Reducing Restrictive Practice Programme

Learning Set 6

5th November 2019

NCCMH

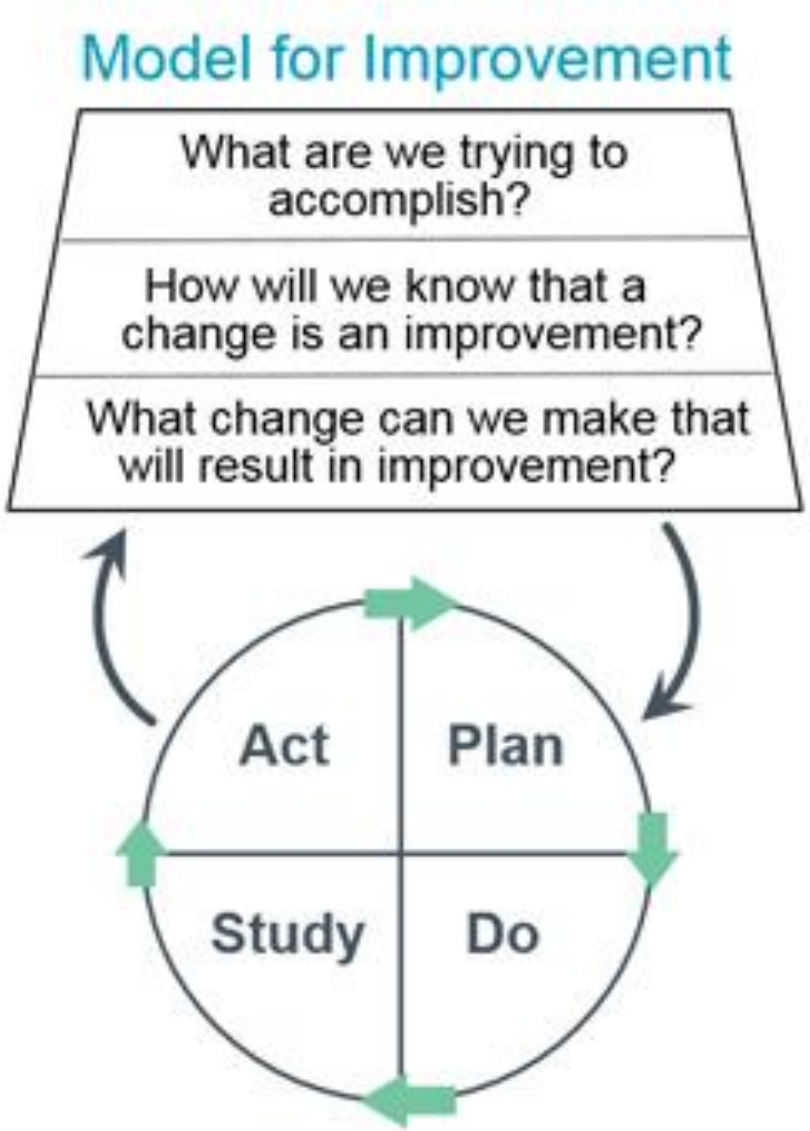
Welcome

Housekeeping

- A fire alarm test is planned for 11:00am today, no further tests are planned
- Toilets are located to the right of the lifts on Level 1 and the ground floor
- Lunch will be served at 12:50
- Please refer to your name badge to find out if you are in **Group 1**, **Group 2** or **Group 3** for your breakout sessions

Our aim

To reduce the use of restrictive practice (restraints, seclusion and rapid tranquilisation) by one-third by April 2020



Design

Reducing Restrictive Practice

Tools and Resources for Change Ideas

For change ideas in the Reducing Restrictive Practice driver diagram, there are resources listed below to assist you in your quality improvement initiatives. If you would like to learn more about the tools or talk through how they can be applied in practice, the individuals listed in the 'contact details' column are happy to be contacted if you would like to discuss more. All resources are available at www.rcpsych.ac.uk/mhsip

Change Idea	Tools and resources	Contact details for more information
DASA/ BVC	Dynamic Appraisal of Situational Aggression (DASA) Tool to assess the likelihood that a service user will become aggressive within an inpatient environment • This is helpful to use with service users and their specific triggers • DASA Recording Sheet • DASA Scoring Sheet DASA Recording Sheet.doc	• ership NHS Trust) • outh London and Maudsley ation Trust) • persaud@slam.nhs.uk
	BROSET Violence Ch http://riskassessment.n	• Dr Keith Reid (Northumberland, Tyne & Wear NHS Foundation Trust) keith.reid@ntw.nhs.uk
Display data visually/ make it easy to understand	Co-produced posters	• Jack Pooler (Central and North West London NHS Foundation Trust) jack.pooler@nhs.net
	NTW Dashboard	• Ron Weddle (Northumberland, Tyne & Wear NHS Foundation Trust) ron.weddle@ntw.nhs.uk

