
REsTRAIN YOURSELF
Implementing the Six Core Strategies© UK to reduce harm as a result of the use of physical restraint


The Health Foundation


uclan


aqua
Shape Change Inspire Quality Transform Care


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LIVERPOOL


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1824
The University of Manchester

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- Windsor Ward, Mersey Care NHS Trust
- Norbury Ward, Pennine Care NHS Foundation Trust
- Redwood Ward, Manchester Mental Health and Social Care NHS Trust

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The ReSTRAIN YOURSELF programme is adapted for the UK from the Six Core Strategies© developed in the USA by;

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Overview

In order to help you and your team/organisation achieve a reduction in restraint the toolkit will:

- Provide information on the REsTRAIN YOURSELF Programme and the six core strategies ©
- Outline how these can be applied within your organisation
- Outline what restraint is and why it should only be used as a last resort
- Share an approach to improvement, including some tools and techniques, to support you with
- Implementation and sustainability

About this programme

Restraint

Improvement approach

About this programme

Why should I be involved?

Who benefits	Why be involved
Patients and carers	• Reduction of incidents of harm • Improved clinical outcomes • To become actively involved in the development and redesign of services • Increased patient and staff experience/satisfaction
Service providers	• Standardisation of working practices • Improved clinical outcomes • Data to inform the improvement and redesign of services • Increased productivity and efficiency
Commissioners	• The opportunity to influence service delivery and redesign
Trust staff	• The opportunity to become involved with the development of improved methods of delivering services

What is it?

This was a two-year programme, which started in June 2014, and involved seven North West Mental Health Trusts.

‘The project’ is part of the Health Foundation’s ‘Closing The Gap’ programme. The Health Foundation is an independent charity working to improve the quality of healthcare in the UK.

The programme had three waves, with each wave lasting for 6 months. Importantly, the learning from each wave informed the next.

Wave	Mental Health Trusts involved
Wave 1	• Cumbria Partnership NHS Foundation Trust • Lancashire Care NHS Foundation Trust
Wave 2	• Mersey Care NHS Trust • 5 Boroughs Partnership NHS Foundation Trust • Cheshire and Wirral Partnership NHS Foundation Trust
Wave 3	• Manchester Mental Health and Social Care Trust • Pennine Care NHS Foundation Trust

The programme will be evaluated by the University of Central Lancashire, University of Liverpool and University of Manchester, with this being a continual evaluation for the duration of the programme.

About this toolkit

What is it?

This toolkit covers the REsTRAIN YOURSELF programme which encompasses the 6 Core Strategies ©.

The REsTRAIN YOURSELF programme is based on the US model, which was developed through extensive literature reviews and dialogues with experts.

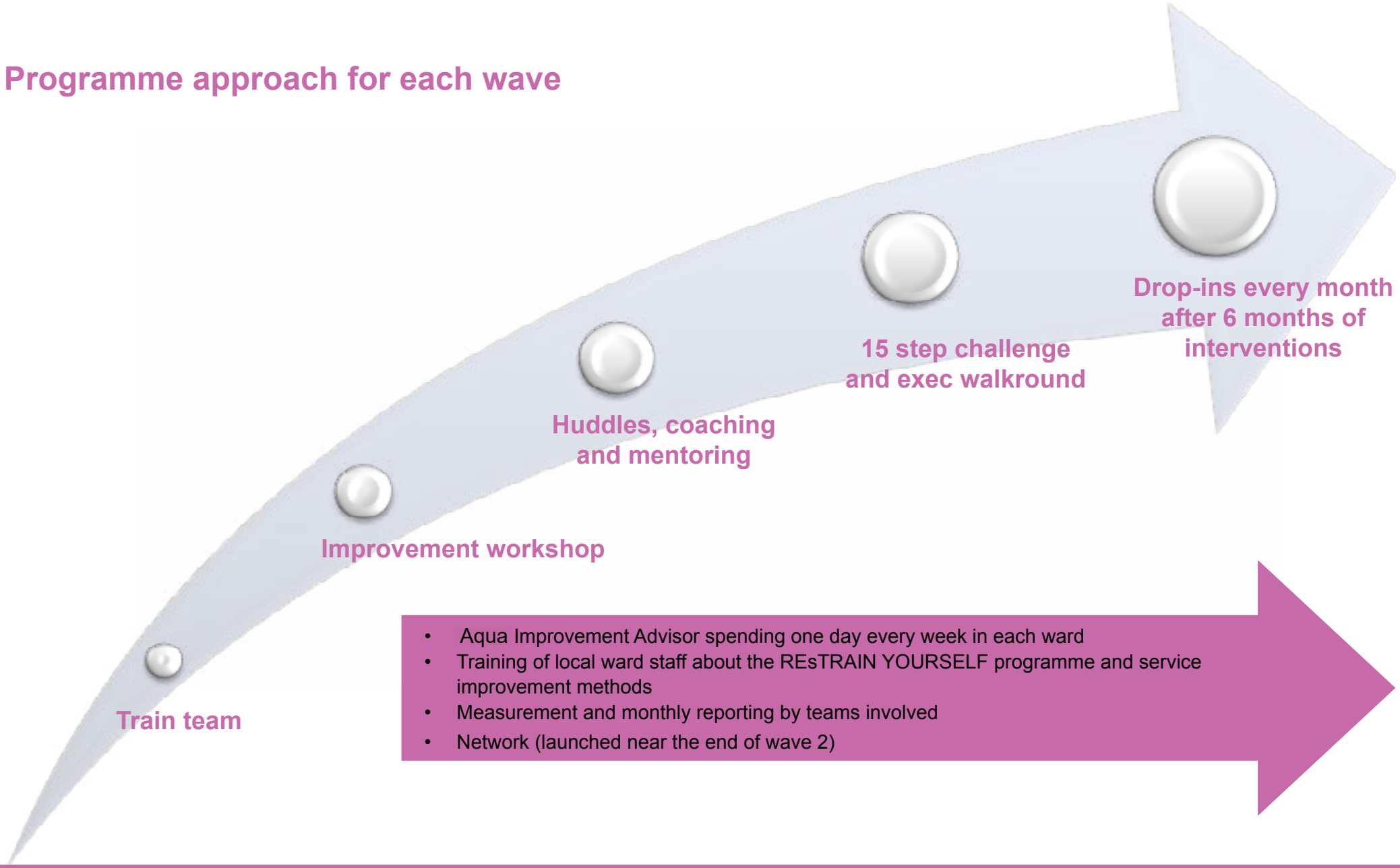
Use of this model has successfully reduced the use of restraint and seclusion in a variety of mental health settings, for children and adults across the US and internationally.

This programme draws on complex adaptive theory and human factors theory, in order to bring about the changes needed to avoid causing harm to patients through the use of restraint.

REsTRAIN YOURSELF Driver Diagram

About this programme

Programme approach for each wave



Programme measures

Programme measures:

- Number of restraints per month
- Number of days between restraints
- Number of violent incidents
- Number of days between violent incidents

Balancing measures:

- Number of medication led restraint per month
- Number of transfers to PICU/seclusion per month

Restraint: What is it?

Physical restraint is a coercive intervention that is commonly used in mental health services, which should only be viewed as a ‘last resort’.

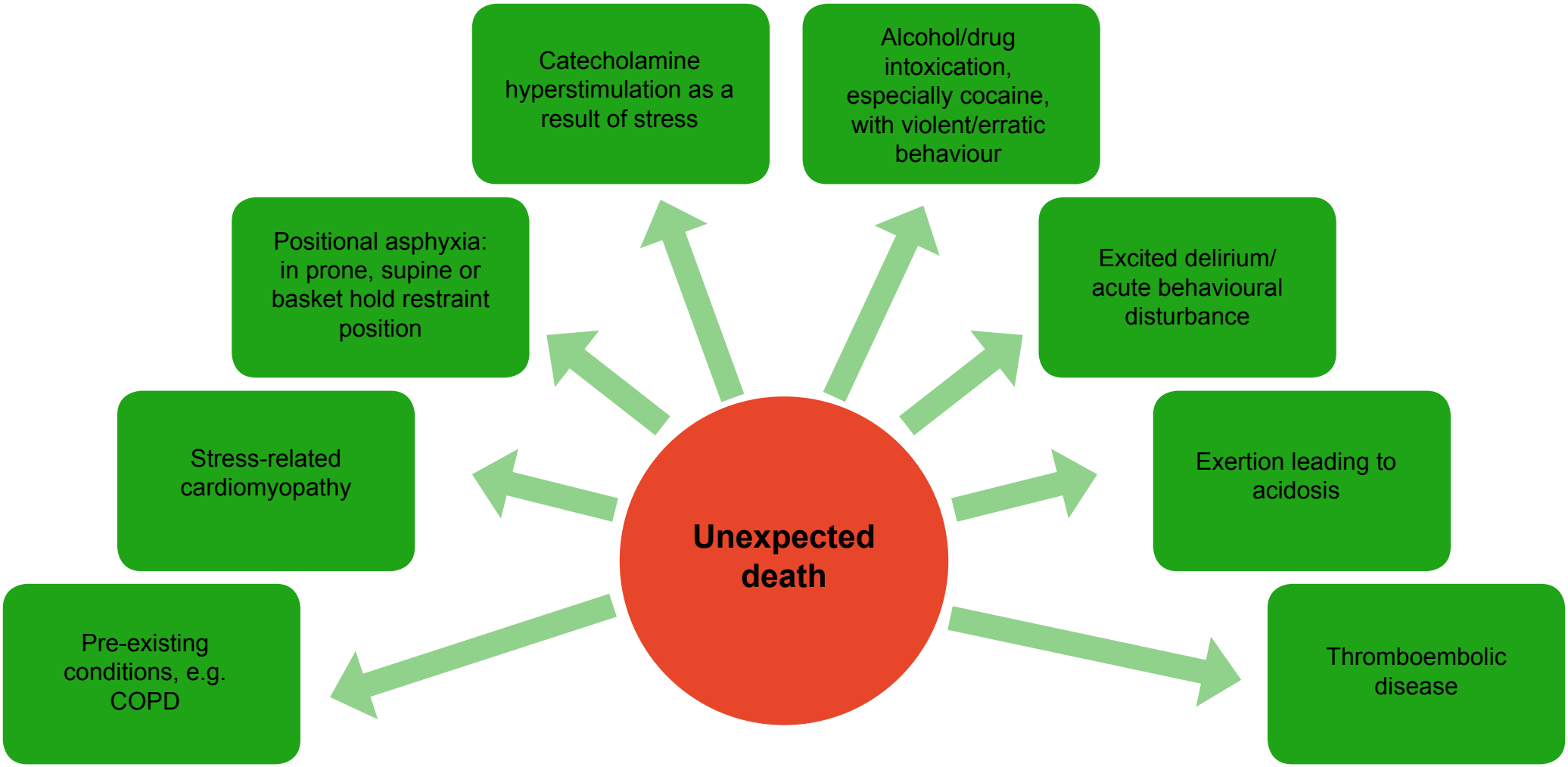
Increasingly serious concerns have been raised about its overuse and significant adverse effects. These have ranged from patient and staff discomfort and distress, both physical and psychological, to substantial injury and in some cases death.

The definition of restraint applied throughout this Toolkit is:

A skilled hands-on method of physical restraint involving trained designated healthcare professionals, to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned.

NICE, The short term management of disturbed/violent behaviour within inpatient settings, Feb (2005)

Multi-factorial causes of restraint-related deaths



Restraint

Did you know……

Holzworth & Wills (1999) conducted research on nurses' decisions based on clinical clues of patient agitation, self-harm, inclinations to assault others and destruction of property. Nurses agreed just 22% of the time. Nurses with less than 3 years clinical experience made the most restrictive recommendations.

UK Mental Health Act Commission's 12th Biennial Report (2008) still reports complaints of racism, disproportionate coercive care, and over-representation of BME community in acute inpatient settings. However, other reports cite inconsistent findings.

(Aitken, Duxbury, Dale & Harbinson, 2011)

Duxbury (2002) analysed 221 reported incidents of aggression and violence over a six month period in three acute psychiatric units.

Duxbury found that:

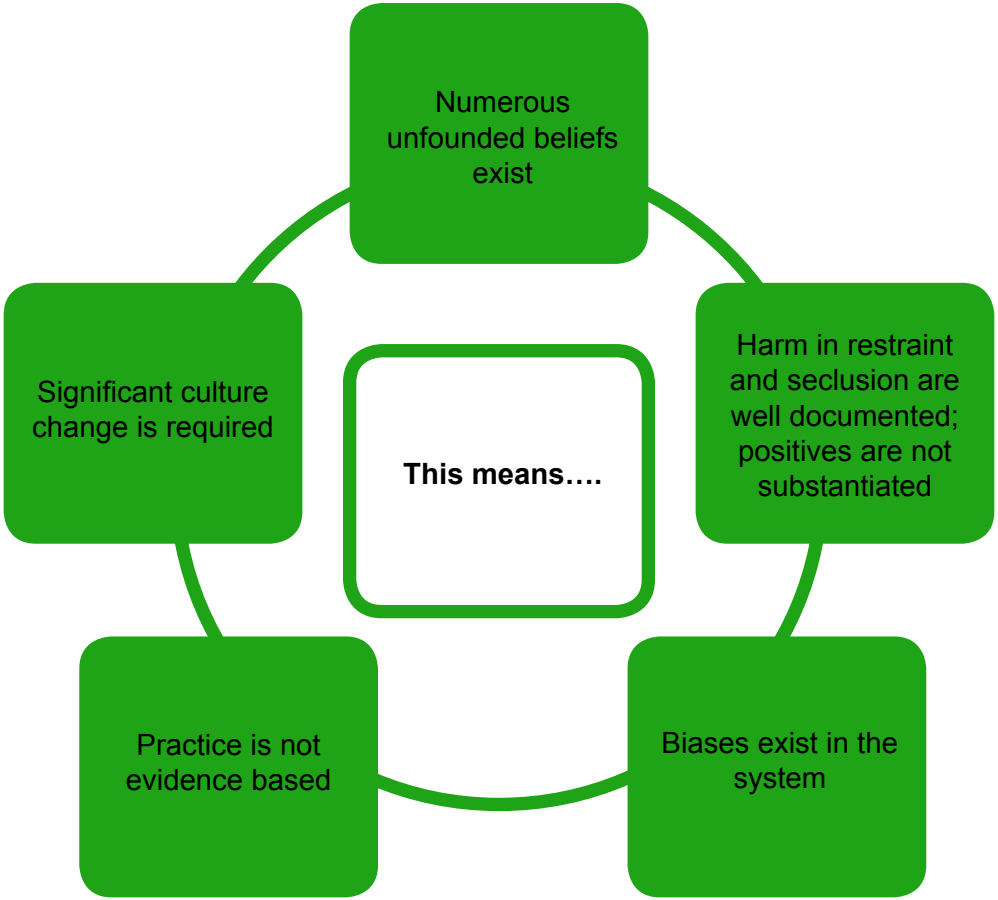
- de-escalation was used as an intervention less than 25% of the time
- semi-structured interviews identified a lack of training.

Currently, critics of the NHS cite institutional racism in NHS staffing – reporting only 1% of NHS executives are BME, and are nearly twice as likely to face disciplinary procedures than white counterparts.

Research indicates that, at best, trained mental health professionals alone can predict the potential for violence somewhat better than chance.

(Mossman, 1994; Lidz, Mulvey & Gardner, 1993; Jonofsky, Spears & Neubauer, 1988)

This means……


Numerous unfounded beliefs exist
Harm in restraint and seclusion are well documented; positives are not substantiated
Biases exist in the system
Practice is not evidence based
Significant culture change is required
This means….

Improvement Approach

Overview

"If you fail to plan, you are planning to fail!"

(Benjamin Franklin)

This quote is particularly important to consider as:

70% of improvement projects fail to deliver the promised results

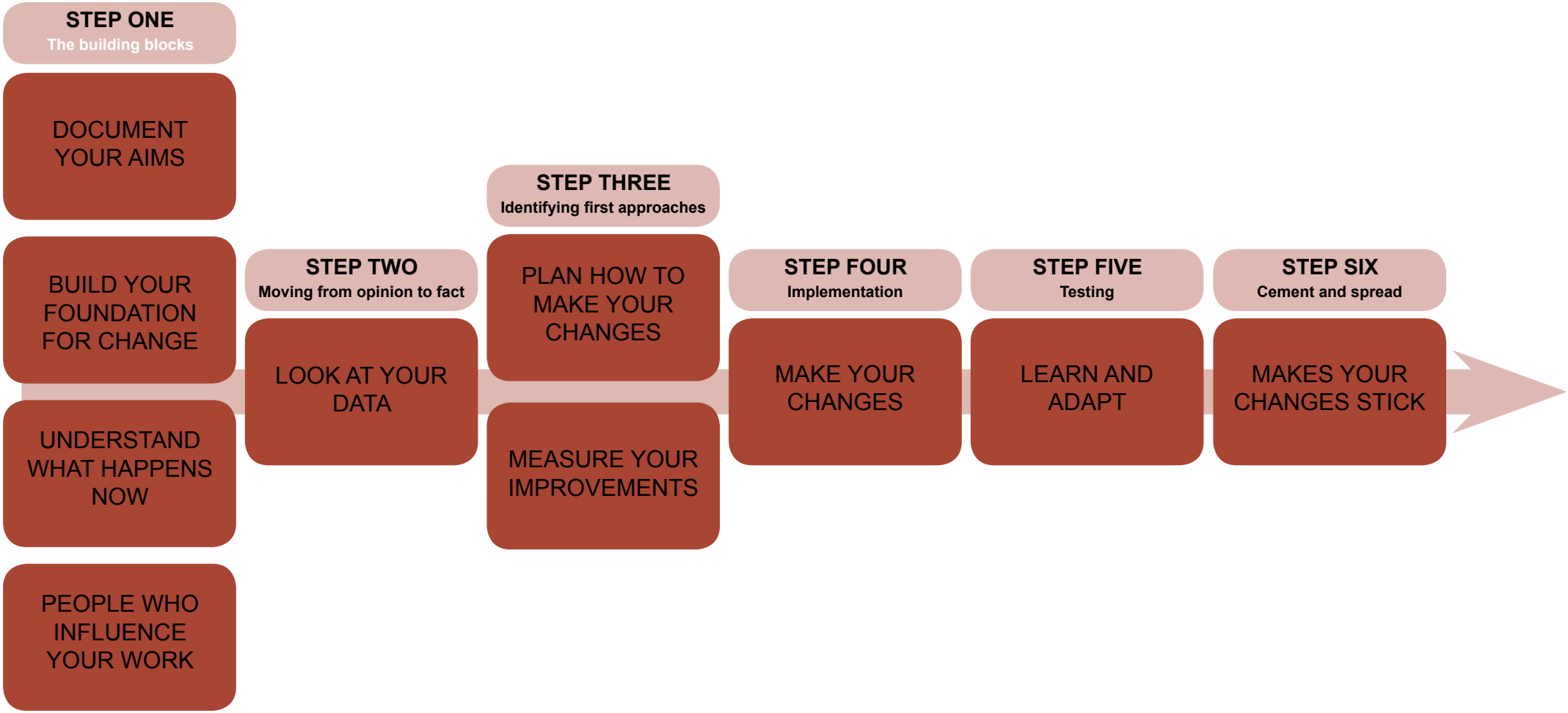
(Daft, R and Noe, R., Organisational Behavior, 2000, LONDON: Harcourt)

This means that only 30% of improvement projects deliver on what they set out to achieve. However, with careful planning and the application of a small number of quality improvement tools, you can considerably increase your chances of achieving success.

