the Research and Development Committee for the Mental Health Trust involved in the research. The nature and objectives of the study were explained to all potential participants. Written informed consent was obtained from each participant prior to data collection. Capacity to consent for service users was determined by the respective ward manager/s at the appropriate stages of the project. All participants were assured of their confidentiality and their right to withdraw from the study without penalty. Anonymity was always maintained as participant identifiers were used.

It should be noted that the PFA trainer, a Consultant Psychiatrist with much experience of PFA in the UK and beyond, sought permission to undertake the PFA training in this environment from the relevant parties.

## DATA AVAILABILITY STATEMENT

All data relevant to the study are included in the article. For more information about the raw data contact the lead and corresponding author at xckantaris@outlook.com.

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