Tools and resources

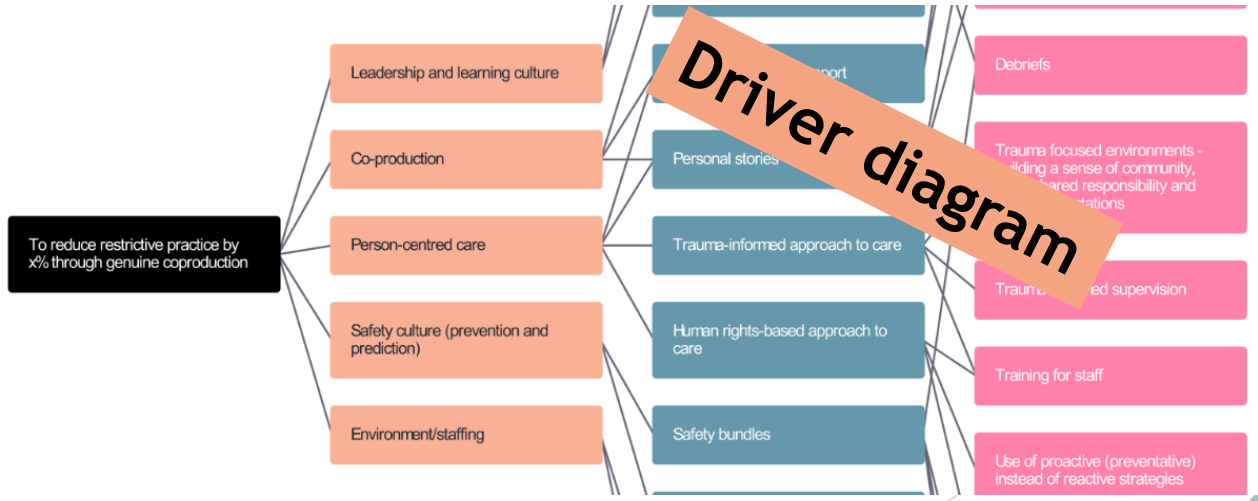
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

IMPROVING MENTAL HEALTH SAFETY
Reducing restrictive practice

Change ideas linked to secondary drivers for the reducing restrictive practice programme

Secondary driver	Change ideas linked to secondary driver	Associated resources/tools to support change ideas (further details/contacts can be found in Tools ...esources document)
Use of data to promote learning	DASA/B	...ding Sheet ...g Sheet
	Display	...d posters ...oard Data
	Dashboard live (time since...)	• Training materials to support running • Data and user guides • Talk First (Northumberland, Tyne & Wear NHS Foundation Trust) • 4 Steps to Safety Storyboard (this is a template to allow wards to report their progress at collaborative events) • NTW dashboard and annual projection data
	Patient and carer feedback	
	Leadership training programme	• PROactive Governance of Recovery Settings and Services • REsTRAIN Yourself