This section outlines the planning and quality improvement tools which you need for this programme.

These are based on Aqua's Six Step Improvement Model which is shown on the next page. This is a tried and tested approach to making improvement happen, and to keeping the improvements you make sustained.

Aqua's Six Step Improvement Model



Improvement Approach

Establishing a core group

All improvement projects need a core group to champion, troubleshoot and drive work forward.

Consider the following questions when looking to develop your core group:

- What is the purpose/remit of the group?
- Who will be the overall lead? You may want to consider here a model of leadership which consists of:
    - Project Lead: for the day-to-day running of the programme to keep it on track
    - Clinical Lead: for clinical input and expertise
    - Executive Sponsor: a senior executive/director whos responsible for the success of the programme
- Who else needs to be involved (recognising the need for patient and carer participation)?
- What will the structure of the team be? What is the role of each member within the group?
- How often does the group need to meet?
- Have the dates of meetings been booked in the diaries?
- How will the group communicate between meetings?

Creating a Driver Diagram

Put simply, a Driver Diagram is a strategy on a page.

A Driver Diagram outlines:

Overarching aim	What you aim to achieve by being involved in this programme
Primary drivers	The areas of focus to achieve your aim
Secondary drivers	Information on projects which need to be completed to ensure delivery on the primary drivers

It is advised that your team/organisation develop its own Driver Diagram so it is relevant to meeting the needs of your patients. You should take some time to do this. This is important because the Driver Diagram represents the strategy of what you are aiming to achieve. If the strategy is wrong you will not achieve your aim.

Improvement Approach

Creating a Driver Diagram

Creating a Driver Diagram

Many projects are started with a simple desire to improve things. However, this means you never really know whether you have reached where you need or want to be. It is advisable to take some time to understand what you need/want to achieve and develop this into the project aim.

Aims should be **SMART**: **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**ime-bound

The overall aim for participating organisations is to:

Reduce the incidence of harm caused to patients and staff as the result of an 80% reduction in physical restraint by the end of the programme (June 2016)

In order to make this aim SMART for your team/organisation further information will need to be added, for example:

Reduce by x% the incidence of harm caused to patients and staff as a result of the use of physical restraint from [insert number] **to** [insert number] **by** [insert date] **on ward** [insert ward name]

Creating a Driver Diagram

Primary Drivers

Your primary drivers for this programme are the six core strategies of the REsTRAIN YOURSELF programme as shown on page 26:

- Leadership
- Using data to inform practice
- Workforce development
- Restraint reduction tools
- Patient roles within inpatient settings
- Debriefing techniques

Secondary Drivers

The REsTRAIN YOURSELF secondary drivers are outlined on the Driver Diagram. However, you may want to add others (or even remove some of these) to make your Driver Diagram relevant to your organisation.

A Driver Diagram blank template can be downloaded from the Aqua website by clicking **here**.

Creating a ‘Plan on a Page’

A **‘Plan on a Page’** is a one page document which defines the programme plan, thereby demonstrating how the strategy (outlined in the Driver Diagram) will be delivered. Anyone looking at the ‘Plan on a Page’ document should be able to understand the programme aims and what is involved. An example of a ‘Plan on a Page’ is shown on the next page.

The ‘Plan on a Page’ is often supported by additional documentation, such as a stakeholder analysis and communications plans.

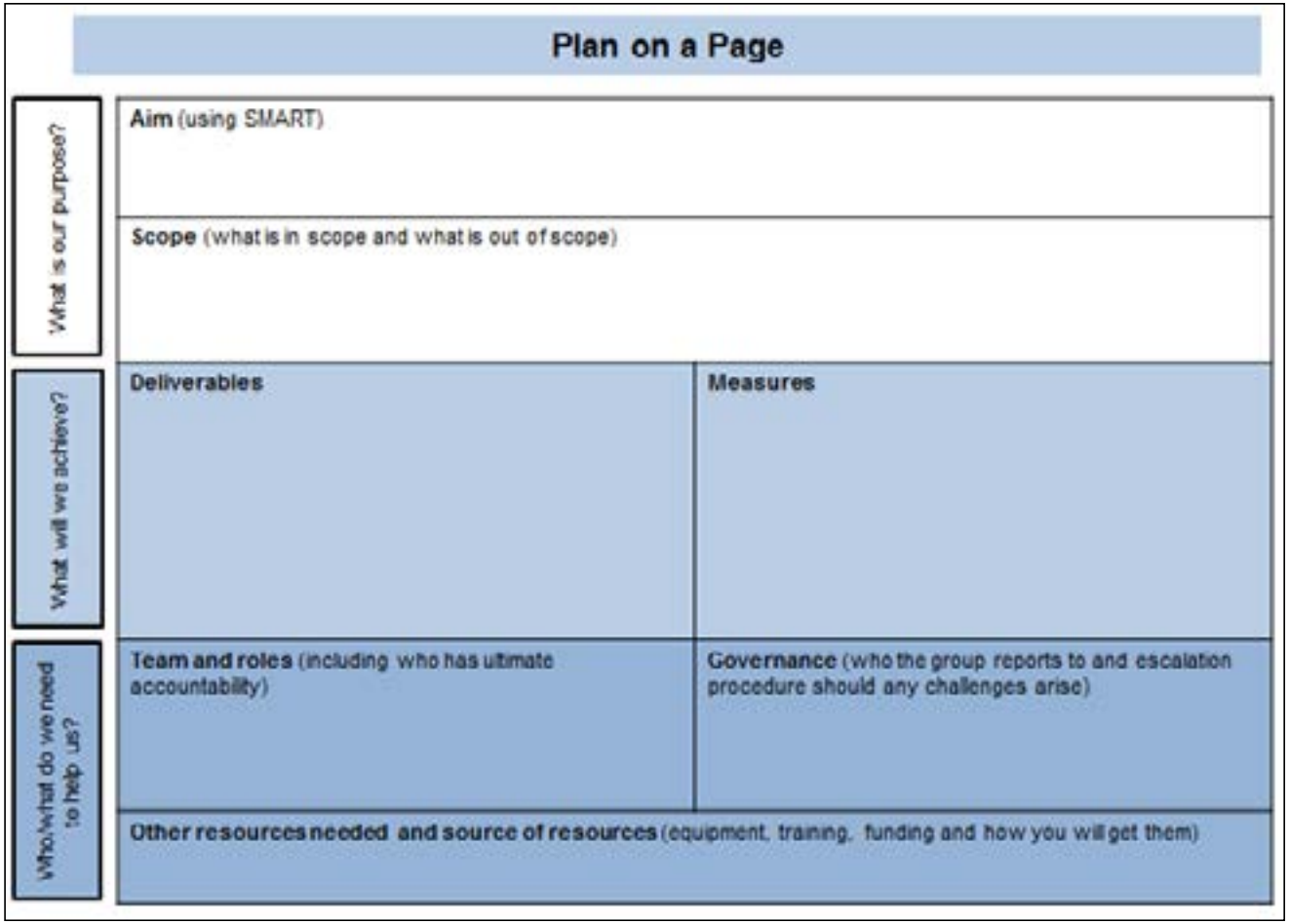
It is advisable at this stage to start developing a ‘plan on a page’ because it:

- Clearly outlines the programme in a concise way (which is also useful when explaining the programme to others)
- Can be used as a ‘sense check’ to ensure all key areas have been considered
- Should help keep the programme focused on what it aims to achieve, as it should be used as a reference point throughout the lifespan of the programme
- Can support in programme authorisation (if needed)

A ‘Plan on a Page’ blank template can be downloaded from the Aqua website by clicking **here**.

Improvement Approach

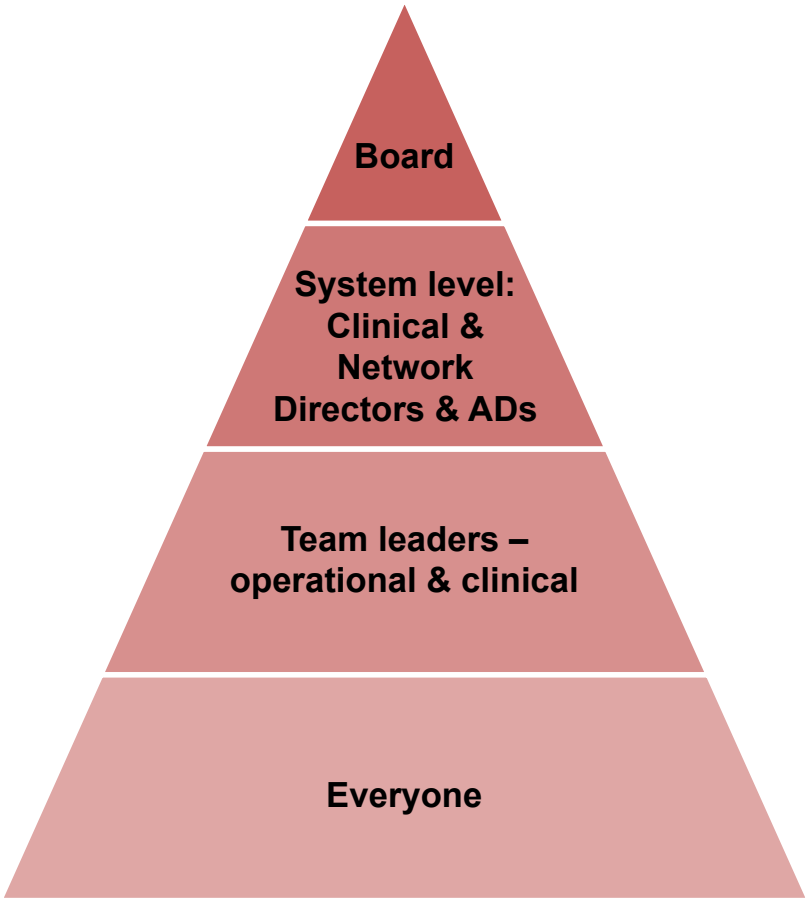
Creating a ‘Plan on a Page’



Plan on a Page

What is our purpose?	**Aim** (using SMART)	
	Scope (what is in scope and what is out of scope)	
What will we achieve?	**Deliverables**	**Measures**
Who/what do we need to help us?	**Team and roles** (including who has ultimate accountability)	**Governance** (who the group reports to and escalation procedure should any challenges arise)
	Other resources needed and source of resources (equipment, training, funding and how you will get them)	

When completing your driver diagram it important to look across the organisation at what you need at each level



Outlining governance arrangements

To keep the programme on track, don't forget about governance arrangements. Things to consider are:

- **Who is accountable and who is responsible for ensuring the programme succeeds?**

  The same individual often ends up being both accountable and responsible, but this should not always be the case. The person accountable might be your Chief Executive or a Director within your organisation, whereas many people should be responsible (i.e. the members of the core group). It is worth documenting who is accountable and who is responsible, so people understand their roles and required level of commitment.

- **What should happen if something isn't going to plan?**

  For example, what are the reporting mechanisms and escalation procedures, should a deadline slip or if something goes wrong? Agree and then communicate the agreed process to all involved, so they can act quickly should a problem arise.

Developing a communications strategy

Communication is key when involved in any improvement programme.

It is important to think about:

- Which stakeholders need to be kept informed? (for example, staff groups where this will impact either now or in the future)
- What communication channels will be used?
- What information needs to be communicated?
- How often does information need to be communicated?
- Who has overall responsibility for ensuring this information will be communicated?

Think about using a number of communication methods tailored to meet the needs of each stakeholder group, so they receive the right amount of information they need.

It is very easy for people to become disengaged by receiving too much or too little information, so it is useful to write a communication strategy so it is clear to everyone what is required.

Improvement Approach

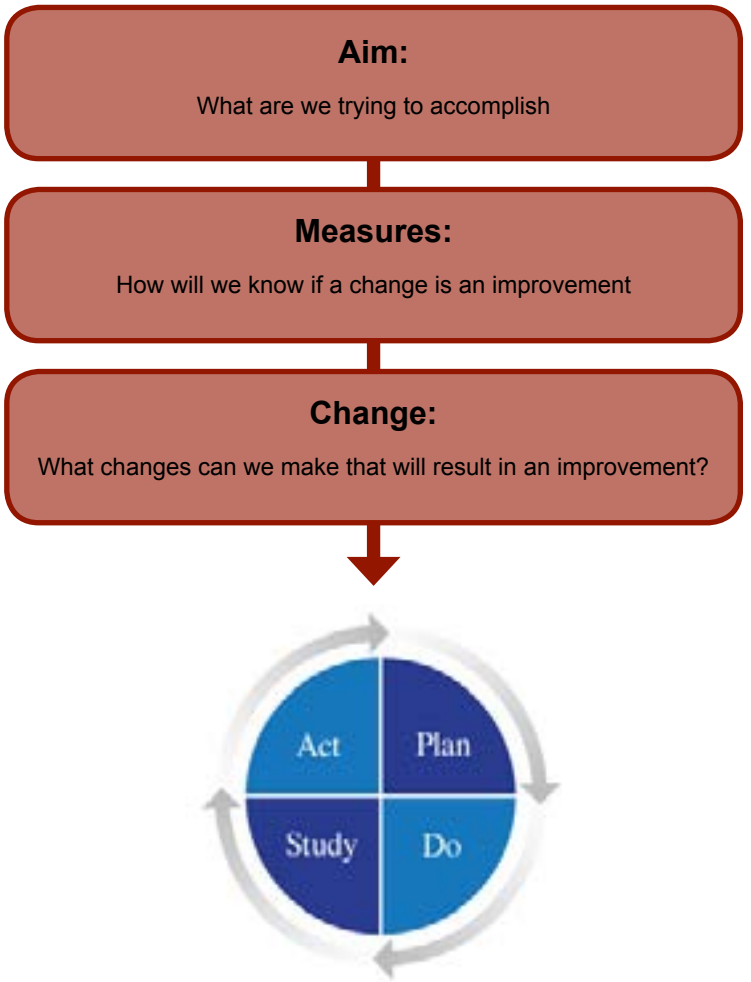
Implementing change using the Model for Improvement

The Model for Improvement

If you are not familiar with the Model for Improvement, it is strongly recommended that you speak to your Aqua Improvement Advisor regarding this.

The Model for Improvement is a nationally recognised improvement tool which is used in many countries around the world.

It provides a great framework for developing, testing and implementing changes that lead to sustainable improvements.



Implementing change using the Model for Improvement

The use of PDSA cycles is part of The Model for Improvement.

It is useful to use PDSA cycles to test out your ideas in bite sized chunks; refining each PDSA until you reach the point where you are sure that your idea will definitely deliver your aims.

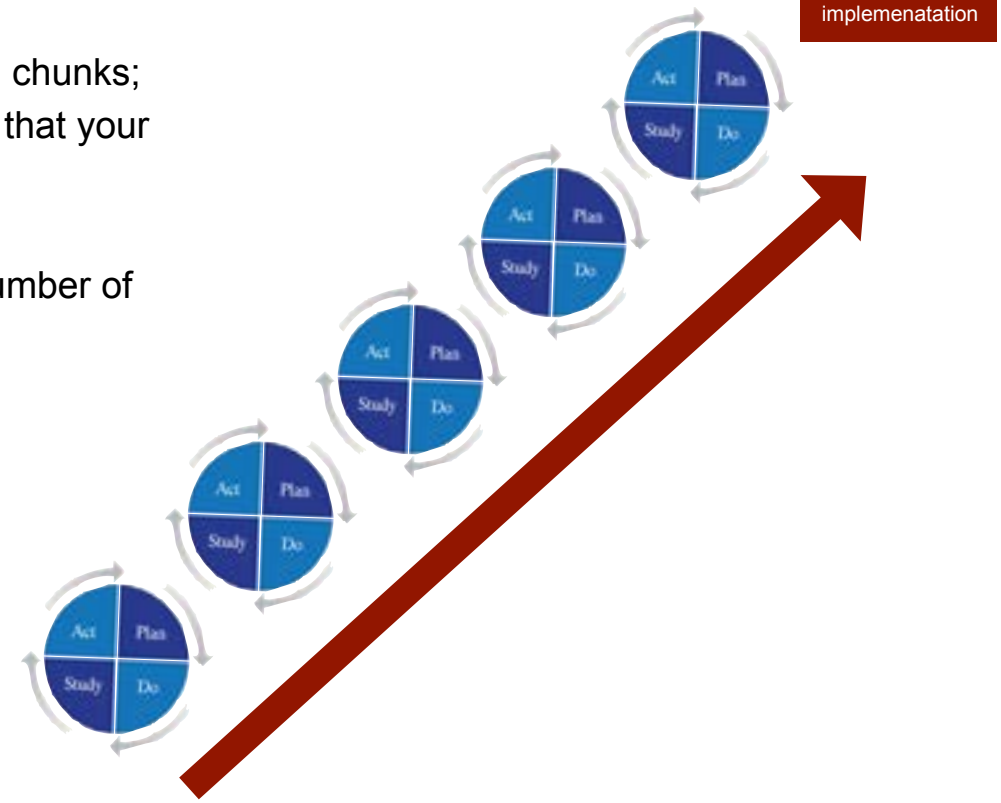
The diagram here demonstrates the point that it is likely that a number of PDSAs will need to be completed, before your design is ready to implement fully.

PDSAs from participating teams are included throughout this Toolkit.

Aim:
What are we trying to accomplish

Measures:
How will we know if a change is an improvement

Change:
What changes can we make that will result in an improvement?



A ‘Plan on a Page’ blank template can be downloaded from the Aqua website by clicking **here**.

Improvement Approach

Ensuring sustainability

It is recommended that you and your organisation use the Sustainability Model and Guide developed by the Institute for Innovation and Improvement.

This Model and Guide was developed as an easy-to-use tool to help teams:

- Self-assess against a number of key criteria for sustaining change
- Recognise and understand key barriers for sustainability, relating to the specific local context
- Identify strengths in sustaining improvement
- Plan for sustainability of improvement efforts
- Monitor progress over time

A diagram demonstrating the Model is shown on the next page. As you can see from this, there are 10 factors it recommends should be considered. The Guide enables you to assess how well you are performing against these, which therefore helps you in deciding where you need to concentrate your efforts to ensure sustainability is maintained in the long term.

The Sustainability Model and Guide can be downloaded from Aqua website by clicking **here**.

(Institute for Innovation and Improvement Sustainability Model and Guide, 2010)

Improvement Approach

Action: Putting theory into practice

Questions to consider

1. Core group
   - Who are the members of your core group?
   - Have core group roles been clearly identified?
   - How often will the core group meet?
   - Have the dates been placed in diaries?
2. Strategy
   - Who needs to be involved in developing the Driver Diagram and 'Plan on a Page' document?
   - Has time been allocated to do this?
   - Who do these documents need to be shared with initially?
3. Governance
   - What will the governance arrangements be?
   - How will those involved in the programme be informed of this?
4. Communications strategy
   - Has time been allocated to develop the communications strategy and process?
   - Who will be responsible for making sure the communications strategy is implemented?
5. The Model for Improvement
   - Does anyone need training in this improvement approach?
6. Sustainability
   - When will this first be discussed?