Change ideas

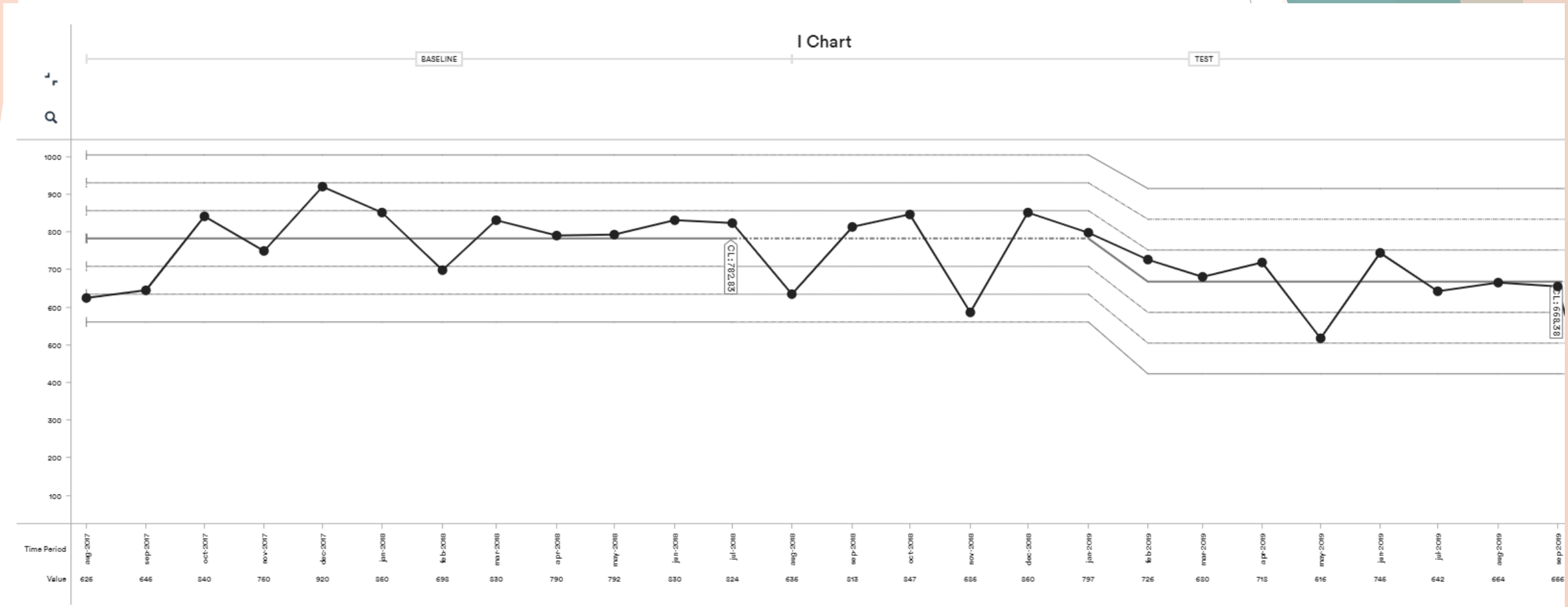


Driver diagram

Overall Data

Across the 38 wards

Aggregated Data



Reviewing Our Process for New Admissions

Galaxy PICU – East London NHS FT

Ben Quinn, Katie McCarthy and Ravi Patel

NCCMH

NHS
East London
NHS Foundation Trust

Admissions and Restrictive Practices

Dr Ravi Patel, Ben Quinn, Katie McCarthy

Background

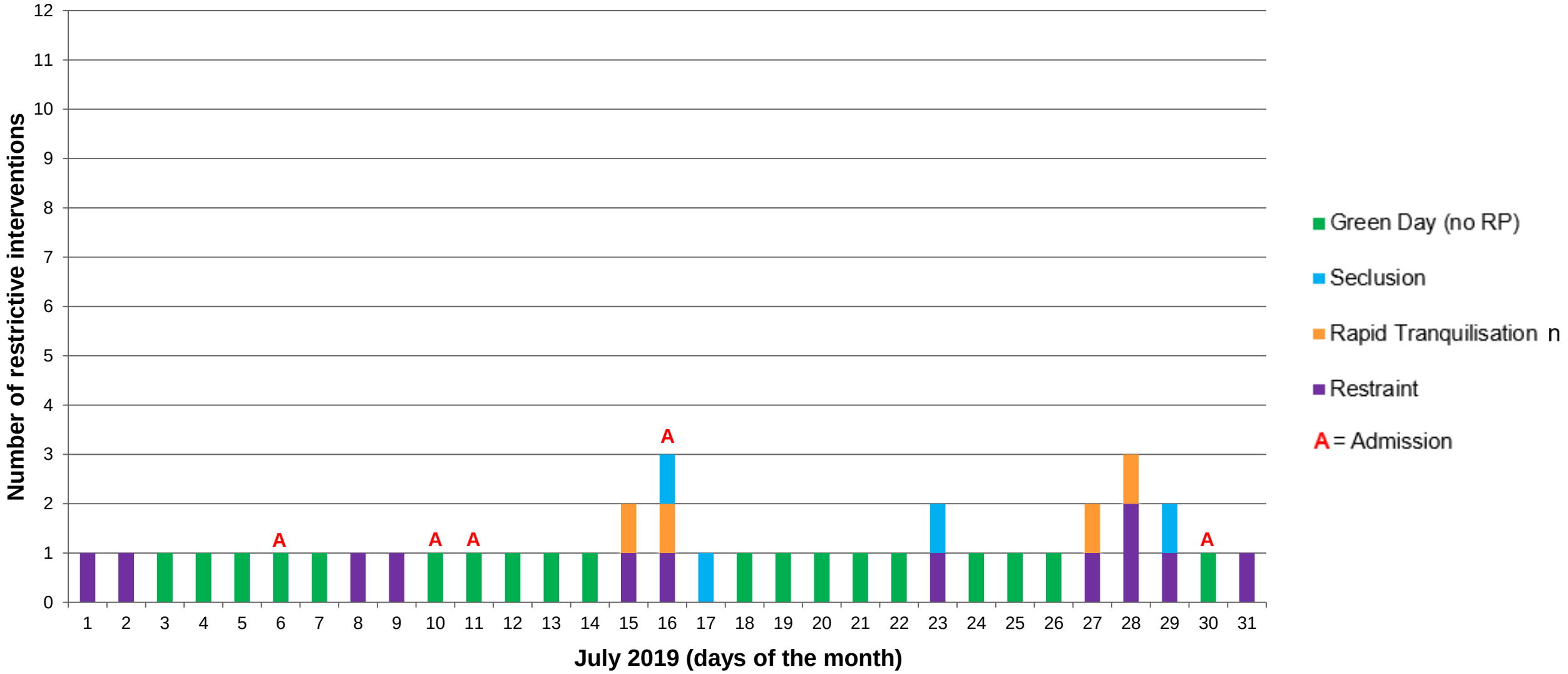
- Galaxy has stretches of ‘Green’ days
- However, Galaxy Ward continues to see some spikes in use of restrictive practice (RP)

- Changes in ward dynamics?
- What is the impact of admissions?