Top Tips

- Keep decision makers involved so they can keep the improvement/s on the agenda
- Keep people informed of developments and how the improvements affect them
- Manage fears and concerns raised by staff – how they feel about the improvement is critical to the programme's success
- Continue to involve patients and carers every step of the way
- If things aren't going to plan, refer to the governance arrangements in place in order to take action
- Use the tools outlined in this section
- Use data rather than making assumptions
- If you are unclear about anything regarding the programme, ask your Aqua Improvement Advisor or your organisation's service improvement lead.

Leadership Toward Organisational Change

To reduce the incidence of harm caused to users and staff as a result of a reduction in physical restraint by X% by the end of the programme

Primary drivers	Secondary drivers
Leadership	• Philosophy of care and values • Exec walkround
Using data to inform practice	• Visual display data
Workforce development	• De-escalation sessions • Handover
Restraint reduction tools	• My Safety Plan • Sensory room • Advanced statements • Advocacy support
Patient roles within inpatient settings	• Community meetings • Peer Support Worker role
Debriefing techniques	• Debriefing process

You are here

Main Menu

This section includes information and guidance on:

Types of leadership

Philosophy of care and values: The Restraint Reduction Network™

Executive walkrounds

This section ends with:

Action: Putting theory into practice

Top tips

Case study

Leadership Toward Organisational Change

Types of Leadership

Formal Leadership

Formal leadership is the most important component in successful restraint reduction projects and programmes.

The reason for this is that only formal leaders have the authority to make the changes that are necessary for success to:

- Make restraint reduction a high priority
- Assure for Reduction Development Plan
- Reduce/eliminate organisational barriers, including changing policy and procedures
- Provide or re-allocate the necessary resources
- Hold people accountable for their actions

Informal Leadership

It is important to have informal leaders too. All organisations have informal leaders who have their own power (influenced with peers or supervisors). Informal leaders can also use their influence in very important ways:

- To model patient-directed care
- To model compassion, respect and listening skills
- To provide feedback to colleagues on good and not so good practice
- To make suggestions to supervisors

Philosophy of care and values: The Restraint Reduction Network™

The Restraint Reduction Network™ is an independent network which brings together committed organisations providing education, health and social care services for people who may challenge. The network has an ambitious vision to deliver restraint-free care and support, and make a real difference in the lives of people who use services.

As leaders within your organisations, if you haven't already you should consider 'taking the pledge', and also encouraging others to do so, to demonstrate your commitment to reducing restraint. Taking this pledge demonstrates your belief that everyone deserves person-centred care and support, and should be treated with respect and dignity.

Pledges can be made as a……	
Professional	Individuals who work in health, social care or education
Organisation	Providers or commissioners of health, social care or education organisations
Supporter	Anyone who supports the efforts of the network and its members

restraint reduction network

For further information on the Restraint Reduction Network™

click here

Philosophy of care and values: The Restraint Reduction Network™

Vision

Our vision is to deliver restraint free services.

Mission

As a member of the Restraint Reduction Network™ we give a clear and transparent commitment to the people that use and work in our services that all our leaders, managers and front line staff will work together to ensure that the use of coercive and restrictive practice is minimised, and the misuse and abuse of restraint is prevented.

We will work together to create restraint free services built on continuous learning and improvement.

Philosophy of care and values: The Restraint Reduction Network™

1. **All people are entitled to equal enjoyment, social justice and the protection of human rights and fundamental freedoms.** Regardless of the behavioural challenges people might present, everyone will be treated with respect and dignity and their care, welfare, safety and security will be maintained.

2. Supporting people, **especially those individuals who at times may present with significant challenging behaviour**, requires a commitment to develop personalised services, care and support which places the person at the centre of everything we do.

3. People are experts in their own experiences. **Understanding people's needs, history, future wishes and aspirations is essential, and a commitment to listen to**, and collaborative with the individual, and **those significant others who are important in their lives, is fundamental in order** to deliver high quality services and outcomes.

4. **Our leaders and managers will take an active role in reviewing the use of all coercive and restrictive practices, and will develop a range of organisational approaches to ensure all forms of restraint are minimised.** Our leaders and managers will create a positive culture, and work alongside all staff to ensure restrictive practices are not misused or abused and remain the last, and not the first resort.

5. **We will ensure all forms of restrictive practice are recorded and reported.** The use of restrictive practice will be considered an organisational inability to deliver effective support, care or treatmen, and as such will be reviewed in an open and transparent way, so that we can learn more about the person in order to offer more person-centred, effective services which do not rely on such restrictions.

6. People who may be subject to restrictive practices will be **given clear information about the range of restrictive approaches approved and authorised within the service**, the circumstances which govern their use, and whom to complain to if there is concern about how these measures are implemented.

Leadership toward organisational change

Philosophy of care and values: The Restraint Reduction Network™

7 **People who are subjected to or are involved in applying restrictive practices, will have access to someone they can talk to about their experiences.** It is essential that people have access to support and help if required and are supported to complain if they are unhappy regarding any aspect of the care and support we provide.

8 Use of any restrictive practice will be undertaken in the best interests of the person, and **only as a last resort** in an emergency to maintain safety in circumstances where there is immediate or imminent harm, where none restrictive alternatives cannot be used or have failed.

9 We will make everyone **accountable** for the use of restrictive practices, and require a clear and robust justification when such approaches are used.

10 Wherever possible, the use of restrictive interventions will be assessed and planned to **meet the specific needs of the individual**, taking account of their history, physical and psychosocial needs and preferences, in order to minimise distress, trauma or risk of harm.

11 **The use of any restrictive practice which is considered degrading, abusive or inhumane is unacceptable and will be prevented.** We will not authorise or approve any restrictive intervention which, by design or misapplication, is likely to lead to avoidable pain or injury. Restrictive practices will not be used to enforce rules, to punish or coerce, or as a substitute for a lack of resources.

12 We will ensure that all our **staff are appropriately trained** to use restrictive practices, as part of a wider commitment which will ensure our workforce are knowledgeable and skilled in using non-restrictive interventions which are embedded in person-centred thinking, positive behaviour support, recovery and social inclusion.

Executive walkround / 15 step challenge

It is recommended that Executive walkrounds are supported through the use of the 15 Steps Challenge Model developed by the Institute for Innovation and Improvement.

What is the 15 Steps Challenge?

It is a tool to help staff, patients and others to work together to identify improvements that will enhance the patient experience. The Challenge is a ward walkround, seeing the ward through a patient's eyes.

The Challenge focuses on four key areas, and under each area there are a series of questions which provide prompts and pointers regarding things to consider and look out for.

The Challenge focuses on the four areas outlined in the diagram, with these being discussed in turn on the following pages in this Toolkit.

Who should be part of the Challenge Team?

The team should consist of between 5-6 people, including a patient/carer, a member of staff and a board member.

The Challenge should not be used as an audit or performance management tool

Leadership toward organisational change

Executive walkround / 15 step challenge

Welcoming questions you ask yourself

- How have the staff made me feel?
- What made me feel welcome?
- Did any staff members introduce themselves?
- What is the atmosphere like?
- What is the physical environment like?
- Is there any information visible that is useful and reassuring? If so, what is it?
- What interactions are taking place with staff?
- How long did I have to wait to enter the ward?

Executive walkround / 15 step challenge

Welcoming things to look out for

- Welcoming signs or welcoming information available
- Acknowledged by staff – eye contact, smiling, greeting you
- Time and attention given to people entering the ward
- Staff introducing themselves
- Patients able to approach staff
- Staff photo boards with names
- Body language of staff
- Visiting times displayed
- Contact details for the ward visible
- Area available for visitors
- Staff dressed appropriately
- Tidy and clean environment
- Well maintained decor

Leadership toward organisational change

Executive walkround / 15 step challenge

Safety questions you ask yourself

- What aspects of safety can I see?
- Is information visible that tells me about the quality of care and its link to safety?
- Can I identify staff? How are they identifiable?
- What tells me that staff take safety seriously?
- What did I experience that made me feel safe?
- How are medicines managed on the ward?
- What have I noticed that gave me confidence?
- What makes me less confident?

Executive walkround / 15 step challenge

Safety things to look out for

- Reader friendly data displayed and understandable
- Information boards with transparent safety information
- Identifiable staff, with badges or lanyards clearly visible
- Staff in communal areas
- Equipment and environment well maintained
- Protected mealtimes
- Separate male and female areas
- Staff interacting with patients
- Protected time/area for staff to dispense medication

Executive walkround / 15 step challenge

Caring and involving questions you ask yourself

- What can I understand about the patient experience on this ward?
- Is there evidence that patients and carers are involved in their own care?
- How do staff interact with patients?
- Is the routine of the ward evident for patients and visitors?
- How is privacy and dignity maintained?
- What can I see about meeting the needs of diverse patients?
- What information is available about more support, for example mental health forums, carer groups, PALS?
- What have I noticed that builds my confidence?
- What makes me less confident?
- Do I get a sense of community?

Executive walkround / 15 step challenge

Caring and involving things to look out for

- Staff and patients positively interacting
- Meaningful activities taking place
- Information visible about what to expect at different phases of treatment
- Patients speaking positively about staff and the care being received
- Staff acknowledging patients and visitors with warmth and kindness
- Open ended questions being used
- Information about how to complain and compliment
- Patient feedback displayed openly
- Appropriate language used
- People not being patronised or put down
- Able to identify nurse in change for that shift
- People being kept informed
- Staff having time for patients
- Signs that equality and diversity needs are being met
- Staff available to discuss care and progress being made
- Information about carer groups
- Patient user support information/contacts available

Leadership toward organisational change

Executive walkround / 15 step challenge

Well organised and calm questions you ask yourself

- Does the ward feel calm even though it may be busy?
- Are resources/equipment stored in designated places?
- Can I see colour coding or clear labelling for items?
- Is the environment well managed?
- What are the noise levels like on the ward?
- Does it feel like a therapeutic environment?
- Can I identify different areas of the ward?
- What can I tell about teamwork?

Executive walkround / 15 step challenge

Well organised and calm things to look out for

- Noise levels
- Staff not looking like they are under pressure
- Organised and tidy communal areas
- Notice boards have up to date and relevant information
- Evidence of a well organised ward
- An uncluttered clean environment including the nurses' station, communal areas, kitchen etc
- Positive comments from patients and carers
- Clear signage to rooms, WC etc
- Patients and visitors looking relaxed
- Ward protocols displayed
- Reasonable temperature
- No raised voices
- Information is visible and organised on communal board/s

Executive walkround / 15 step challenge

Tips for giving feedback

- Avoid delays – delays in feeding back can result in reduced momentum and power of the recommendation
- Ensure facts are right before you give feedback
- Plan in advance how you are going to give feedback – who will do this from the Challenge team?
- Identify appropriate methods of giving feedback (verbal or written?)
- Encourage staff to feel part of the process in advance so that it does not feel like a “them” and “us” situation
- Encourage the recipients of feedback to undertake their own self-assessment
- Provide non-judgemental feedback which is truthful, direct and constructive
- In feeding back, offer some positive examples, followed by some recommendations for improvement and end with some positives - this is a constructive way to deliver feedback
- Enable recipients of your feedback to give you feedback on how they found the process and help you to understand how it could be more effective
- Ensure that there is an opportunity for staff to action plan based on feedback and have ways to share good practice

Executive walkround / 15 step challenge

Actions and next steps

- Discuss the Challenge outcome with the ward leader and other relevant staff. Feeding back specific details to the ward and key themes to the trust leaders, will make sure that the right actions are owned by the right people
- Agree on the actions at a ward level and themes for action at a trust wide level
- Record what the actions are, who is taking these forward, and by when
- Identify and celebrate the positives – agree what actions need to happen to do this. It is essential for sharing good practice
- Be clever about tracking your actions – you may wish to develop an action plan specifically for the Challenge. However, wards can sometimes be inundated with action plans for a wide range of initiatives. Can some of the identified actions be linked to existing action plans, for example training plans or estate maintenance plans? This way there is an existing process to ensure actions are completed, monitored and reviewed
- Review the actions at an agreed date. Revisit the ward walkarounds regularly. Agree to repeat the Challenge within a specific timescale. This will help keep track of the progress and improvements that are being made within the trust.

A 15 Steps Challenge Action Planning Template can be downloaded from the Aqua website by clicking **here**.

Leadership toward organisational change

Action: Putting theory into practice

Questions to consider

1. Leadership
   - Do staff understand their leadership role, regardless of whether this is formal or informal?

2. Restraint Reduction Network™
   - Will your organisation take the pledge and sign up to the vision, mission, values and principles of the Restraint Reduction Network™?

3. Executive Walkrounds/15 step challenge
   - Who will be involved?
   - When will they take place?
   - What process will be implemented to ensure good practice is shared and improvements are actioned?

Top Tips

- Does the team understand and recognise the role of being a leader in themselves?
- Teams must include ward clerks, housekeepers as well as the Clinical team.
- Work on how the values and principles are evidenced in practice.
- Avoid one person taking on an improvement and seek to pull together small teams.
- Work towards a small group of staff who can drive change on the ward ‘Leadership team’.
- To ensure the 15 step challenge brings in individuals with no experience of mental health wards, utilise your local Healthwatch, as many are skilled in the 15 step challenge including enter and view.
- Discuss with your Exec so that walkrounds become a quarterly event, and include opportunities to meet with patients.

Case Study: 15 Step Challenge

Plan:

Organise and implement the 15 step challenge

I hope this produces:

Reasonable feedback for the ward to enable them to consider their environment and how it may be seen and experienced by other people. I want the ward to be able to think about how the environment may impact both positively and negatively on the people who use the service

Measurement:

- Project plan and the 15 step challenge paper work

Steps to execute:

- Identify the team to take part in the challenge
- Work towards an appropriate date for this to take place
- Gather together the information which would inform the participants about the challenge
- Facilitate the challenge

Do:

It was difficult to get together the right people to give diversity to the challenge group.

Outside agencies are under pressure and I struggled to get them to engage on a small scale. Non-executive buy-in could not be obtained. Getting the ward to engage was difficult. This was due to both the nature of the acute ward and the change in management they experienced at the time.

Supportive measures, such as the local steering group were poorly attended with a lack of stability, and relationship between the ward and the project.

When we conducted the challenge I think that it felt too prepared and consequently the first impression was a little lost. I brought them onto the ward first to talk about it. I think that it felt like a tour rather than being able to be instinctive. It was planned and so all the staff knew about it. I think that next time, although it needs to be managed in terms of the ward acuity, the wider staff should not be aware so that a “true picture” can be obtained, whereby staff are not concerned with giving the right impression and consequently feel pressured.

Case Study: 15 Step Challenge

Study:

My own inexperience with the process caused my lack of confidence and consequently I think I could have done more to extend the group of challengers.

Some of the difficulties on the unit were beyond my control and it was OK to wait for the right time to get the process completed.

The relationship and usefulness of the local steering group isn't used to its full potential.

Really good response from the ward when it was completed. I felt it was taken seriously. Not to contradict my previous point regarding the need for it to be more spontaneous but it felt like a safe environment to feedback.

Act:

- Discuss with the ward how we can make it more 'natural'.
- Liaise with my own line manager to look at their influence with regards to non-executive sign up for the challenge as I think that this was a missed opportunity.
- Use the local steering group to support the process.
- Ensure tighter dates and its continuous process as we have finally got things started.

Use of data to inform practice

To reduce the incidence of harm caused to users and staff as a result of a reduction in physical restraint by X% by the end of the programme

Primary drivers	Secondary drivers
Leadership	• Philosophy of care and values • Exec walkround
Using data to inform practice	• Visual display data
Workforce development	• De-escalation sessions • Handover
Restraint reduction tools	• My Safety Plan • Sensory room • Advanced statements • Advocacy support
Patient roles within inpatient settings	• Community meetings • Peer Support Worker role
Debriefing techniques	• Debriefing process

You are here

Main Menu

This section includes information and guidance on:

Quantitative and qualitative data

A framework for the measurement and monitoring of safety

Programme measures

Defining measures

Developing your baseline

Presenting your data

Safety Crosses

Visually displaying data

This section ends with:

Action: Putting theory into practice

Use of data to inform practice

Quantitative and qualitative data

Data can be quantitative or qualitative.

Quantitative

Is typically descriptive data, such as number of restraints, violent incidents, transfers etc

Qualitative

Gathers information that is not in numerical form. For example, open-ended questionnaires, unstructured interviews and unstructured observations.

Some people do find data collection confusing. If you find you struggle with some of the information over the following pages don't worry, just speak to your Aqua Improvement Advisor who will explain in further detail.

A framework for the measurement and monitoring of safety

Considerations	
Past Harm	Has patient care been safe in the past?
Reliability	Are your clinical systems and processes reliable and why?
Sensitivity	Is care safe today?
Anticipation and preparedness	Will care be safe in the future?
Integration and learning	Are you responding and improving?

The Health Foundation Inspiring Improvement

(Source: Vincent C, Burnett S, Carthey J. The measurement and monitoring of safety. The Health Foundation, 2013)

Use of data to inform practice

Programme measures

Programme measures:

- Number of restraints per month
- Number of days between restraints
- Number of violent incidents
- Number of days between violent incidents

Balancing measures:

- Number of medication led restraints per month
- Number of transfers to PICU/seclusion per month

You may wish to add additional local measures, particularly when working on specific areas as part of your PDSA cycles.

Defining measures

Developing a baseline and collecting data on a regular basis is key to using data to inform practice.

Obviously you want to collect the right data. However, it is surprising how many people/teams/organisations collect the wrong data, only to find that it doesn't provided them with the information they need to make the right decisions.

To ensure this doesn't happen to you, make sure you can clearly answer the questions below:

- What population are we focusing on? i.e. which wards/patients?
- What are we trying to achieve?
- What is the definition of each measure?
- How will the data be collected? Is this data already collected, or do you need to implement a process for collecting this?
- How often will it be collected?
- Who has overall responsibility for making data collection happen?
- Who will collect the data?
- Who will analyse the data?
- How will decisions then be made on next steps?

Use of data to inform practice

Developing your baseline

Once you are clear what about what your measures are and the process of how this is going to be managed you need to develop your baseline.

You develop your baseline by gathering historical data. As a minimum it is advisable to have 6 months – 1 year's data.

It is vital that you understand your baseline before making any changes. Making changes based on assumptions and inaccurate data can at best result in you not achieving your aims and at worst have disastrous impacts on the services you provide.

Presenting your data

How data is presented is crucial to its interpretation. A great way to present quantitative data is by using SPC (statistical process control), specifically control charts.

Control charts help you:

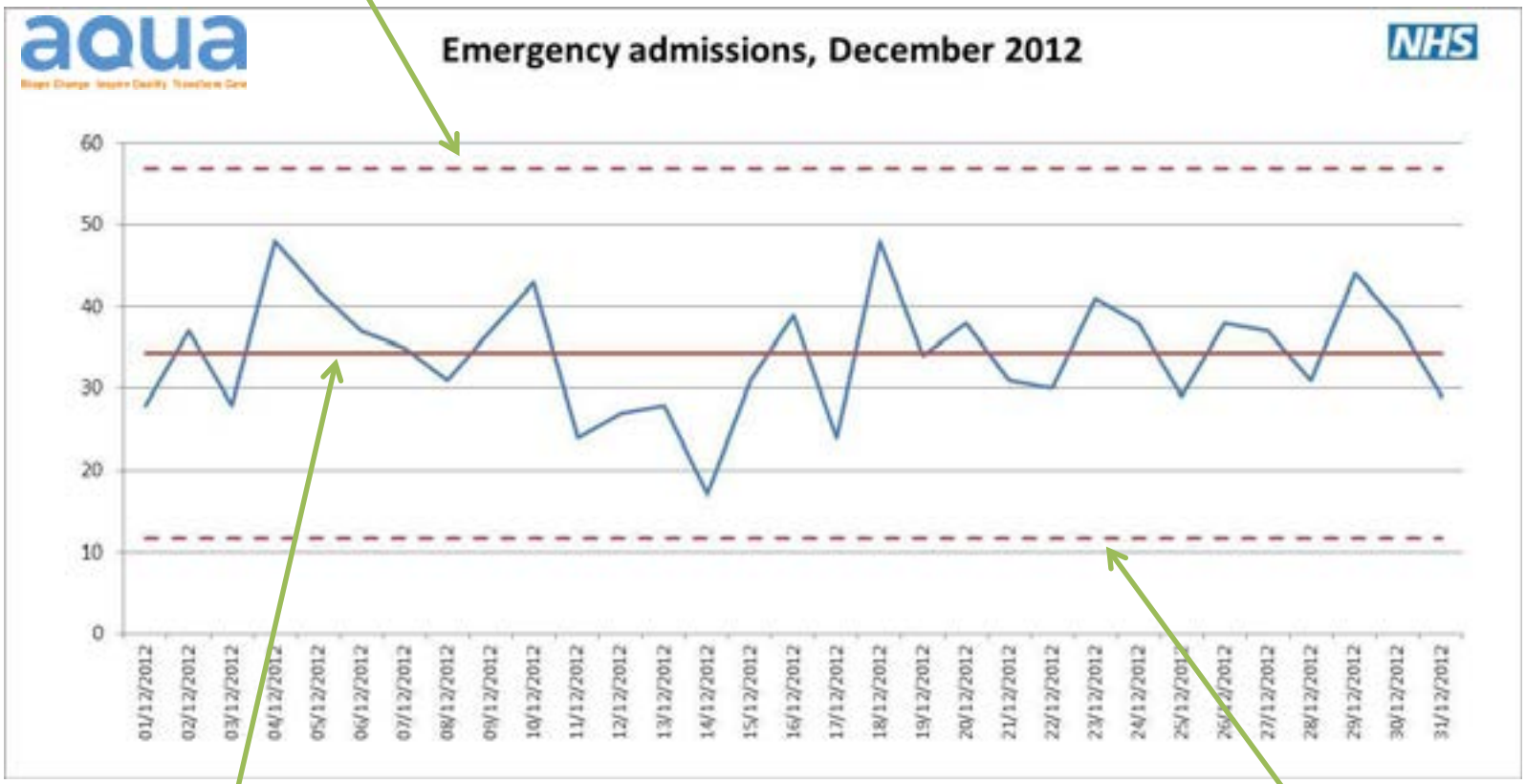
- Recognise variation
- Evaluate and improve the underlying process
- Prove/disprove assumptions and (mis)conceptions
- Help drive improvement
- Use data to make predictions and help planning
- Reduce data overload

Your organisation may well have access to its own SPC software, if not speak to your Aqua Improvement Advisor who will be able to organise you access to SPC through Aqua.

Aqua has developed a guide on using SPC which can be downloaded from the Aqua website by clicking **here**.

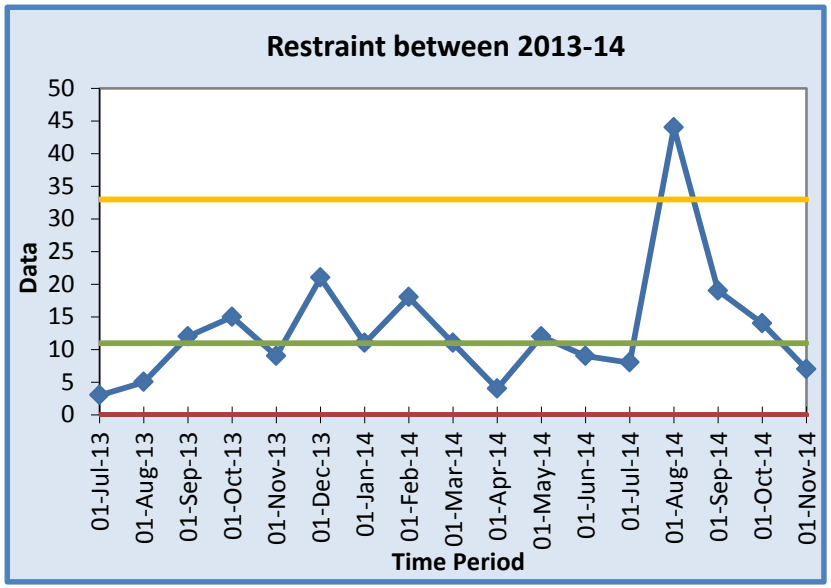
Use of data to inform practice

Presenting your data



Presenting your data

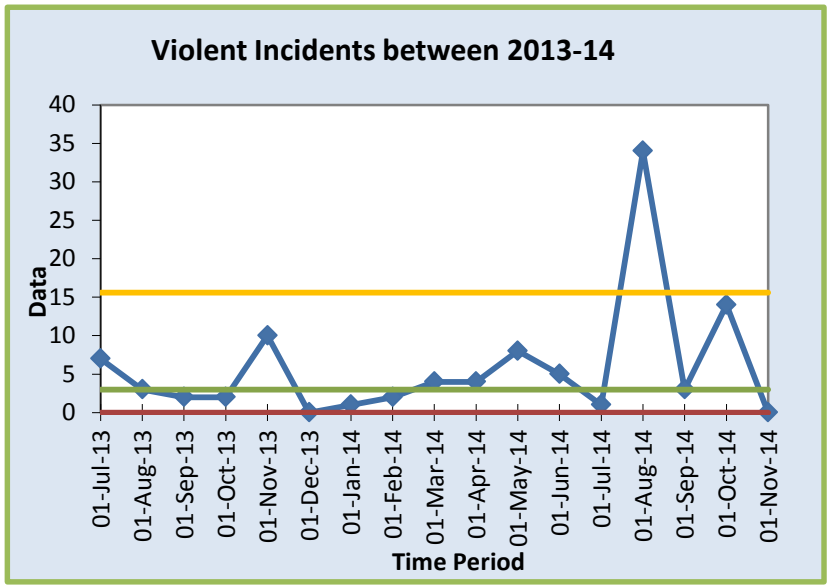
UCL



Mean

LCL

UCL



LCL

The control charts above are from two of the programme sites involved to this programme.

Use of data to inform practice

Variation

A control chart enables the monitoring of the process levels and identification of the type of variation in the process over time with additional rules associated with the control limits. It is advisable to have a minimum of 10 data points of baseline data to create a valid chart, however, there is increased reliability when using 20 or more data points.

There are two types of variation:

Type of variation	What it is
Common cause	If the process is stable and predictable any variation is known as ‘common cause variation’. A process is ‘in control’ if it only displays common cause variation.
Special cause	If the process is unstable or ‘out of control’ any variation is known as ‘special cause variation’. This means that it is not an inherent part of the process. Special cause variation highlights that something unusual has occurred within the process and is attributable to factors that were not within the original process design.

Variation

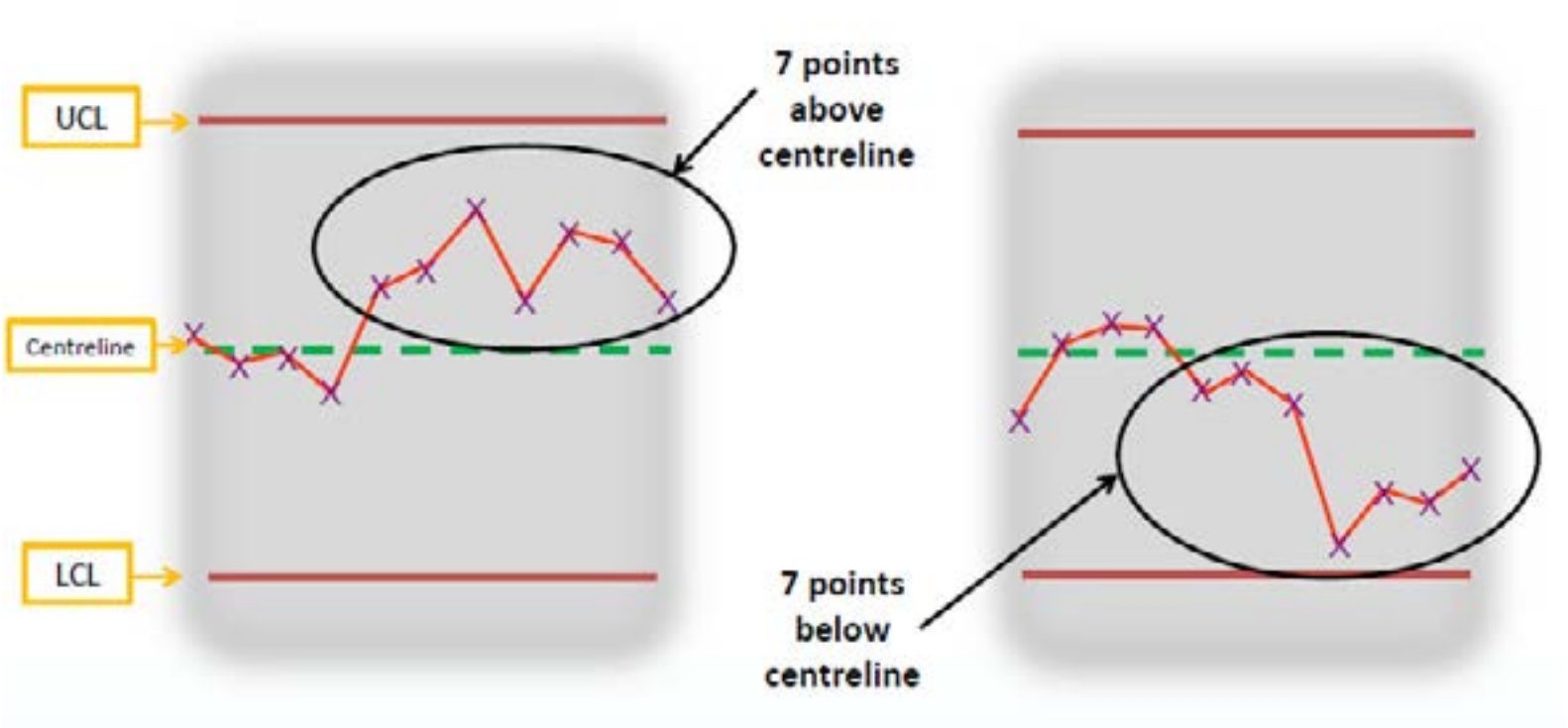
If you can see any of the following it means that there is special cause variation:

Name	How to identify special cause variation
Shift	Seven or more successive data points falling on the same side of the centreline
Trend	Seven or more successive data points heading in the same direction (either increasing or decreasing)
Zig-Zag	Fourteen or more successive data points decreasing and increasing alternatively (creating a zig-zag pattern)
Cyclical Pattern	A regular pattern occurring over time
Control Limits	One or more data points falling outside the control limits
Middle Third	The number of points within the middle third of the region between the control limits differs markedly from two-thirds of the total number of points

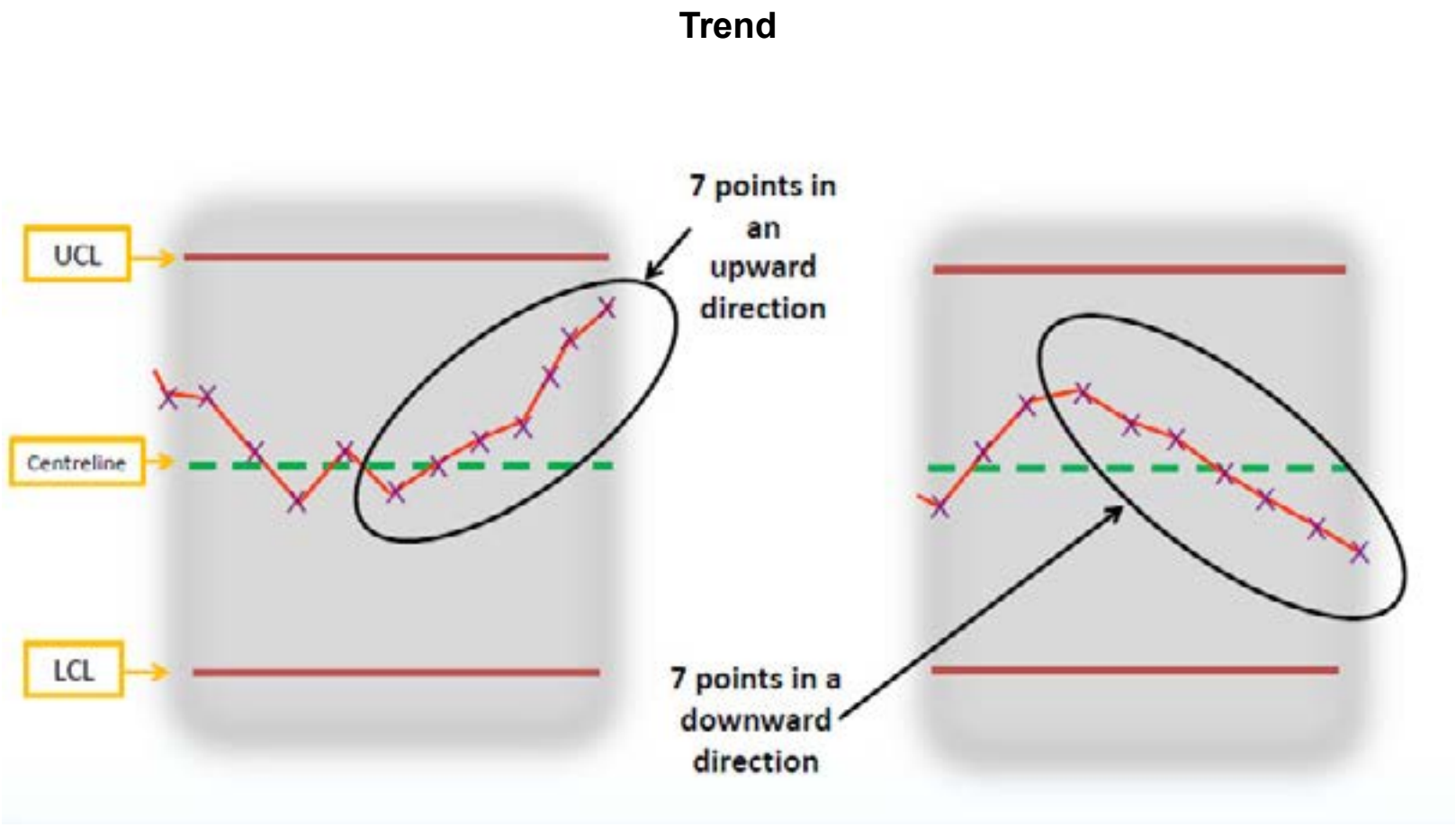
Confused? The following pages should help as they illustrate each of these rules.

Variation

Shift

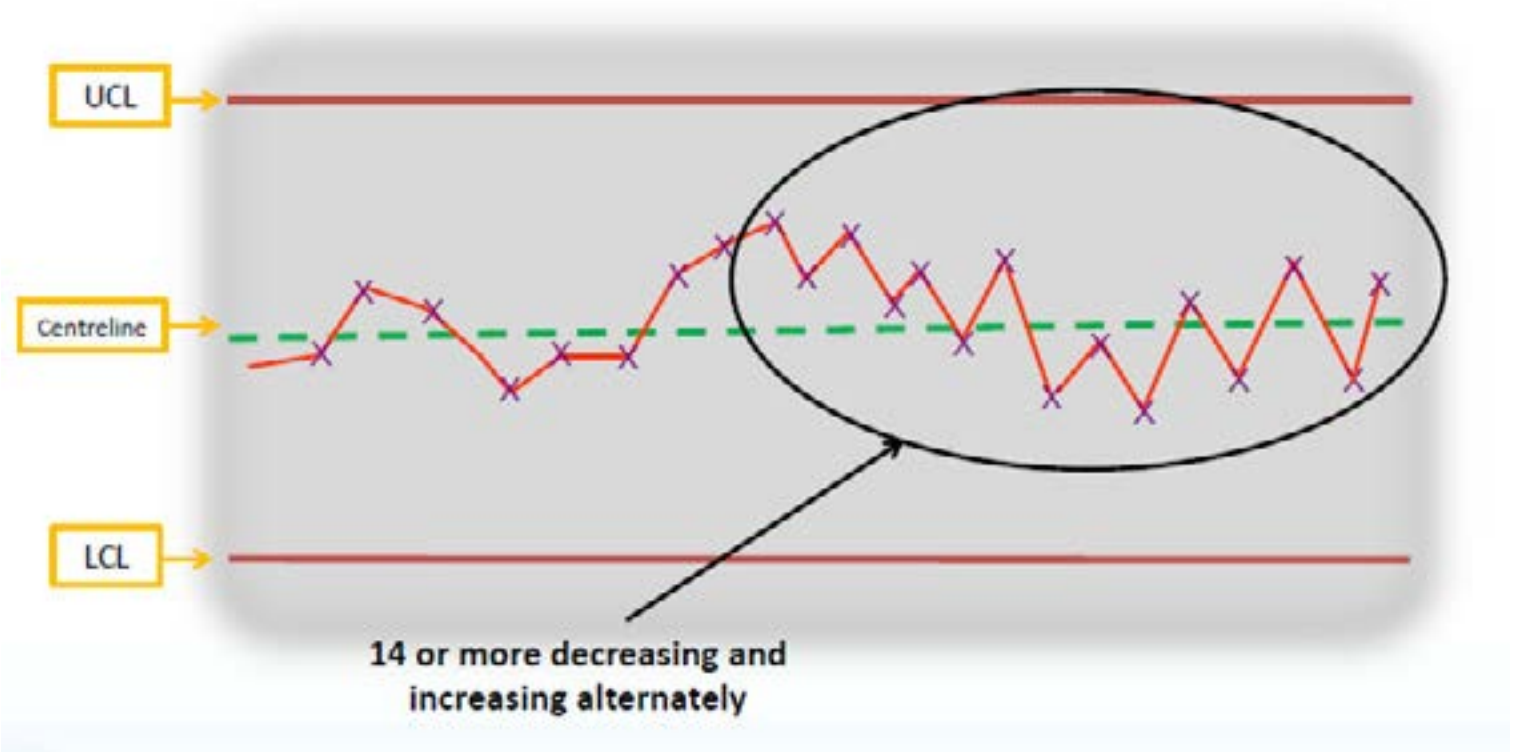


Variation


Trend
UCL
Centreline
LCL
7 points in an upward direction
7 points in a downward direction