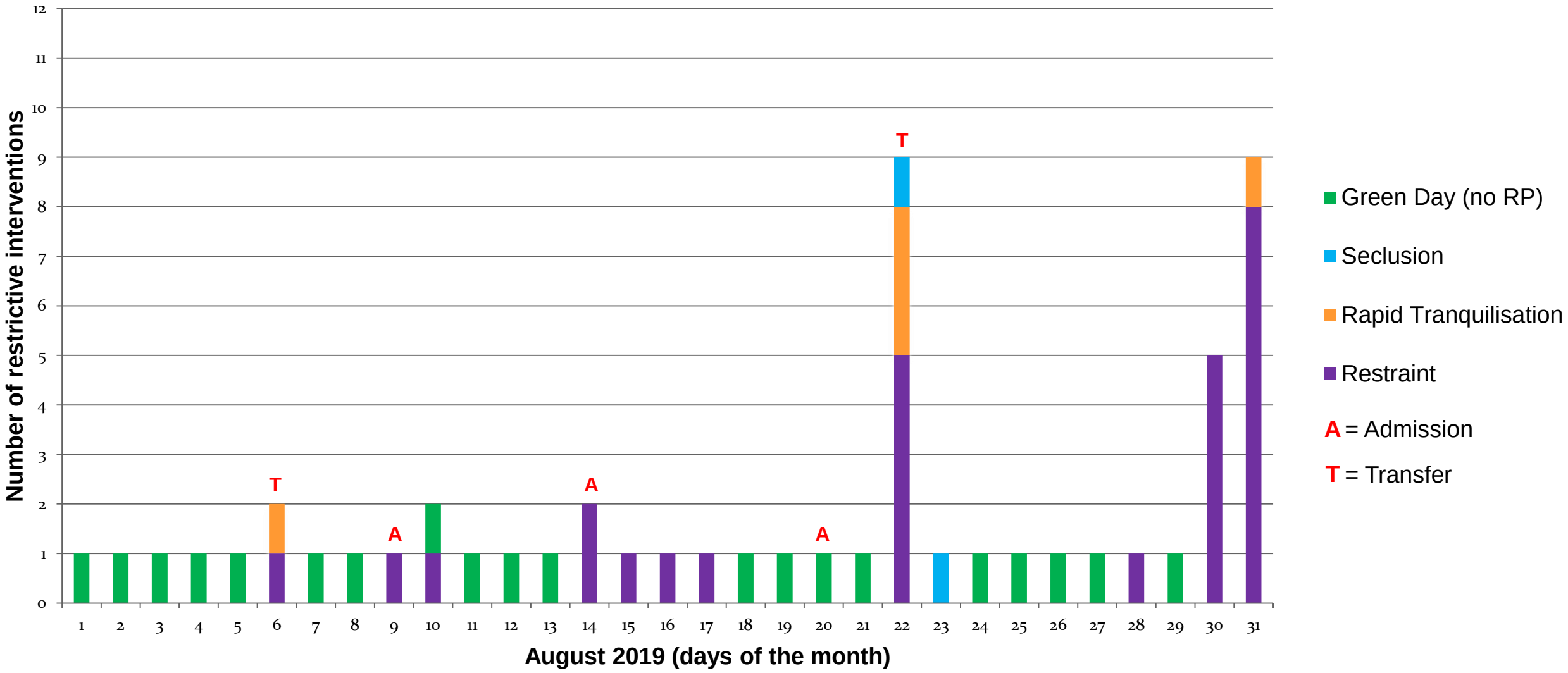
What we looked at

- Data for the past quarter (July – September 2019)
- Admissions (three days following)
- Internal transfers (PICU/ACUTE → GALAXY)
- Patient profiles of RP (diagnosis)

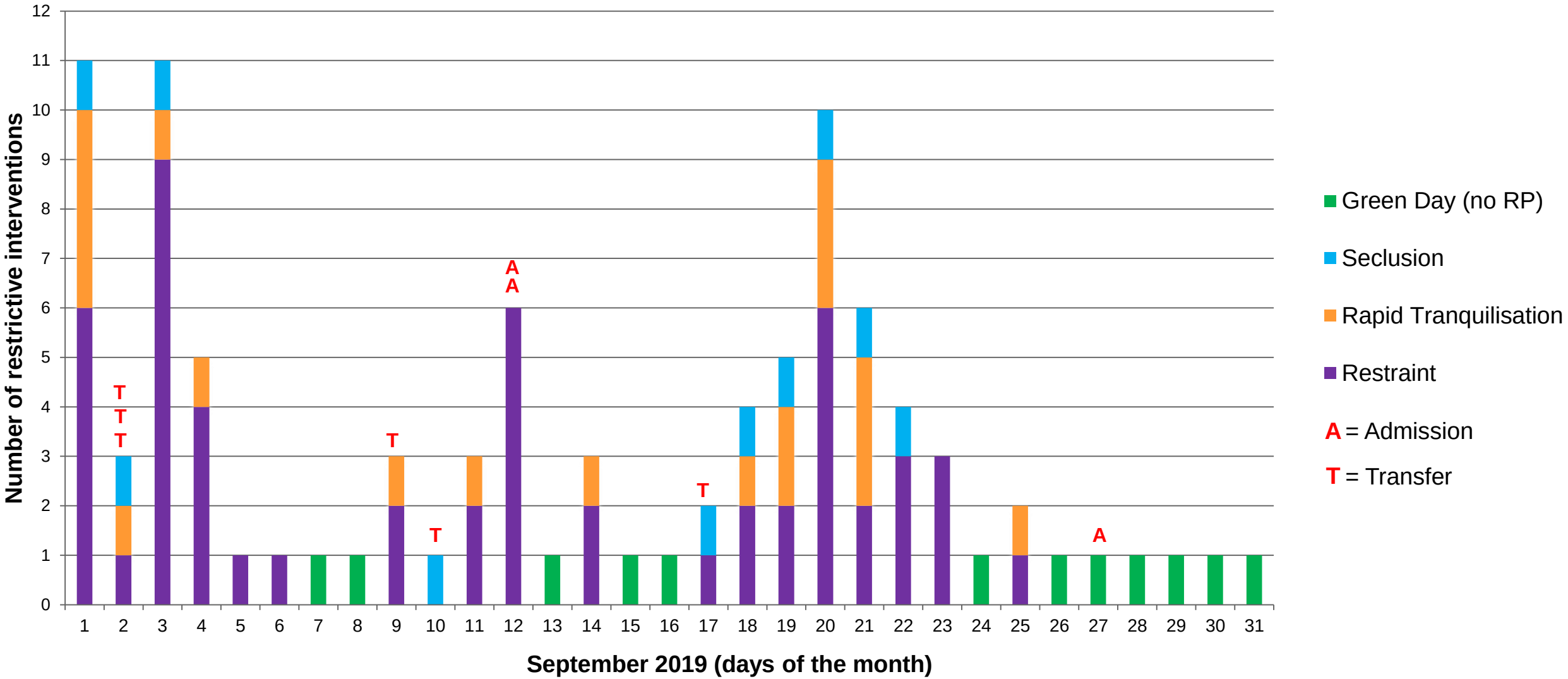
Galaxy PICU - July 2019



Galaxy PICU - August 2019



Galaxy PICU - September 2019



Patient Profile

New patients, internal transfers and existing patients

July	Percentage of RP
New Admission	35%
Internal Transfer	N/A
Existing Patients	65%

August	Percentage of RP
New Admissions	9%
Internal Transfers	15%
Existing Patients	76%

September	Percentage of RP
New Admissions	3%
Internal Transfers	21%
Existing Patients	76%

Patient Profile

Diagnosis

Diagnosis (July)	Percentage of RP
Learning Disability	70%
Psychosis	20%
ASD	10%

Diagnosis (August)	Percentage of RP
Psychosis	35%
Learning Disability	32%
ASD	12%
EUPD	15%
Conduct Disorder	6%

Diagnosis (September)	Percentage of RP
Learning Disability	63%
Psychosis	34%
ASD	3%

What we found

- Spikes during certain admissions
- A higher percentage RP involve existing patients
- A higher percentage RP involve a diagnosis of LD/NDD

Who we asked

- Young people focus groups
- Nursing staff focus groups
- Nursing staff away days
- Parent survey