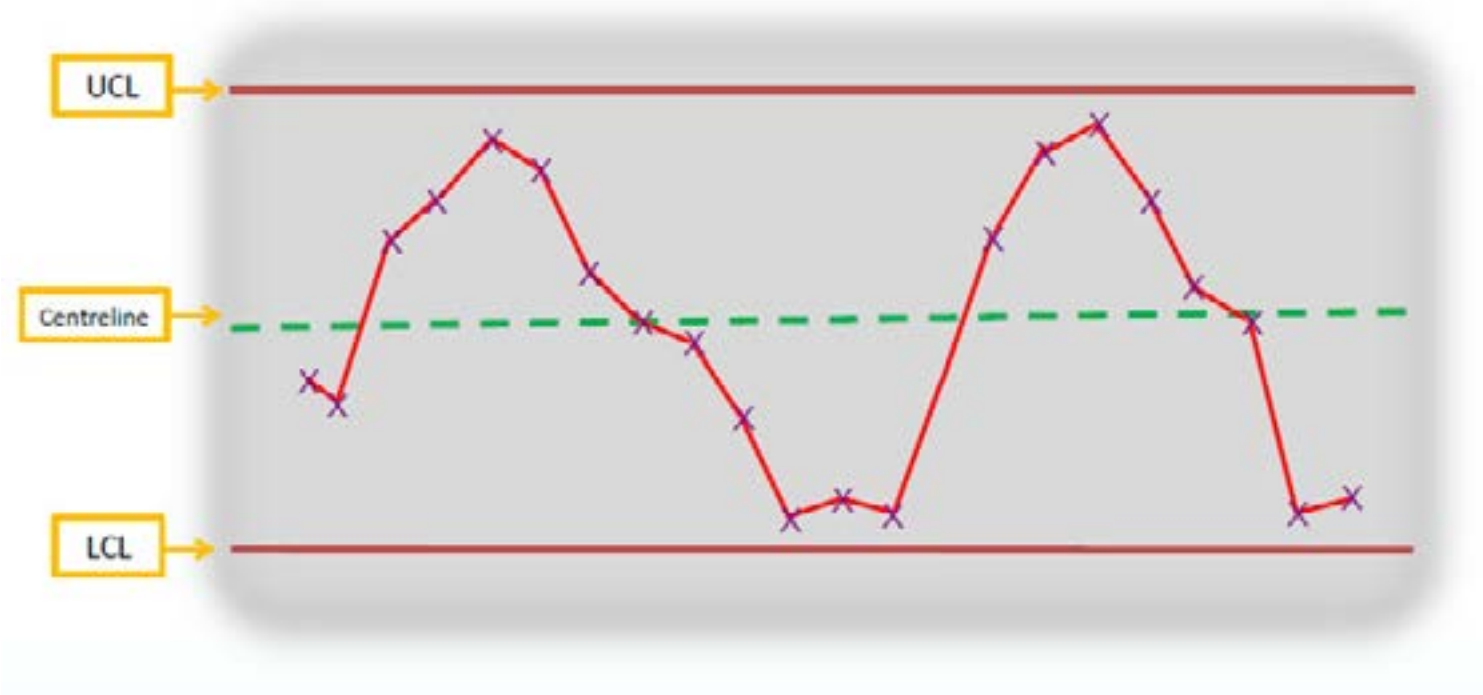
Variation

Zig-Zag



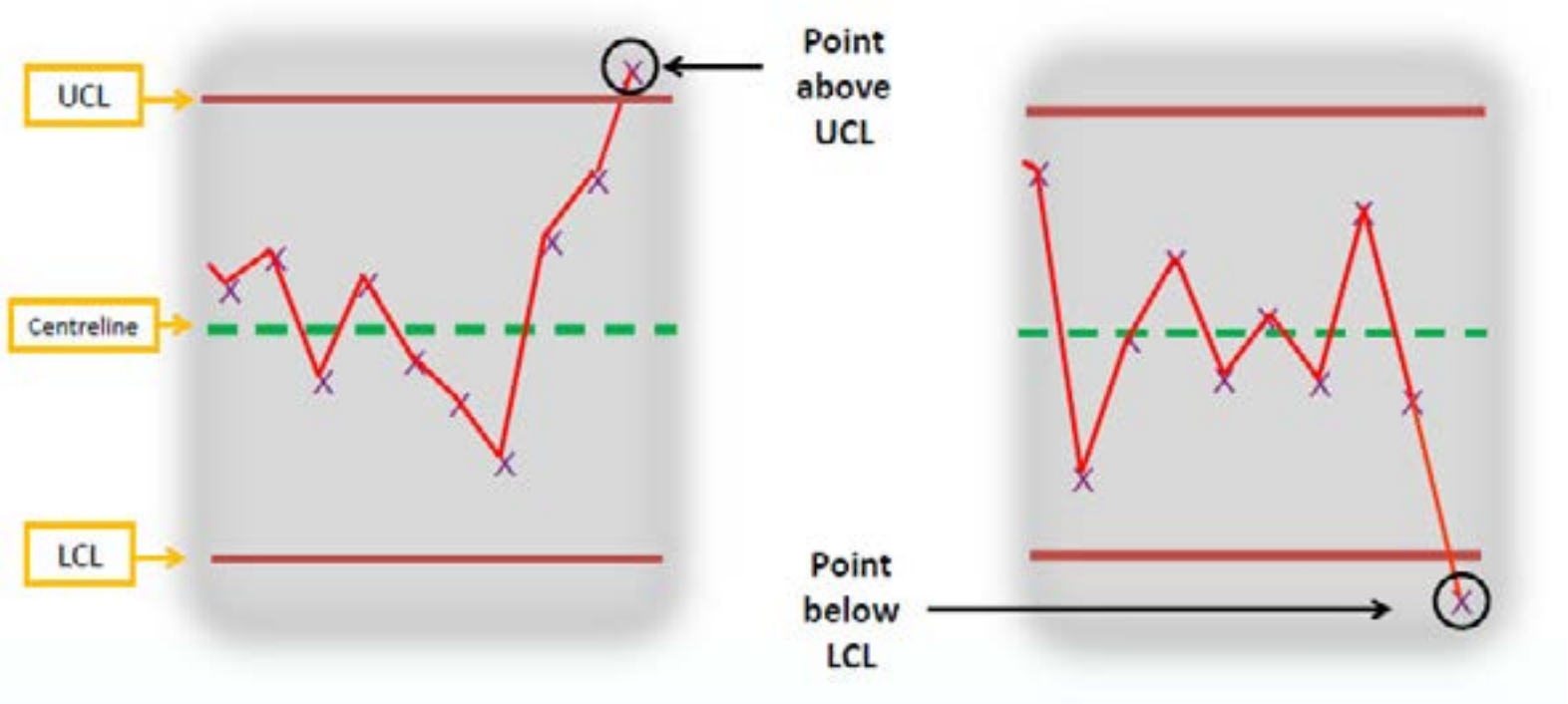
Variation

Cyclical Pattern



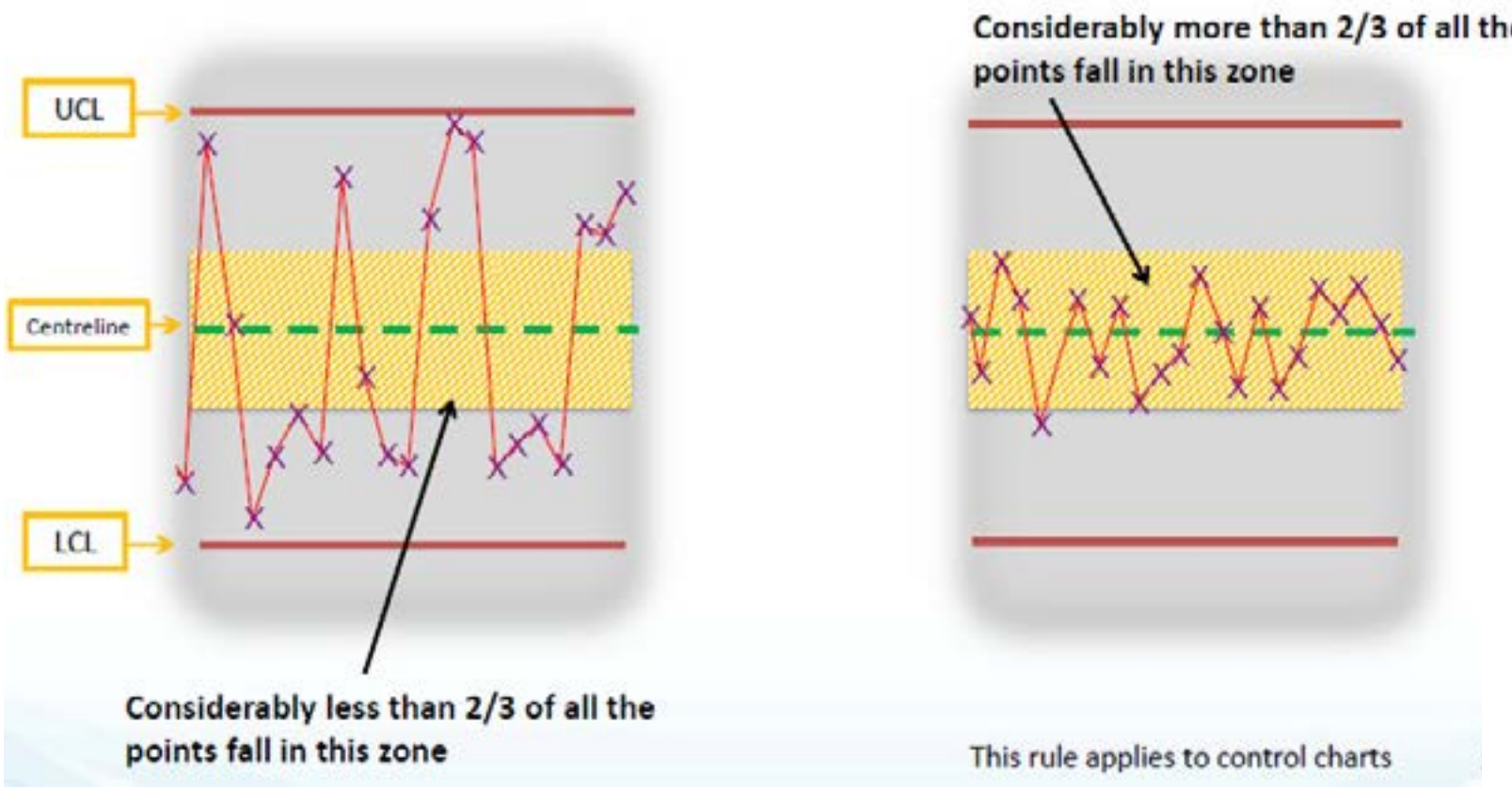
Variation

Control Limits



Variation

Middle Thirds



Use of data to inform practice

Safety Crosses Templates

Safety Calendar - Physical Restraint

			1	2			
			3	4			
			5	6			
7	9	11	13	15	17	19	21
8	10	12	14	16	18	20	22
			23	24			
			25	26			
			27	28			
			29	30			
			31				

Month

Days without physical restraint

Safety Calendar - Violent Incidents

			1	2			
			3	4			
			5	6			
7	9	11	13	15	17	19	21
8	10	12	14	16	18	20	22
			23	24			
			25	26			
			27	28			
			29	30			
			31				

Month

Days without violent incidents

Your organisation may well have access to its own SPC software but if not speak to your Aqua Improvement Advisor who will be able to organise you access to SPC through Aqua.

Safety Crosses

What is the purpose of a Safety Cross?

A Safety Cross enables you to:

- Use the data collected to raise awareness in the team regarding the number of restraints
- Use it to promote good practice (i.e. look at how many days have gone by without a restraint)
- Provide real time incidence data
- Creates a discussion on the subject within the team

How do we fill this in?

Each Safety Cross presents one calendar month. Within each cross there are 31 boxes, as each box represents a single day. The Safety Cross must be filled in after each event with a cross. Restraint within the NICE definition (Trust defined levels) and violent incident based on individuals own judgement (violent incidents include self harming behaviour).

What should we do with this information?

Discuss at handovers each time sharing what has been learned and, where appropriate, outline what would be done differently next time.

Use of data to inform practice

Safety Crosses

It is important for all staff, regardless of their role, to understand what is happening on the ward.

One way of achieving this is through visually displaying information on a white board or plasma screen. The information needs to be meaningful and up to date and should include:

- SPC charts and any other graphs
- Safety Crosses
- PDSA forms
- Staffing rotas/holidays etc

Someone needs to be given the responsibility of keeping the board/ plasma screen up to date.

It is recommended that meetings/handovers are held round the board/ plasma screen so information can be referred to and updated.

Action: Putting theory into practice

Questions to consider

1. Data Collection
    - Are you able to answer the questions?
    - What is your data telling you?
    - Do you have common or special cause variation?
    - What actions do you need to take as a result of this?
2. Safety Crosses
    - What is the process for completing these?
    - When and how are the findings shared and discussed?
3. Visually Displaying information
    - Where will the board/plasma screen be displayed?
    - What information will be displayed?
    - Who will be responsible for keeping the board/plasma screen up to date?
    - How will you ensure the board/plasma screen will be used? (for example during meetings/handovers)

Workforce development

To reduce the incidence of harm caused to users and staff as a result of a reduction in physical restraint by X% by the end of the programme

Primary drivers	Secondary drivers
Leadership	• Philosophy of care and values • Exec walkround
Using data to inform practice	• Visual display data
Workforce development	• De-escalation sessions • Handover
Restraint reduction tools	• My Safety Plan • Sensory room • Advanced statements • Advocacy support
Patient roles within inpatient settings	• Community meetings • Peer Support Worker role
Debriefing techniques	• Debriefing process

You are here

Main Menu

This section includes information and guidance on:

Understanding three violence models

Understanding trauma

De-escalation: trauma informed care

Handover

Handover using SBAR

Handover template

This section ends with:

Action: Putting theory into practice

Top tips

Case studies

Understanding three violence models

Folger et al, 1995, outlined three violence models:

- Patient characteristics (blame the patient)
- Environmental factors (setting “triggers”)
- Situational: a combination of the above

The **situational model** has been the most useful in understanding the violence that leads to use of restraint. Attention to only the “patient” or only to “the setting” ignores this multi-dimensional relationship and the variables that inter-relate to lead to conflict.

In order to consider the situational model we first need understand what **trauma** actually means and how to provide **trauma informed care** to ensure **de-escalation** of potential situations.

Understanding trauma

The basic definition of trauma was adopted by NASMHPD in 2014

(National Association of State Mental Health Program Directors)

The experience of violence and victimisation including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters

DSM V (APA, 2003) further defines the impact of trauma on the person:

Person's response will include:

- Intense fear, horror, and helplessness
- Extreme stress that overwhelms the person's capacity to cope

Understanding trauma

Mentalisation is the ability to understand the mental state of oneself and others which underlies overt behaviour. There are individual differences in the threshold for switching from mentalising to automatic fight/flight/freeze responding, including:

- Development age
- Genetic endowment
- Past experiences

The threshold for this switching can be lowered as a result of exposure to early stress and trauma, which is very common for people with personality disorder.

Generally speaking the most harmful trauma experiences which are typically considered most problematic and can lead to serious mental health problems are those which:

- Are interpersonal in nature, intentional, prolonged, repeated and severe
- Include sexual and physical abuse, severe neglect, emotional abuse
- Witnessing violence, repeated abandonment, sudden traumatic loss
- Often occur in childhood and adolescence and may extend over an individual's life span

(Terr, 1991; Giller, 1999, Felitti, 1998)

De-escalation: trauma informed care

Jennings, 2004, defines trauma informed care as:

Treatment that incorporates:

- An appreciation for the high prevalence of traumatic experiences in persons who receive mental health services
- A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual

The trauma informed approach incorporates three key elements – the 3 Rs:

Realising….	the prevalence of trauma
Recognising….	how trauma affects all individuals involved with the programme, organisation, or system, including its own workforce
Responding….	by putting this knowledge into practice

De-escalation: trauma informed care

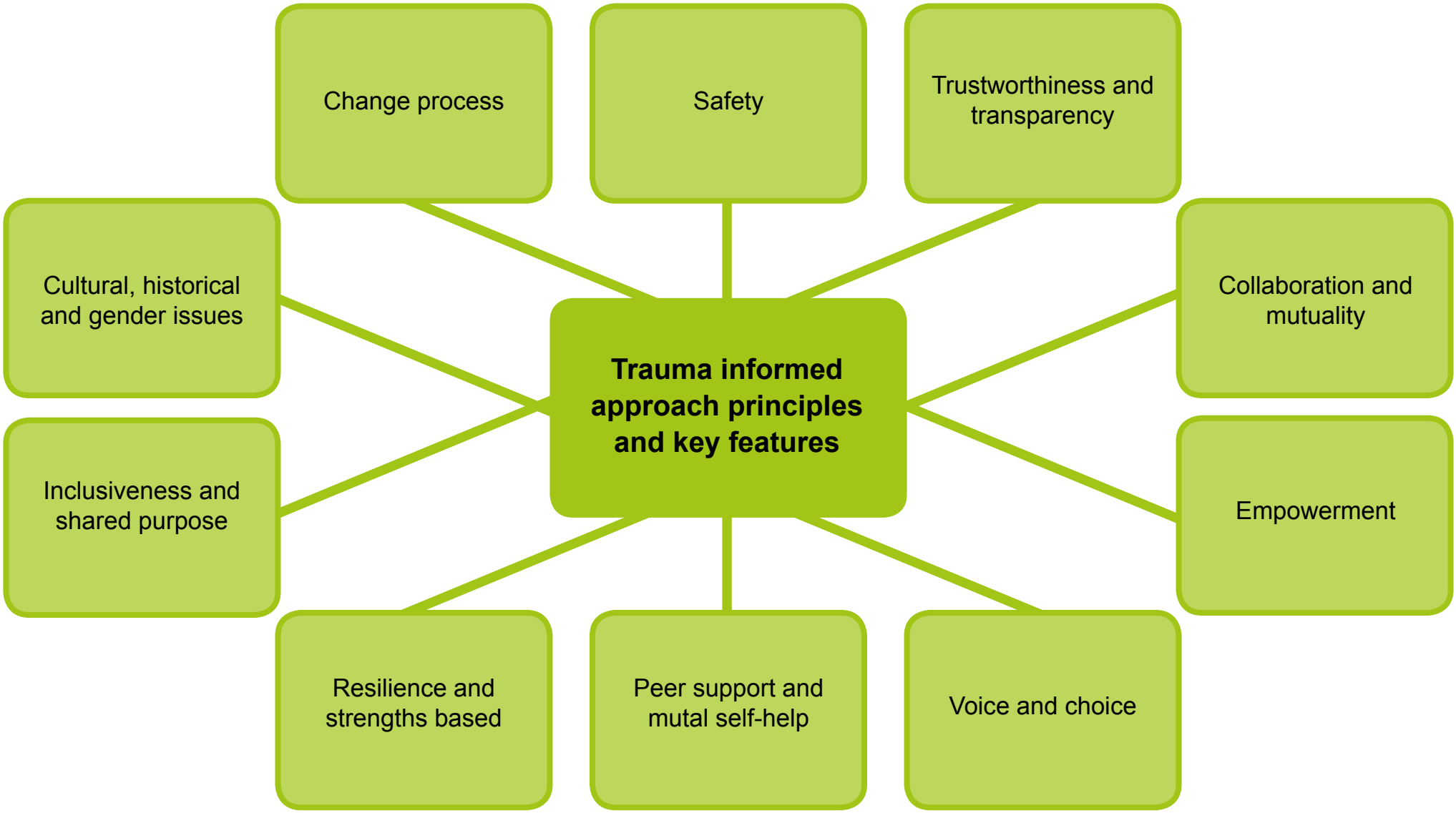
Prevalence of trauma in adults	Reference
51-98% of public mental health clients have been exposed to trauma	Goodman et al, 1997; Mueser et al, 1998
Study in South Carolina CMHC found 91% of patients had histories of trauma	Cusack, Frueh & Brady, 2004
Most have multiple experiences of trauma	Mueser et al, 2004; Mueser et al, 1998
Current rates of Post Traumatic Stress Disorder in people with Serious Mental Illness range from 29-43%	CMHS/HRANE, 1995; Jennings & Ralph, 1997
Majority of adults diagnosed with Borderline Personality Disorder (81%) or Dissociative Identity Disorder (90%) were sexually or physically abused as children	Herman et al, 1989; Ross et al, 1990

This means…..

We need to presume the clients we serve have a history of traumatic stress and exercise "universal precautions"

(Hodas, 2004)

In order to consider the situational model, we first need understand what trauma actually means and how to provide trauma informed care to ensure de-escalation of potential situations.


Change process
Safety
Trustworthiness and transparency
Cultural, historical and gender issues
Trauma informed approach principles and key features
Collaboration and mutuality
Inclusiveness and shared purpose
Empowerment
Resilience and strengths based
Peer support and mutal self-help
Voice and choice

Workforce development

Trauma informed	Not trauma informed (insensitive)
Recognition of high prevalence of trauma	Lack of education on trauma prevalence and “universal precautions”
Assess for traumatic histories and symptoms	Cursory or no trauma assessment
Recognition of culture and practices that are re-traumatising	“Tradition of Toughness” valued as best care approach
Power/control minimised – constant attention to culture	Keys, security uniforms, staff demeanour, tone of voice = **power**!!
Caregivers/supporters - collaboration	Keys, security uniforms, staff demeanour, tone of voice = **power**!!
Staff understand that violence and conflict arise, most often due to situational factors	Rule enforcers - compliance
Understand that all behaviour has meaning	‘Patient blaming’ is the norm
Objective, neutral language	Behaviour seen as intentionally provocative and volitional
Patient is at the centre of their treatment	Labelling language: ‘manipulative, needy, attention-seeking’
Education and illness self-management	Lack of self-directed care and over reliance on medication
Transparent systems open to outside parties	Closed system – advocates discouraged/barred

What would you hear?	
Trauma informed	**Not trauma informed (insensitive)**
Asking people how they prefer to be addressed	Calling people by first name without permission or last name without title
Quietly making rounds and informing people of schedule	Yelling ‘lunch’ or ‘medications’
Routinely ‘checking-in’ with the person – eye contact	Checks to simply locate – focus on task, not person
Saying hello and goodbye at beginning/end of shift	Coming in and leaving without acknowledgement
Offering respectful help: “Let’s talk and find you something to do” “May I help you?”	Disrespectful directives: “If I have to tell you one more time” “Step away from the desk”

What would you see?	
Trauma informed	**Not trauma informed (insensitive)**
Modified nursing station without barrier – open	Large barrier around nursing station – ‘them/us’
Natural light	Artificial light
Comfortable individual seating	Large sofas, group seating
Furniture maximises view (back not to door)	Furniture in large square, against walls
Wall colour is soothing, calming artwork	Wall colour is harsh/stark, provocative artwork
Clean, ‘picked-up’	Dirty, cluttered, conveys lack of care/attention

De-escalation: trauma informed care

Trauma Assessment: Key Principles

Assessment	Therapeutic engagement	Focus	Understanding
Trauma assessment should ideally be undertaken upon admission or shortly afterwards	Importance of therapeutic engagement during interview cannot be over-emphasised	Focus on what 'happened to you' in place of what is 'wrong with you' *(Bloom, 2002)*	Attempt to gain an understanding of the impact of the trauma focusing on cognitions, emotions and behaviours

A very important point to remember comes from Dr Sandra Bloom, a psychiatrist, who developed a trauma sensitive model of care called the 'Sanctuary Model' and implemented it in hospitals, residential programmes and shelters.

Dr Bloom says the focus of questioning and thinking should be on *'what happened to you'* rather than *'what is wrong with you'*. *'What is wrong with you'* focuses on problems, labels and diagnoses and suggests the problem is within the individual rather than treating people who have had something terrible happen to them which is outside of their personal control.

Handover

As we all know the purpose of handovers is to ensure that the staff on the next shift are fully aware of what is happening on the ward: what has gone well, problems which have arisen, and anything else outstanding which needs to be addressed.

The Royal College of Nursing states:

Handovers have been identified as a communication ‘hotspot’. Misinformation, missing information or untimely information contributes to a significant number of patient safety incidents and workflow problems *(British Medical Association, 2004)*. Effective communication is identified as one of the key principles in nursing practice *(Royal College of Nursing, 2010; Casey and Wallis, 2011).*

In order to ensure handovers run smoothly two tools will be shared which should be used as part of the handover process:

- S-B-A-R (Situation – Background – Assessment – Recommendation)
- Handover template

Handover using SBAR

What is SBAR and how can it help me?

SBAR is an easy to remember mechanism that you can use to frame conversations, especially critical ones, requiring a clinician's immediate attention and action. It enables you to clarify what information should be communicated between members of the team, and how. It can also help you to develop teamwork and foster a culture of patient safety.

The tool consists of four sections, to ensure that you are sharing concise and focused information. It allows you to communicate assertively and effectively, reducing the need for repetition.
The tool helps you anticipate the information needed by colleagues and encourages assessment skills.

Using SBAR prompts staff to formulate information with the right level of detail.

SBAR

S - Situation

B - Background

A - Assessment

R - Recommendation

Handover using SBAR

When does it work best?

SBAR	
S	Situation
B	Background
A	Assessment
R	Recommendation

The NHS is often criticised for poor communication, however, there are few tools around that actively focus on how to improve communication, in particular verbal communication.

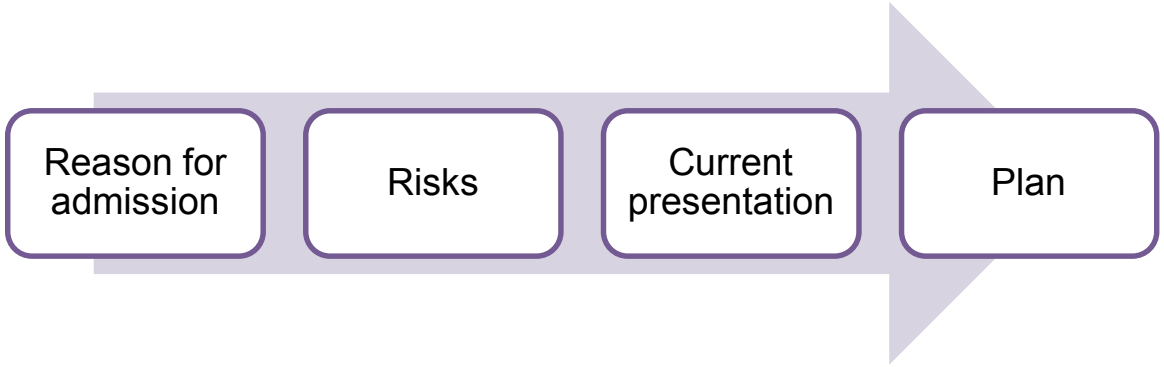
The tool can be used to shape communication at any stage of the patient's journey. When you use the tool in a clinical setting, you make a recommendation which ensures that the reason for the communication is clear. This is obviously useful in any situation but can be particularly important in situations where you may be uncomfortable about making a recommendation.

The use of SBAR prevents the hit and miss process of 'hinting and hoping'.

(Information from the Institute for Innovation and Improvement)

How do I use it?

During handover, for each patient, you should be able to answer the following clearly, accurately and in a concise way.



Handover template

Outlined on the next page is a sample handover form, which uses the SBAR principles.

It is recommended that this is completed for each patient for handover.

It has been developed so it includes all the information needed in a clear and concise way.

This can be used in paper form but you may wish to adopt an electronic version or use a whiteboard or plasma screen.

PDSAs on the development and use of the handover template (incorporating SBAR) are outlined **here**.

A handover blank template can be downloaded from the Aqua website by clicking **here**.

Handover template

Ward (to be completed)

Date:

Day Shift Staff *(All who attended handover Please sign.)*

Night Shift Staff *(All who attended handover, please sign.)*

Patient Information	S-B-A-R	Night report	Cardiometabolic	Does patient have a Safety Plan?	Safeguarding Issues? / Referrals?
	Reason for admission: Risks: Current presentation: Plan:				

Action: Putting theory into practice

Safety questions you ask yourself

1. **Trauma Informed Care**
    - Do you or your team require training on the following:
        - Understanding trauma
        - Situational violence model
        - De-escalation: trauma informed care
        - Trauma assessment
        - Developing a trauma informed environment

    If you answered yes to any of the above, who will deliver this and when?

    - Is there anything which needs to be changed on the ward itself, i.e. removal of barrier around the nursing station. If yes, how will this be done and when?

2. **Handover**
    - How will the use of the SBAR model be implemented?
    - How will the use of the handover template become part of the daily routine – what will the process be and who will be responsible?

Top Tips

- Incorporate trauma informed care into PMVA training.
- Utilise trauma informed care into formulations.
- Use SBAR pads in the Nurses office to get team use to the process when taking phone calls.
- Seek to use plasma screens or smart boards for handovers to avoid a paper trail.
- Run de-escalation sessions on the wards focused on current incidents on the ward.

Case Study: Handover (1 of 3 PDSAs)

Plan:

Introduce a handover approach utilising SBAR and incorporating physical health, safeguarding and safety plans

I hope this produces:

An improvement in communication within the team that enables more effective identification of patient needs

Measurement:

- Feedback from patients and staff
- Reduction in violence and restraint

Steps to execute:

- Work with team to develop handover
- Implement first using a paper-based approach
- Transfer to patient whiteboard or plasma screen
- Monitor quality of information
- Follow up a sample of permanent and bank/agency staff for feedback
- Monitor over one month
- Seek feedback from the wider team as well as patients to understand if there is an improvement in meeting patient needs

Do:

I formulated and developed a new handover/SBAR on the ward and arranged a review meeting to discuss progress

Study:

I asked staff to provide me with feedback and information on the new SBAR with the following being noted:

- Time consuming having to repeat physical observations on a daily basis due to it being on paper
- There was nowhere to write night shift
- Confusing
- Nowhere to write risks
- Plan for whiteboard not in the near future
- Admission circumstances
- Not being filled out correctly
- Many of the team not happy with it

Act:

I held a meeting and agreed to make changes to the SBAR. I have since made changes to tweak the SBAR and I am in the process of obtaining feedback re new handover tool

Changes made based on the feedback are:

- Changed SBAR to: reason for admission, risks, current presentation and plan
- Taken out all physical health screening and replaced with yes/no

Plan to review in one month

Case Study: Handover (2 of 3 PDSA cycles)

Plan:

Introduce an amended handover approach utilising SBAR and incorporating physical health, safeguarding and safety plans after alternations from cycle 1

I hope this produces:

An improvement in communication within the team that enables more effective identification of patient needs and risks

Measurement:

- Feedback from patients and staff
- Reduction in violence and restraint

Steps to execute:

- Work with the team to develop and amend handover
- Continue with paper based approach until we move wards
- Transfer to patient whiteboard or plasma screen when available
- Monitor quality of information
- Follow up a sample of permanent and bank/ agency staff for feedback
- Monitor over one month
- Seek feedback from the wider team as well as patients to understand whether there is an improvement in meeting patient need

Do:

From the feedback given by staff it was noted the SBAR formulated was not appropriate for the ward and changes made have been received positively by the team

Study:

- I learnt that staff felt it important to have space to be able to document the night shift
- A staff member suggested it would be useful to have ‘day report’ heading as well as this was being written in the other boxes and was making the handover look more untidy
- Completing the template on paper was too repetitive and therefore amendments and updates are now made on the computer instead

Act:

- I have sent out a short questionnaire to selected staff, some unqualified, some health care assistants and one bank/agency health care assistant with four simple questions to determine the effectiveness of the revamped SBAR. I have had two positive feedback comments and one returned questionnaire with a suggestion I will look into
- Due to moving ward I will give time for the handover to settle in and review again in three to four months

Case Study: Handover (3 of 3 PDSA cycles)

Plan:

Review the handover tool now the ward has moved
identify any issues that have developed over recent months

I hope this produces:

An improvement in communication within the team that enables more effective identification of patient needs and risks

Measurement:

- Feedback from patients and staff
- Reduction in violence and restraint

Steps to execute:

- Review quality of information inputted onto the template over a period of seven handovers including night shift reporting
- Focus on where there are gaps, why, and what needs to be done to ensure the tool is completed
- Consult with staff on what are possible issues and learning needs based on quality of data
- Consult team on whether they feel the handover has improved communication
- Review the discussions regarding the use of a whiteboard/plasma screen to see if this is required/might resolve some of the possible issues identified by the team
- Note the time taken to complete handovers compared to previously

Do:

- Team have settled into using template and information is clearer
- A few of team still struggle to complete template but this is sometimes about level of acuity on ward and staffing levels

Study:

- The template is fine and will review in 6 months.
- Still following paper format but would be good to have it on plasma screen so it can be stored more effectively and accessed anytime of day or night to input information

Act:

Review in 6 months.

Case Study: De-escalation (PDSA cycle)

Plan:

Implement de-escalation training on the ward identify champions within the ward team

I hope this produces:

An improvement in de-escalation skills within the team that enables more effective reduction in violence and aggression

Measurement:

- Feedback from patients and staff
- Reduction in violence and restraint

Steps to execute:

- Discussion and agreement sought with PMVA team to support team.
- Ward Manager to identify champions from within team who will be trained in de-escalation skills.
- Deliver training to identified champions with agreement on monthly support sessions.
- Each ward de-escalation champion to be allocated small grp of ward staff to train in de-escalation skills and be point of support.
- Monitor Datix/Ulysses data on violence and aggression and restraint.
- Seek feedback from staff and patient survey evidence

Do:

- Champions have found training positive.
- A lot easier to train other staff up using champions rather than trainer coming down on ward every week.

Study:

- Still early days put team response to de-escalation training is positive. Will need to continue to monitor data on violence and aggression and restraint.

Act:

Review in 6 months.

Restraint reduction tools

To reduce the incidence of harm caused to users and staff as a result of a reduction in physical restraint by X% by the end of the programme

Primary drivers	Secondary drivers
Leadership	• Philosophy of care and values • Exec walkround
Using data to inform practice	• Visual display data
Workforce development	• De-escalation sessions • Handover
Restraint reduction tools	• My Safety Plan • Sensory room • Advanced statements • Advocacy support
Patient roles within inpatient settings	• Community meetings • Peer Support Worker role
Debriefing techniques	• Debriefing process

You are here

Main Menu

This section includes information and guidance on:

Overview of restraint reduction tools

Safety Plan

Sensory room

Advance statements

Advocacy

This section ends with:

Action: Putting theory into practice

Top tips

Case studies

Restraint reduction tools

Overview of restraint reduction tools

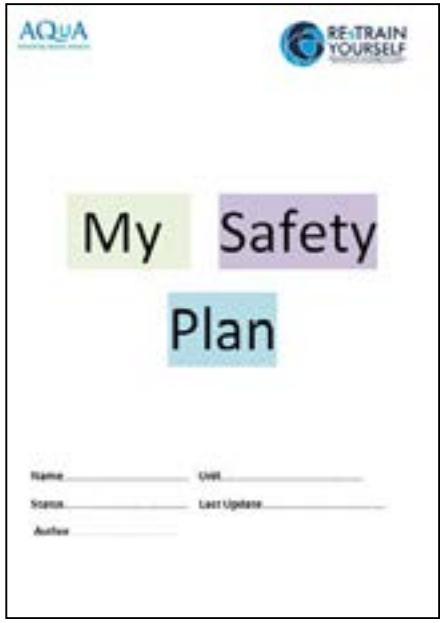
Restraint reduction tools:
Safety planning
Sensory resources/activities
Sensory rooms
Advance statements
Peer support/specialist
Advocacy
Debriefing techniques
De-escalation techniques
SBAR

Safety Plan

What is a safety plan?

A safety plan is an individualised plan developed proactively by a patient and staff before a crisis occurs. It is a:

- Therapeutic process
- Task that is trauma sensitive
- Partnership of safety planning
- Patient-owned plan written in easy to understand language
- Strategy



Why are they used?

They are used to help:

- The patient during the earliest stages of escalation before a crisis erupts
- The patient identify coping strategies before they are needed
- Staff plan ahead and know what to do with each person if a problem arises
- Staff use interventions that reduce risk and trauma to individuals

What are the safety plan components?

Essential components of a safety plan are:

- Triggers
- Early warning signs
- Calming strategies

Restraint reduction tools

Safety Plan

What does a Safety Plan look like?

A Safety Plan is an A5 leaflet. It is split into the following sections:

- Triggers
- Warning signs
- Calming strategies (for the patient and supporting strategies for staff)
- Reviews
- Examples of triggers, early warning signs and calming strategies

How do I use a Safety Plan?

- Identify patients who you feel may benefit from completing the Safety Plan, for example patients who become distressed, agitated and aggressive.
- Let the patient complete the plan. They can take it away and do it themselves or sit with you to complete it.
- To aide the discussion use the examples of triggers, early warning signs, and calming strategies.
- Once complete, photocopy the Safety Plan and give the copy to the Named Nurse.
- The Named Nurse needs to identify the elements of the Safety Plan which should go into the care plan.
- Follow up with the patient over the next coming days to review the Safety Plan.
- If there are any amendments to the Safety Plan these changes should be passed to the Named Nurse.
- All Safety Plans should be placed in the patient notes and attached to their care plan.

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Safety Plan

Examples of triggers

- Not being listened to
- Lack of privacy
- Feeling lonely
- Darkness
- Being teased or picked on
- Feeling pressured
- People yelling
- Arguments
- Being isolated
- Being touched
- Loud noises
- Not having control
- Room checks
- Contact with family

Patients have unique histories with uniquely specific triggers, so it is essential to ask and incorporate these into the Safety Plan.

Safety Plan

The Universal Trigger

‘Every restraint and seclusion I have reviewed started with a member of staff enforcing a rule…..’

(Ross Greene, Ph.D., 2004)

When thinking about the statement above you should consider:

- Do all our rules make sense?
- Or are they just the way things have always being done?