What they said

- Feedback from focus groups
- Young people
- Staff

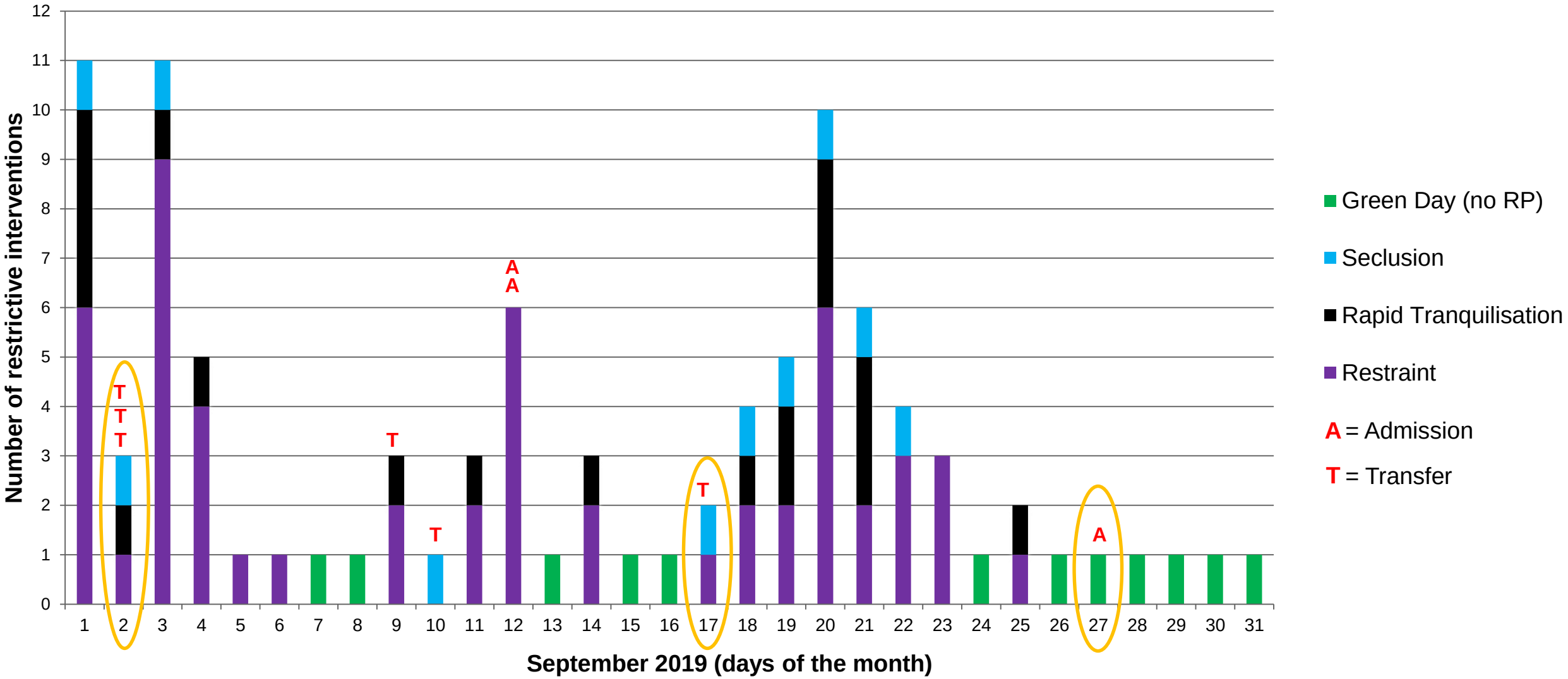
Admission Processes

- Informing other patients
- Planning support for specific patients
- Transferring team to inform new admission of Galaxy ward
- Transferring team to give detailed account of current mental state prior to arrival

Narrative - 27th September 2019

- Patients informed of admission in AM
- Bed manager/DSN supported ward (allows floor staff to support existing patients)
- Patient waited in van before arriving on ward
- Paperwork started before arrival (Meds chart etc.)
- Drs aware and ready to attend ward on arrival
- Admission ran smoothly and patients had a green day

Galaxy PICU - September 2019



Thank you

Any Questions?

Breakout Sessions

	Group 1	Group 2	Group 3
11:35 - 11:55	Start in Room 1.1	Start in Room 1.2	Start in Room 1.7

Lunch

12:50 – 13:30

Supporting Reduction Though Training and Communities of Practice

The Restraint Reduction Network
Sarah Leitch

NCCMH

Restraint Reduction Network

Raising the standards

Restraint Reduction Network (RRN) Training Standards 2019

Restraint Reduction Network

A Community of Practice with a collective vison to reduce the unnecessary use of restraint and all restrictive practices

http://restraintreductionnetwork.org/

Aim of the Restraint Reduction Network

Restraint Reduction Network

- An independent charity that brings together professional bodies, government departments, people with lived experience, practitioners and academics
- A coalition of the willing who are passionate about restraint reduction and human rights

Wednesday Webinars

Laura Higgins	Using Positive Behaviour Support to reduce Restrictive Practices in secure forensic settings	6 November 2019
John Baker	Reducing restrictive practices: understanding key intervention components	8 January 2020
Andy Johnston	Title to be confirmed	4 March 2020
Michael Nunno	The impact of organisational climates and cultures on critical incidents and the use of restraints	6 May 2020
Jennifer Kilcoyne and Danny Angus	Reducing the use of physical restraint through the 'No Force First' programme	3 July 2020
Ada Hui	Equality and cultural issues around restraint	2 September 2020
Calthorpe Academy	Reducing the use of restrictive practices in a school environment using PBS	2 November 2020

http://restraintreductionnetwork.org/

Join the RRN community

Visit this link to join the community:

http://bit.ly/32OE3Ji

Overview

Raising the standards for training in restrictive interventions

http://bit.ly/31ynUX7

The concern

- Range of quality of training (some good, some less so)
- Lack of quality assurance of training
- Focus on reactive techniques and technical competence
- Not sufficient focus on human rights, prevention, and de-escalation to reduce restraint and promote positive culture