Restraint reduction tools

Safety Plan

Examples of early warning signs

- Clenching teeth
- Wringing hands
- Bouncing legs
- Shaking
- Crying
- Giggling
- Heart pounding
- Singing inappropriately
- Pacing
- Eating more
- Breathing hard
- Shortness of breath
- Clenching fists
- Loud voice
- Rocking
- Cannot sit still
- Swearing
- Restlessness

Safety Plan

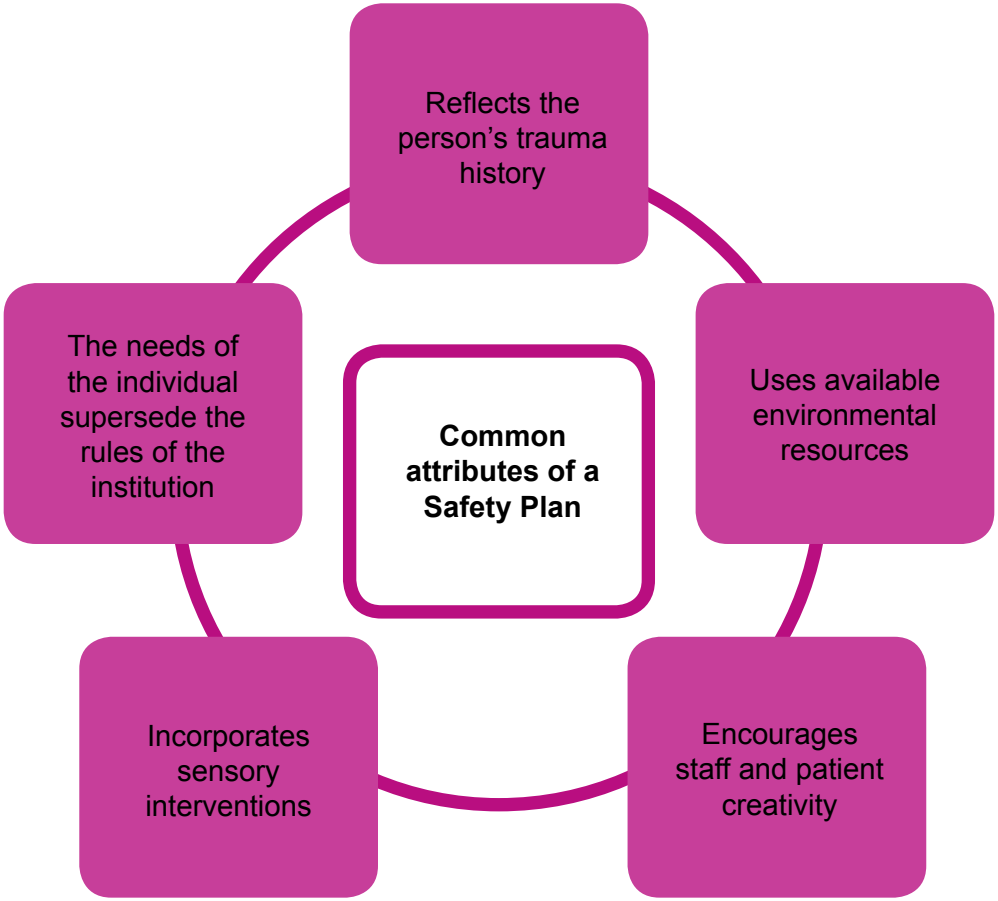
Calming strategies

- Reading a book
- Pacing
- Colouring
- Hugging a stuffed animal
- Taking a hot shower
- Deep breathing
- Being left alone
- Talking to peers
- Therapeutic touch (describe……)
- Exercising
- Eating
- Writing in a journal
- Taking a cold shower
- Listening to music
- Moulding clay
- Calling friends or family (who?)

You must consider, ask and document what has not worked on the Safety Plan, so it can be avoided in the future.

Restraint reduction tools

Safety Plan



Safety Plan

Staff and patients know the purpose of the tool and plan, the words that are used, and what it means

How the discussion is initiated

- Authentic interest
- Development of relationship
- Time spent

Continuously using the tool throughout the stay of the patient and in the treatment team

- Practice, revise, use

Where the discussion occurs

- Calm, quiet space

PDSAs on the use of ‘My Safety Plan’ are outlined **here**.

Restraint reduction tools

Sensory room

What is a sensory room?

A sensory room is an overarching term which can be used to identify a number of therapeutic spaces which have specifically been designed to:

- Help create a safe space
- Support a therapeutic environment, providing spaces where therapeutic activities can take place
- Provide opportunities for engagement in prevention and crisis de-escalation strategies
- Promote self care, resilience and recovery.

Sensory room resources

Physical activities

- Consensual holding
- Weighted blankets
- Heated blankets
- Arm/hand massage
- Push ups
- Body socks
- Wrist/ankle weights
- Aerobic exercise
- Candles
- Walking

Sensory based approaches

- Hot shower/bath
- Wrapping in a heavy quilt
- Decaffeinated drink
- Rocking chair
- Bean bag tapping
- Yoga/mindfulness sessions
- Drumming/music

Sensory/comfort room

- Dimmer switch lighting
- Aroma fans
- Bubble lighting
- Artwork
- Music
- Comfortable seating
- Plants

Advance statements

Although you may not be directly involved in advance statements, it is important to understand their meaning and how they may affect a patient's treatment.

An advance statement is when a person specifies what treatment or care they would like to be given, if they no longer have the capacity to make their own decisions.

Type of advance statement	What it means
Advance requests	A person asks for certain treatments or other arrangements. A person says in advance how they would like to be treated if they lose mental capacity (for example, being admitted to a certain ward in a particular hospital).
Advance directives or advance decisions	A person says which treatments they do not want. The Mental Capacity Act (2005) gives people a legal right to refuse medical procedures in advance but they have to be over 18 and have capacity to make the decision when the advance directive is produced.
Advance agreement	This is an agreement with the main service/s that cares for a person. The agreement contains a plan of what to do in a future crisis (for example, being treated with a particular drug).
Crisis cards	A person may carry a crisis card which identifies they have an advance statement.

Advocacy

Although you may not be directly involved in advocacy support, it is important to understand how this can help a patient

As a mental health professional you can be supportive and helpful, but it can be difficult if the patient is doing things which you do not agree with. As you know, you have a 'duty of care' to the people you work with, which means you cannot support patients in doing things which you believe will be bad for them.

However, an advocate is independent, and will represent a patient's wishes without judging or putting forward their own personal opinion.

Advocacy is a process of supporting and enabling people to:

- Express their views and concerns
- Access information and services
- Defend and promote their rights and responsibilities
- Explore choices and options

(MIND website)

Action: Putting theory into practice

Safety questions you ask yourself

1. **Safety Plans**
    - Is staff training required before Safety Plans are introduced?
    - How will you identify which patients should have a Safety Plan?
    - What will the process be for ensuring relevant information identified in the Safety Plan is:
        - shared within the team
        - forms part of the care plan
        - copied and put in the patient notes
    - How will the impact of introducing Safety Plans be measured?
2. **Sensory rooms**
    - What space could be used for a sensory room?
    - What would the sensory room be used for?
    - What equipment and furnishing etc will be needed and how will these be sourced and paid for?
    - How will the impact of introducing a sensory room be measured?
3. **Advance statements**
    - Do all staff understand the different types of advance statements? If not, what can be done?
4. **Advocacy**
    - Do staff understand the role of advocacy? If not, what can be done?

Restraint reduction tools

Top Tips

- Prior to implementation, identify a small group of individual patients to trial the safety plan or develop ideas that can be trialled
- Develop a list of unmet needs identified in the calming strategies section of safety plan
- Engage with external organisations e.g. public health, local gyms and art based organisations, animals/pets visiting wards services
- Note that safety plans work well with patients with identified issues of anger and violence
- To develop sensory or comfort rooms/spaces, work with a small group of patients/staff to identify safe spaces, design and resource requirements for the room and to collaborate on working up a proposal
- Some resources (e.g. cushions and heavy blankets) could be made by patients as part of the room's development.

Case Study: Safety Plan (1 of 3 PDSA cycles)

Plan:

Introduce ‘My Safety Plan’ to the ward as part of trauma informed care with a sample of patients on the ward.

I hope this produces:

A tool which will indicate patient triggers, early warning signs and calming strategies to help both staff and patients identify when a patient is becoming agitated and distressed and help alleviate any further deterioration in emotional state.

Measurement:

- Feedback from patients
- Feedback from nursing staff

Steps to execute:

- Identify a sample of patients to test out the Safety Plan
- Inform staff via handover and staff meetings
- Monitor over two weeks
- Seek feedback from patients on the Safety Plan
- Seek feedback from staff on the Safety Plan and how it compares to patients without a plan

Do:

- Patients completed plan, some with help and some on their own
- Issue picked up on strategies e.g. a patient wanted to see their dog so we arranged it so the dog came onto the ward the next day
- Problem with what to do with the copied plan and just placed it in the notes
- Was told by a doctor that we needed training to complete Safety Plans
- If we go back to the patient to review plan it is worth putting in a review section

Study:

- Patients responded positively to the plans and had no problem completing them and included lots of examples
- The biggest problem is how we ensure that the information in the plans get passed onto the Lead/Named Nurse

Act:

- The Safety Plans were helpful in identifying strategies to calm people down
- Users found it helpful to identify what helped
- It is early days to say that it reduced restraints and we will need to continue doing them with a range of patients over the coming weeks
- The Plans need to be amended to include a page for writing comments for reviewing
- We need to look at how the information is embedded into the handover and into the patient care plans
- We need to ensure that the Named Nurse gets a copy of the Safety Plans - they are the person who makes the decision as to what is needed to be put in the care plan

Case Study: Safety Plan (2 of 3 PDSA cycles)

Plan:

- Introduce the amended ‘My Safety Plan’ (a review section added) to the ward as part of trauma informed care with a sample of patients on the ward
- Ensure that all Safety Plans are passed onto the Named Nurse so information is then added to the care plan where appropriate

I hope this produces:

- A tool which will indicate patient triggers, early warning signs and calming strategies to help both staff and patients identify when a patient is becoming agitated/distressed and help alleviate any further deterioration in emotional state
- A tool that improves communication amongst the team through handover and in care plans

Measurement:

- Feedback from patients
- Feedback from nursing staff

Steps to execute:

- Continue to identify patients to test out the Safety Plan alongside reviewing those who have completed one
- Pass completed plans to Named Nurse to add any information into the care plan
- Inform staff via handover and staff meetings
- Monitor over two weeks
- Seek feedback from patients on the Safety Plan
- Seek feedback from staff on the Safety Plan and how it compares to patients without a plan

Do:

Completed safety plans with a small group of patients and informed staff of process and mentioned in handover.

Study:

- Patients needed support to understand what a trigger is etc.
- The patients do find the examples helpful.
- Found it is helpful to review after 3 days as this helps to pin down key issues in helping the patient understand what causes agitation, aggressive outbursts etc..
- Currently safety plans are in patient notes but fear they might get forgotten.

Act:

- To incorporate safety plan onto IT software in care plan so they don’t get lost.
- Ensure process ensures patient followed up 3 days later to review plan.

Case Study: Safety Plan (3 of 3 PDSA cycles)

Plan:

Trial a process to maximise the benefits of the Safety Plans:

- The Named Nurse will be responsible for placing Safety Plan information into the care plans so the information gained is not lost in the system
- The Safety Plan will be highlighted in the handover process
- All admission packs will contain a 'My Safety Plan'

I hope this produces:

An ultimate change in the acute care plan that ensures a dedicated element is for inputting the Safety Plan. This can then be spread across the Trust in future. The handover process will ensure staff know who has and hasn't got a Safety Plan.

Measurement:

- Feedback from patients and nursing staff, particularly named nurses
- Number of Safety Plans completed by patients and numbers without

Do:

Confusing when trying to put safety plan into care plan on the system. Works better when patients keep a copy and staff attach safety plan to care plan.

Study:

Safety plan does not fit into the current IT system software as it isn't clear on the care plan.

Act:

- All safety plans placed in admission packs for patients.
- Feedback to IT to find way of incorporating space to input safety plan into care plan.
- To continue with safety plan copied and attached to care plan and feedback in handover.

Steps to execute:

- Continue to identify patients to test out the Safety Plan alongside reviewing those who have completed one
- Identify number of patients who want to complete a Safety Plans from admission packs and those who complete it without staff
- Pass completed plans to Named Nurse to add any information onto the acute care plan (via ePEX)
- Inform staff via handover (note new process) and staff meetings
- Monitor over two weeks
- Seek feedback from patients on the Safety Plan
- Seek feedback from staff on the Safety Plans and how it compares to patients without one
- Seek feedback from staff to understand if the ePEX process works and if not what needs changing
- Seek feedback from staff and patient survey evidence

Case Study: Sensory Room (1 of 2 PDSA cycle)

Plan:

Transform the current storage room into a sensory room.

I hope this produces:

A space that patients can utilise and reduce agitation and which staff can access as an option to de-escalate patients. We hope this will lead to a reduction in violence and restraint incidents.

Measurement:

- Restraint and violent incident data
- Patient experience data
- Staff feedback

Steps to execute:

- Identify space
- Identify champions via commitments
- Identify patients to engage in development
- Consult patients and staff on what is needed for the room
- Develop costings
- Put PDSA and costings to Executive Lead
- Ensure process is based on co-production and any resources that can be made with and by patients e.g. cushions, bean bags etc
- Develop protocol in conjunction with small patient group and staff – link to prescribing sensory room and not prescribing medication
- Trial room for a period of one month, putting in place feedback mechanisms for patients to respond to the use, benefits and issues in both environment and staff response
- Monitor identification of sensory room as a calming strategy via ‘My Safety Plans’

Case Study: Sensory Room (2 of 2 PDSA cycle)

Do:

Developed a proposal to go to senior management team for discussion and to seek approval to develop the room.

Study:

Through looking again at the space on the ward we decided that the storage room would be expensive and difficult to turn into a sensory room due to a number of risks within the space. Identified another area on the ward.

Act:

Proposal sent and await approval from senior management to be able to move forward.

Patient roles within inpatient settings

To reduce the incidence of harm caused to users and staff as a result of a reduction in physical restraint by X% by the end of the programme

Primary drivers	Secondary drivers
Leadership	• Philosophy of care and values • Exec walkround
Using data to inform practice	• Visual display data
Workforce development	• De-escalation sessions • Handover
Restraint reduction tools	• My Safety Plan • Sensory room • Advanced statements • Advocacy support
Patient roles within inpatient settings	• Community meetings • Peer Support Worker role
Debriefing techniques	• Debriefing process

You are here

Main Menu

This section includes information and guidance on:

Community meetings

Peer Support/Specialist role

This section ends with:

Action: Putting theory into practice

Top tips

Case studies

Patient roles within inpatient settings

Community meetings

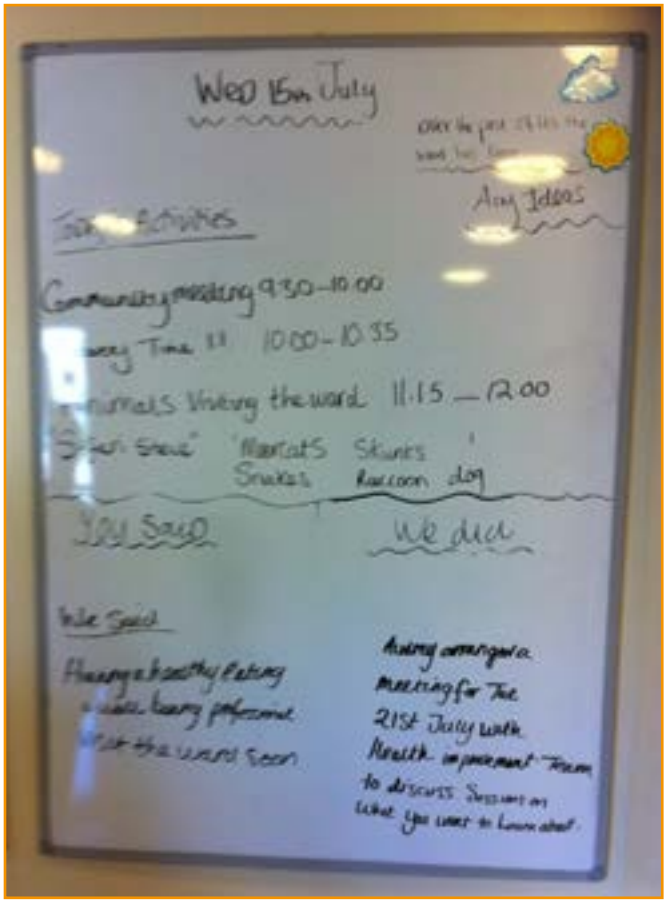
Community meetings are a great way of:

- Understanding the mood on the ward from the patient perspective
- Gaining patient views as to what activities could take place
- Sharing ward information with patients

Community meetings should involve patients on the ward and happen daily if possible.

Topics to be discussed should be developed by the patients themselves and may include:

- The weather symbols to demonstrate the mood on the ward
- Activities for that day
- Any ideas for the evening or next day
- Any reviews or meetings taking place
- Which staff are working on what shift
- You said/We did



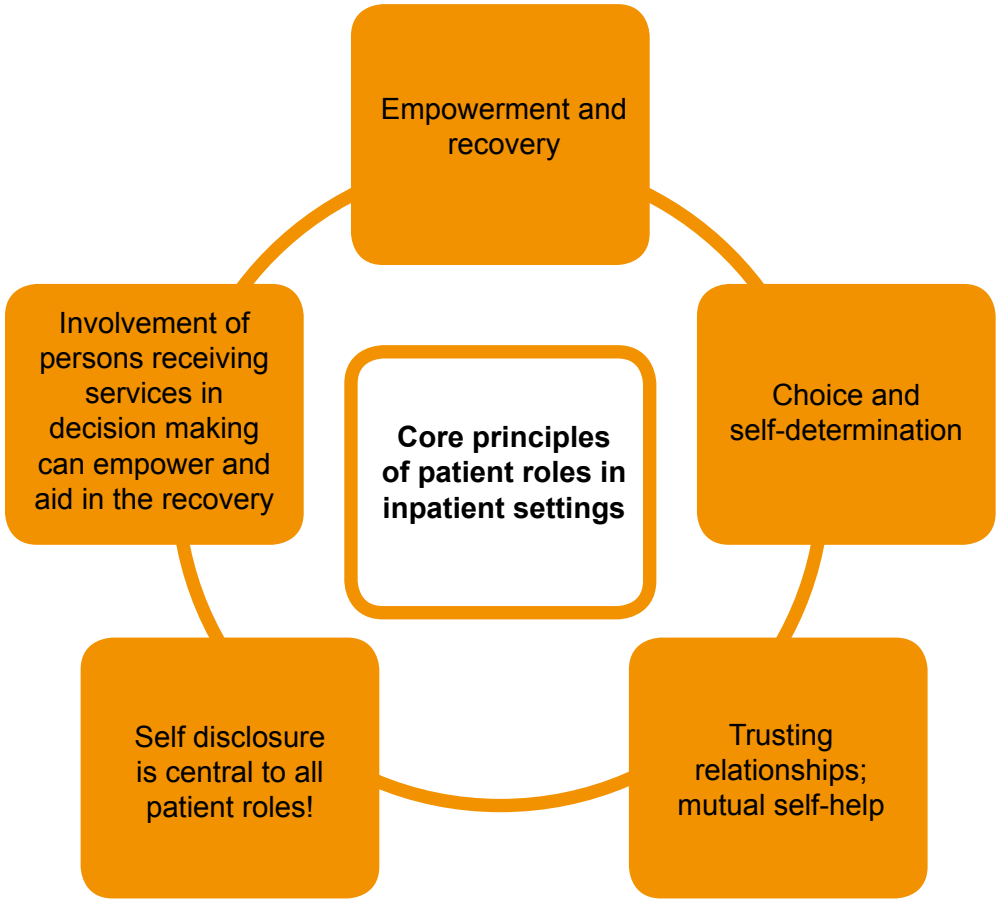
Information from the community meetings should be visible for all patients to see (such as on a whiteboard in the dining room).