Aims of Standards

- **Protect people's fundamental human rights** and promote person centred, best interest and therapeutic approaches to supporting people when they are distressed
- **Improve the quality of life** of those being restrained and those supporting them
- **Reduce reliance on restrictive practices** by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice

Aims of Standards

- **Increase understanding of the root causes of behaviour** and recognition that many behaviours are the result of distress due to unmet needs
- **Where required, focus on the safest and most dignified** use of restrictive interventions including physical restraint

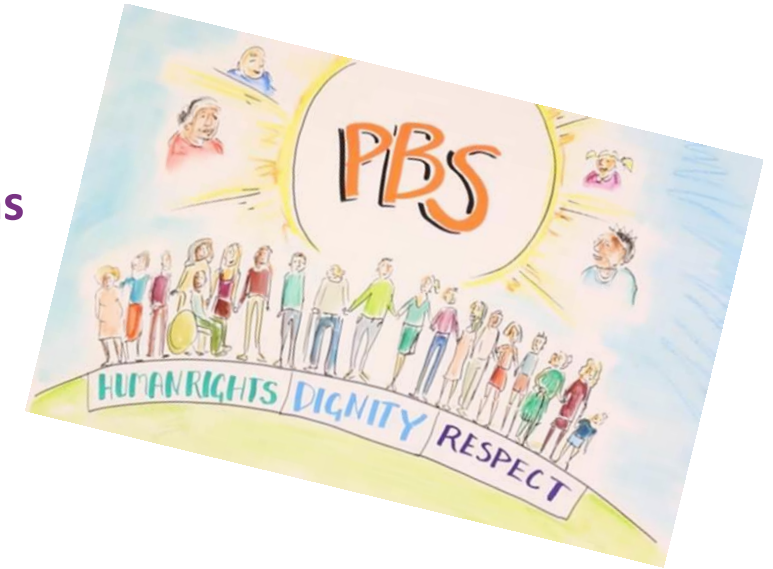
Scope of Standards

Designed for education, health and social care

All populations including:

- **people with learning disabilities**
- **people with mental health conditions**
- **people living with dementia**

Generic standards with appendices
or specific populations



Development process

- Consultation with different stakeholders and expert groups
- Evidence based, unless limited, then professional consensus was sought
- Over 50 critical readers (thematic review of feedback)
- The Restraint Reduction Network Training Standards 2019 were signed off by Health Education England and NHS in autumn 2018 and published in April 2019
- Standards are available on the Restraint Reduction Network website

www.restraintreductionnetwork.org

Format of the Standards

The first part is a rights based framework, in which all training must be delivered. Training providers seeking certification for their programmes will need to use the framework when designing their curriculum

Four sections of standards:

1. Standards supporting pre-delivery processes
2. Standards supporting curriculum content
3. Standards supporting post-delivery processes
4. Trainer standards

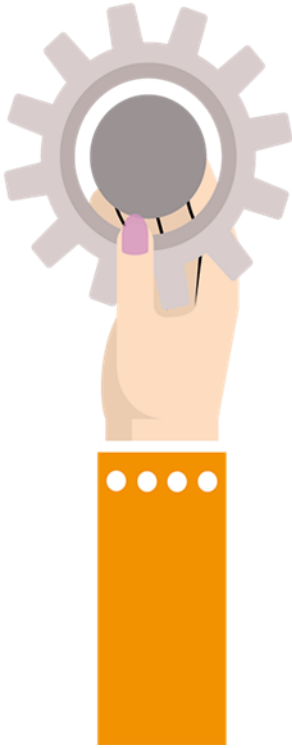
1. Standards supporting pre-delivery processes

Standards 1.1–1.8 cover the part of the process that needs to be completed before a curriculum is developed and authorised.

Section 1

Before developing and delivering any training, a good training provider engages with the organisation or service that needs training and finds out as much information as possible about the needs and characteristics of the staff and the people they support.

This means they are confident that the training they provide is appropriate, proportional, meets identified needs, and any elevated risks are highlighted and adjustments made where needed.



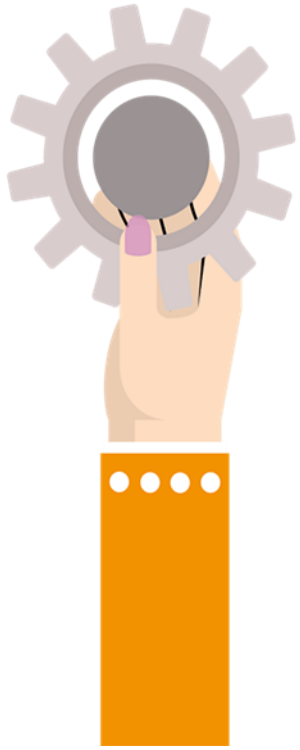
2. Standards supporting curriculum content

Standards 2.1–2.15 describe areas that the curriculum must cover.

Well-designed training programmes can influence learning, and behaviour change programmes that teach people to restrain may inadvertently reinforce the use of restrictive practices.

Section 2

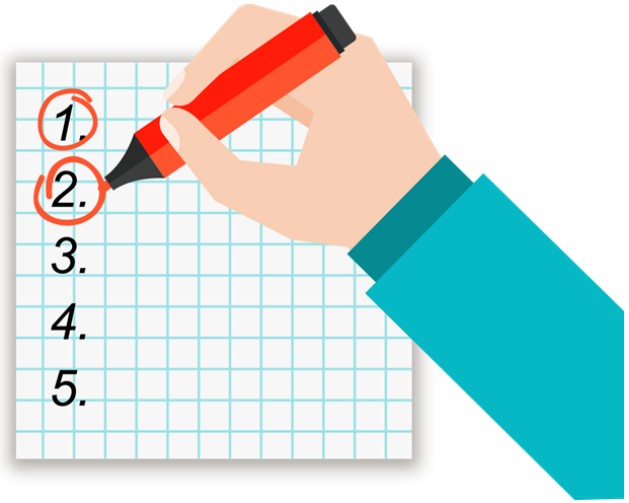
A good training programme will teach the restrictive interventions as only one small part of a whole range of person centred working practices that aim to prevent and minimise distress and crisis rather than the primary focus being on management.



3. Standards supporting post-delivery processes

Good training providers will have a range of different processes for monitoring the quality and effectiveness of their training that feed into a cycle of continuous improvement.

This is so they can be confident the training they provide is having a positive impact on the quality of life for people who are supported in the organisations they provide training for.



4. Trainer standards

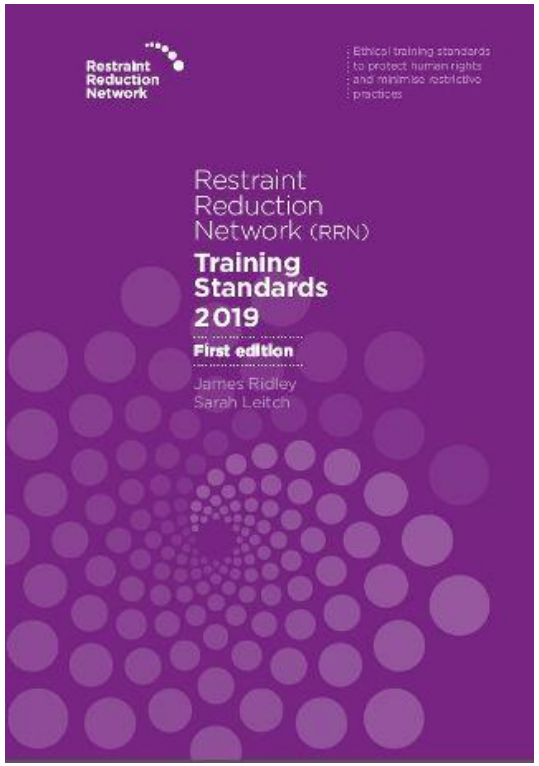
Good restrictive intervention trainers have the potential to change practice, win hearts and minds, and have an important role in supporting a system wide approach to the reduction of the use of unnecessary restrictive practices.

Section 4

They have a range of skills and are confident in their knowledge of all the training content, how it fits within the human rights framework, and best practice for the sector and population they are training in.

They are able to assess competency, encourage potential, and appropriately challenge unhelpful attitudes.

The training gap?



Restraint Reduction Network

RRN Training Standard	Sub Standards	Content covered: Y or N?	Discussed and/or linked to practice: Y or N?	Knowledge or skills assessed: Y or N?	Any observations and/or comments?
Standard 2.1 Training content must support a person centred and rights based approach.	2.1.1 The importance of adopting a person centred approach at all times				
	2.1.2 Legislation supporting individual rights: • Human Rights Act 1998 • Equality Act 2010 • Mental Capacity Act 2005 • Mental Health Act 1983				
	2.1.3 Relevant legislation, regulations and guidance designed to uphold human and individual rights as they relate to specific populations, settings and nations				
Standard 2.2 Training content must cover duty of candour and duty of care in all settings	2.2.1 • Definition of duty of candour and duty of care • Obligations related to both • How they relate to a culture of safety				

Any feedback ?

IMPLEMENTATION: The QI Way

Bethlem Adolescent PICU

Kate Lorrimer

Matthew Milarski

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

UCL

NCCMH

BETHLEM ADOLESCENT PICU

NHS
South London and Maudsley
NHS Foundation Trust

QUALITY IMPROVEMENT PROJECT

REDUCING RESTRICTIVE PRACTICES

NOVEMBER 2019

THE BAPICU….

- 8 beds for young people aged 12-18
- Part of the South London Partnership covering the whole of South London (3 different Trusts), but also admits young people from elsewhere if available beds
- Opened beginning of April 2018 after a quick period for set-up
- An entire new team was recruited and trained in 5 months
- In the first 18months we have discharged 58 young people and reduced the average length of stay from over 100 days to 41 days.

BAPICU…OUTSIDE AREA

AND INSIDE…

BAPICU'S QI JOURNEY….

- Up and down!
- Started the project only 8 months after opening the unit, so our QI journey mirrors the ups and downs of opening a new unit
- Project impacted by issues left over from opening (building only just finished!!!)
- So far results are mixed…

  - rapid tranquilisation use is low

  - seclusion is up and down generally in line with admissions, but it is rather high so an area we look at closely

  - restraint is up and down and generally attributable to specific young people with an EUPD presentation

CHANGE IDEAS – PROGRESS TO DATE

1. High Performing Team (HPT) Group

This has been measured for 6 months. It is now well embedded and attended by staff (weekly). Part of this change idea was to assess the level of compassion in staff alongside their stress levels. Questionnaires were completed about use of restrictive practices (in the ECA) by both staff and young people. As well as weekly stress levels ratings by staff completed in the reflective practice group at the start and finish, they completed a Professional Quality of Life questionnaire at the beginning and 6 months later.

2. Compassionate care readings from young people

These have been taken after community group every week. They are generally positive, as is general feedback we receive from young people, but obviously varies. There continues to be a slot for identifying any necessary improvements in community group, which can feed into the project.

3. Assertive communication group and Dealing with difficult feelings group

These groups are to help equip young people with the necessary skills to deal more effectively with emotions and so reduce the occurrence of unsafe behaviour which can lead to staff intervention and RP. Attendance varies depending on the client group. We need to ensure it remains inclusive and accessible to young people with varying diagnoses. Currently on hold for review whilst we wait to recruit a new psychologist.