Peer Support/Specialist role

Peer Support/Specialists are useful in helping people recover from mental distress.

Other people who have experienced mental health issues can sometimes offer insight and understanding and can draw on their own experiences to help others in similar situations.

What they offer is a complement to the professional support available.



Patient roles within inpatient settings

Peer Support/Specialist role

The recovery college approach

The recovery college approach empowers people with mental health problems to be experts in their own recovery, live well, and make the most of their skills and talents through education.

Peer support/specialists - link to recovery college approach

- Participate in treatment meetings
- Facilitate peer support group meetings
- Provide individual peer support
- Assist with discharge transition, community adjustment and coping skills
- Work as ‘peer bridgers’ to help with post discharge support network and partner with community services to develop capacity

Peer Support/Specialist role

The recovery college based approach supports individuals in institutions 3-5 months prior to discharge and 6-12 months afterward in their homes.

These services should be developed collaboratively with the 3rd sector, peer entities and support groups in the community to:

- Provide intensive support through a balance of social, recreational and skills teaching
- Establish linkages in community services and natural supports

(Mead, 2002)

PDSA on the introduction of a Peer Support Worker onto an acute ward is outlined **here**.

If you would like advice/guidance on how to engage patients in Peer Support/Specialist roles please speak to your Aqua Improvement Advisor.

Patient roles within inpatient settings

Action: Putting theory into practice

Safety questions you ask yourself

1. **Community meetings**
    - How could community meetings be introduced?
    - Which patients will you involve in developing topics for discussion?
    - Who will initially chair the meetings?
    - Which patients will you involve in developing topics for discussion?
    - Who will initially chair the meetings?
    - What time of day will the meetings be held?
    - Where will the information be placed so it is visible for all patients?
    - How will the impact of introducing community meetings be measured?

2. **Peer Support/Specialist roles**
    - How could Peer Support/Specialist roles be used?
    - How could Peer Support/Specialist be identified?
    - What induction would be required? Who would deliver this?
    - How would you assess their impact?

Top Tips

- Using weather symbols to describe the mood of ward creates a good measure (sunny, cloudy or stormy) enabling you to inform patients and visitors at the end of the month the percentage rates of moods for that period. Asking for general comments on mood risks too many variations and is difficult to measure.
- Support opportunities for, patients to chair the community meetings.
- Issues around individuals care need to be given space outside community meeting e.g. observation/leave/medication. Develop a managed open group to talk about why we use observation/leave/meds etc. at least one hour a week
- Useful to have photos of staff on shift rather than just names.
- ‘You said/we did’ placed on the mood/activity board keeps all information in one place, rather than scattered around the

Case Study: Peer Support Worker (1 of 1 PDSA cycle)

Plan:

Support the introduction of a Peer Support Worker onto the ward.

I hope this produces:

An improvement in communication within the team that enables more effective identification and timely intervention of patient needs in a person centred way.

Measurement:

- Feedback from patients and staff
- Reduction in violence and restraint
- Peer Support Worker role measures

Steps to execute:

- Meet with Peer Support Worker Coordinator
- Meet with Chair of Peer Support Workers and agree timings etc
- To train staff in the role
- Induct Peer Support Worker (PSW) onto the ward and to the REsTRAIN YOURSELF programme – prior to attendance on the ward and during period of Wave 2 of this programme
- Agree areas of work/PDSAs which Peer Support Worker can be involved in
- Support Peer Support Worker by coaching and mentoring

Do:

- Meeting highlighted issues regarding PSW expectations – need to work on realities of an acute ward and difficulty in building relationships. One-to-one sessions early on with the PSW to embed difference in role compared to community or recovery wards.
- Agreement on induction to ward including meeting with AQuA Improvement Advisor to get an overview of REsTRAIN YOURSELF programme and what the PSW can 'hook' into regarding PDSAs e.g. safety plans and community meetings, and also to be a fresh pair of eyes in debriefs.
- To meet with PSW in the next two weeks for induction.

Study:

Whilst waiting on interview process and DBS checks the Improvement Advisor met with PSW to discuss project and work through improvement methodology session.

Act:

- Meetings very positive and helpful to work through project and improvement methodology which has enabled me to develop a draft proposal of PSW role in reducing restraint.
- Issues with DBS process and trust policy being addressed by trust.

Case Study: Peer Support Worker (1 of 1 PDSA cycle)

Plan:

Support the introduction of a Peer Support Worker onto the ward.

I hope this produces:

An improvement in communication within the team that enables more effective identification and timely intervention of patient needs in a person centred way.

Measurement:

- Feedback from patients and staff
- Reduction in violence and restraint
- Peer Support Worker role measures

Steps to execute:

- Meet with Peer Support Worker Coordinator
- Meet with Chair of Peer Support Workers and agree timings etc
- To train staff in the role
- Induct Peer Support Worker (PSW) onto the ward and to the REsTRAIN YOURSELF programme – prior to attendance on the ward and during period of Wave 2 of this programme
- Agree areas of work/PDSAs which Peer Support Worker can be involved in
- Support Peer Support Worker by coaching and mentoring

Do:

- Meeting highlighted issues regarding PSW expectations – need to work on realities of an acute ward and difficulty in building relationships. One-to-one sessions early on with the PSW to embed difference in role compared to community or recovery wards.
- Agreement on induction to ward including meeting with AQuA Improvement Advisor to get an overview of REsTRAIN YOURSELF programme and what the PSW can 'hook' into regarding PDSAs e.g. safety plans and community meetings, and also to be a fresh pair of eyes in debriefs.
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Whilst waiting on interview process and DBS checks the Improvement Advisor met with PSW to discuss project and work through improvement methodology session.

Act:

- Meetings very positive and helpful to work through project and improvement methodology which has enabled me to develop a draft proposal of PSW role in reducing restraint.
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Debriefing techniques

To reduce the incidence of harm caused to users and staff as a result of a reduction in physical restraint by X% by the end of the programme

Primary drivers	Secondary drivers
Leadership	• Philosophy of care and values • Exec walkround
Using data to inform practice	• Visual display data
Workforce development	• De-escalation sessions • Handover
Restraint reduction tools	• My Safety Plan • Sensory room • Advanced statements • Advocacy support
Patient roles within inpatient settings	• Community meetings • Peer Support Worker role
Debriefing techniques	• Debriefing process

You are here

Main Menu

This section includes information and guidance on:

Purpose

Principles

Types of debrief and process

Debriefing documentation

Outcomes of debrief

This section ends with:

Action: Putting theory into practice

Top tips

Case studies

Debriefing techniques

Purpose

Definition of debriefing

A stepwise tool designed to rigorously analyse a critical event, to examine what occurred and to facilitate an improved outcome next time (manage events better or avoid event next time)

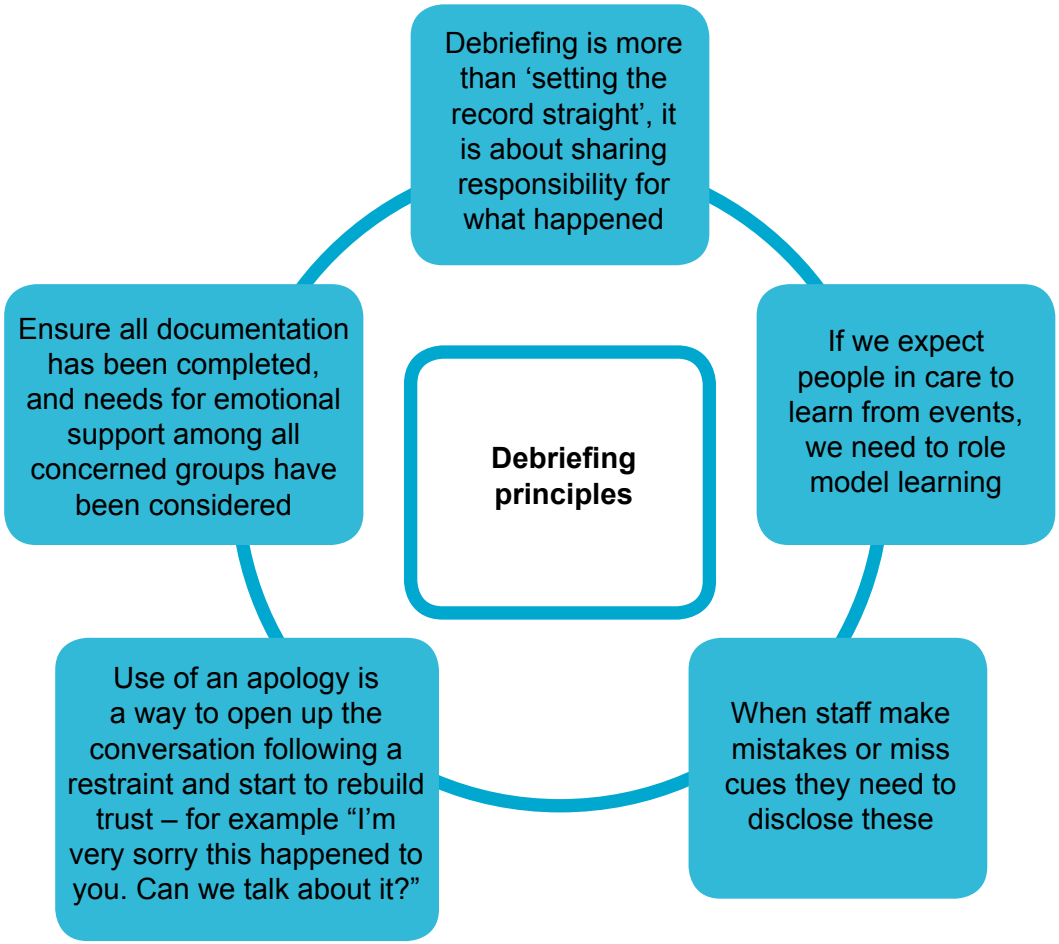
(Scholtes et al 1998)

Debriefing goals

- To reverse or minimise the negative effects of the use of restraint
- To prevent the future use of restraint
- To address organisational problems and make appropriate changes

If you would like advice/guidance on how to engage patients in Peer Support/Specialist roles please speak to your Aqua Improvement Advisor.

Principles


Debriefing is more than ‘setting the record straight’, it is about sharing responsibility for what happened
If we expect people in care to learn from events, we need to role model learning
When staff make mistakes or miss cues they need to disclose these
Use of an apology is a way to open up the conversation following a restraint and start to rebuild trust – for example “I’m very sorry this happened to you. Can we talk about it?”
Ensure all documentation has been completed, and needs for emotional support among all concerned groups have been considered
Debriefing principles

Debriefing techniques

Types of debrief and process

Type of debrief	Process
Immediate 'post acute event'/informal debriefing	1. Ideally this should take place immediately following the incident 2. Ask those involved three questions: • Are you safe? • Is the patient safe? • What just happened? 3. Include patient debrief where possible 4. If you feel informal debrief is insufficient then complete a formal debrief
Formal debrief	1. Ideally this should take place the next working day 2. Formal debrief should be attended by all staff involved in restraint/violent incidents. If this isn't possible outcomes should be fed back to non-attendees on their return 3. Someone not involved in the incident should be present at the formal debrief (this could be a Peer Support Worker if there is one in place) 4. Complete appropriate documentation 5. Documentation to be given to the Ward Manager to ensure actions are completed 6. Complete electronic reporting systems as per organisational policies
Patient debrief	1. To take place at the most appropriate time, but as soon as possible following the incident 2. The focus of this debrief is to let the patient tell their story rather than asking numerous questions 3. A staff member not involved in the incident should complete the appropriate documentation with the patient

Debriefing documentation

Staff Debriefing Form – completed by staff

A face-to-face sample Formal Staff Debriefing Form has been developed, which asks specific questions to support you in the formal debriefing process.

Patient Debriefing Form – completed with the patient

A sample Patient Debriefing Form has been developed to understand from their perspective:

- what happened
- why it happened
- how this can be avoided in future

Copies of the sample Formal Staff Debriefing Form can be downloaded from the Aqua website by clicking **here**.

Debriefing techniques

Outcomes of debrief

- Had a treatment environment been created where conflict was minimised (or not)?
- Could the trigger for conflict (disease, personal, environment) have been prevented (or not)?
- Did staff notice and respond early to events (or not)?
- Did staff choose an effective intervention or de-escalate (or not)?
- If the intervention was unsuccessful was another chosen (or not)?
- Did staff order restraint only in response to imminent danger (or not)?
- Was restraint applied safely (or not)?
- Was the individual monitored safety (or not)?
- Was the individual released ASAP (or not)?
- Did post-event activities occur (or not)?
- Did learning occur and was it integrated into the treatment plan and practice (or not)?

Action: Putting theory into practice

Safety questions you ask yourself

1. **How can the process be implemented?**

2. **How will the process be communicated to all staff?**

3. **Is training necessary so that all staff understand the:**
    - Benefits of using debriefing techniques
    - Debriefing principles
    - Debriefing process

Debriefing techniques

Top Tips

- It is common for people to be ‘too busy’ to do a debrief, so it is important a clear process is in place to ensure completion.
- The chair must not have been part of the restraint and does not need to be the Ward Manager.
- The discussion needs to focus on “Why did we end up restraining” and not “how did we do with restraining”.
- Ensure any actions are signed off by the Ward Manager and that team receive feedback.
- Does your data collection system e.g. ‘Datix’ require you to note whether a debrief has occurred? If so, was it informal/ formal and what actions came out of it? Does it also note that patient had a debrief and what actions came out of it?
- Patient debriefs work better when informal and give space for patient to tell their story, rather than being asked numerous questions.
- Peer Support worker role could be helpful if used in both staff and patient debriefs.
- If there is a difference of opinion within the team due to a recent incident, it is beneficial to have a team debrief, preferably after a handover. This is useful if the team have had a difficult week or month.

Case Study: Debriefing (1 of 3 PDSA cycles)

Plan:

Commence with amended debrief template after all restraints or violent incidents on the ward. The form has been reduced by the team after consultation and will now include an informal debrief which asks three questions:

- Are you safe?
- Is the patient safe?
- What happened?

This will be followed by an agreement as to whether a formal debrief is required or not.

I hope this produces:

- more 1:1 time between nursing staff in reflecting on practice when dealing with restraint or violent incidents
- a more confident team in implementing de-escalation techniques

Measurement:

- Feedback from patients and nursing staff
- A reduction in physical restraint and violent incidents

Steps to execute:

- After any violent incident or restraint an informal debrief will take place asking the three questions
- Ensure formal debrief occurs within a minimum of 3 hours and maximum of 3 days of incident
- All staff involved in the incident to engage in debrief

Do:

- Form is much better and can be filled in quite quickly
- The session can last 10-20 minutes and does not take a lot of time out for staff to do
- The form needs changing as we had actions but nowhere on the form to put them
- It would be helpful to have the Ward Manager sign off the form so they can ensure actions are followed up as they are not necessarily at the debriefs

Study:

- The data shows low levels of restraint and no increase in prescribed medication or transfers to the Psychiatric Intensive Care Unit
- There are issues that note decisions made by a Consultant had led to recent restraints and this will help the manager in discussing the root cause of the restraint
- Staff quickly identified learning/refresher training for restraint techniques

Act:

- Form works well with actions included
- Ward Manager to sign them off, ensuring there is follow up and review
- Concern that due to the low number of restraints requiring a formal debrief there is a risk of the debriefs being forgotten or staff just using the informal approach
- Manager might use Safety Crosses/Datix to identify that debrief has been completed, and where it is highlighted that one has not been undertaken to ensure time is put in the diary to do this

Case Study: Debriefing (2 of 3 PDSA cycles)

Plan:

Introduce the debrief template for use after all restraints or violent incidents on the ward.

I hope this produces:

- more 1:1 time between nursing staff in reflecting on practice when dealing with restraint or violent incidents
- a more confident team in implementing de-escalation techniques

Measurement:

- Feedback from patients and nursing staff
- A reduction in physical restraint and violent incidents

Steps to execute:

- Complete and seek feedback on current form
- Ensure formal debrief occurs within 3 hours of incident
- All staff involved in incident to engage in debrief

Do:

Observations:

- Form is too long and needs reducing, including amending some of the language
- Due to the length of the form staff have said it is more likely that they will not do a debrief because it takes too long

Study:

- The data shows low levels of restraint and no increase in prescribed medication or transfers to the Psychiatric Intensive Care Unit
- Form needs reducing

Act:

- Form to be reduced to include actions
- Forward reduced form to manager to sign off on actions
- To go through an informal debrief – asking 3 questions (doesn't need to be written down)

Case Study: Debriefing (3 of 3 PDSA cycles)

Plan:

Continue introducing the debrief template for use after all restraints or violent incidents on the ward, ensuring actions are followed up and the manager can monitor debriefs done via Ulysses and Safety Crosses.

I hope this produces:

- more 1:1 time between nursing staff in reflecting on practice when dealing with restraint or violent incidents
- a more confident team in implementing de-escalation techniques

Measurement:

- Feedback from patients and nursing staff
- A reduction in physical restraint and violent incidents
- Number of debriefs completed on Ulysses system

Steps to execute:

- Look to ensure Ulysses has debrief on the system
- Manager to monitor debriefs completed
- Ensure formal debrief occurs within 3 hours of incident
- All staff involved in an incident to engage in debrief

Do:

- Due to management changes and current staffing issues on the ward and movement of offices this cycle has not been completed
- Paul Greenwood (AQuA Improvement Advisor) is no longer on the ward on a weekly basis so it has not been implemented

Study:

New Manager in place and staff identified to take a lead on ensuring debriefs are completed.

Act:

Identified leads on ward to promote use of formal debrief and ensure learning is shared in both handover and at staff meetings

Resources

Submit case study

The toolkit contains an area to build up case studies from across the UK and beyond. The toolkit will be updated every quarter which will be sent to you as an automatic update.

If you have an example of improvement work on reducing restraint and would like to share it with a wider audience then please complete the simple submission form. We will upload your case study to the toolkit. Please remember when writing the case study keep it simple using language that is accessible to a wide audience. By sending the case study you consent to your email contact being present on the toolkit so people who might be interested in your improvement work can contact you for more information. If you do not want your email present on the site please make it clear in the brief outline of your improvement section with the name of your organisation.

If you need to amend the case study at a future date complete the submission form noting that the information is an amendment to previous submission and we will amend accordingly.

Submit case study here

Related Resources

Resources

- Driver diagram template
- Face-to-Face Debriefing and Review following violent incidents and restraints
- Handover template
- My Safety Plan
- Patient formal debrief
- PDSA guidance and worksheet
- Peer Support Worker Role in restraint reduction
- Plan on a Page
- Safety Calendar - physical restraint
- Safety Calendar - violent incidents
- Understanding SPC Charts
- 15 Steps Challenge Action Plan
- Sustainability Model and Guide
- Restrain Yourself - Baseline assessment

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