4. Individualised positive behaviour support plans

These are primarily devised in the groups with the psychologist and implemented by the MDT. Some excellent plans have been produced to support young people, some of whom had already had long and very challenging admissions elsewhere. We have been working on ways to ensure these are completed for all young people and are currently reviewing the format alongside the use of the DASA and zoning plan for the unit.

5. Reviewing blanket restrictions/ward routines

The team have reviewed blankets restrictions to identify which ones tend to lead to incidents and RP. Mealtimes were identified as a flash point and also quite stressful for staff. We are on the second PDSA cycle to implement changes (and reduce restrictions) which are so far working well.

6. Reviewing staffing levels

High levels of enhanced observation often exceed the staffing levels. There is a proposal to increase the safer staffing levels to allow a team of permanent and appropriately trained staff. The levels have been increased to date but with temporary staff. Whilst we will need longer to see the impact of this (until we have a whole team of trained staff), the increase in numbers on shift has increased staff wellbeing (seen from the work around HPT) and the numbers of injuries have reduced.

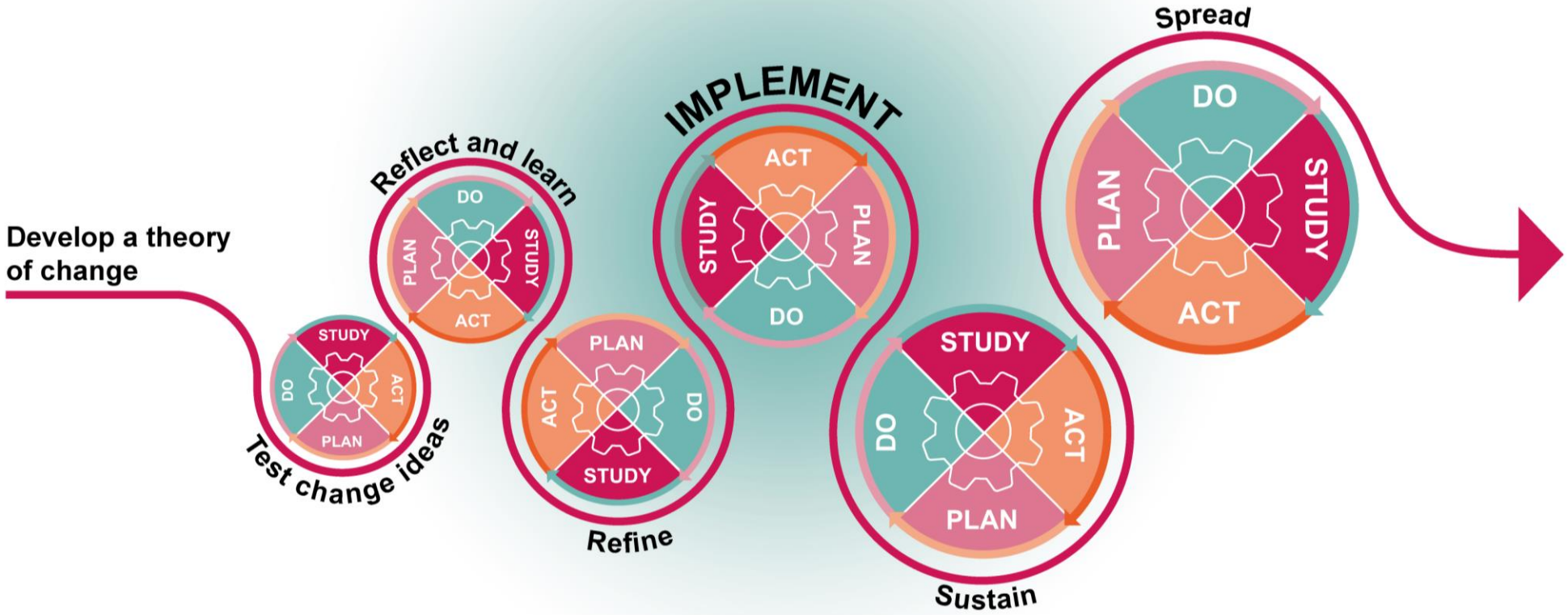
GREATEST IMPACT SO FAR…

The high performing teams work to help reduce staff stress and burnout and maintain compassion:

positive results from the PQOL questionnaire, staff are not more stressed or burnout after 6 months	compassion levels staying high despite challenging young people	staff are reporting greater support from the team	staff continue to attend the weekly reflective practice group	staff injuries are massively reduced

The team are in a positive place to continue the work to reduce RP…

Sequence of improvement



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Testing vs Implementation

TESTING

- Trying changes and adapting what you know on a small scale
- Use this to learn what works (and what doesn't work) in your system
- Basically what you are all doing already! – generating change ideas, testing them using PDSA cycles and learning what works on your ward

IMPLEMENTATION

- Making your changes a part of day-to-day operation on your ward
- This is what you are aiming for after testing your change ideas
- But how can you know if this is happening on your ward ….

If the leads on your ward moved to another service, are you confident that the changes you have introduced would continue?

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The 6 stages of Implementation

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Standardisation

Documentation

Measurement

Staff education, training, induction + support

Managing resources

Socialising the change

Standardisation

- Establishing a model or guidelines for everyone involved in a process
- This would include policies and practices for your ward/unit/trust
- Think about how you could standardise each of your change ideas so that someone else could replicate it

Standardisation

Documentation

- Documenting new procedures that have been integrated into a system
- How will you document the change ideas that you have kept and implemented on your ward? How will you display this information?
- This should be easy to update as you continue to develop new knowledge and improve each idea
- Your documentation should include assigned roles and responsibilities relevant to new procedure

Standardisation

Documentation

Measurement

- Having a way of knowing if performance is maintained
- Measuring over time e.g. using Run charts and SPC charts
- Sharing this data with the team

Standardisation

Documentation

Measurement

Staff education, training, induction + support

- Examples include team away days and supervision
- Consider the needs of current team members, new team members, bank staff
- Think about the whole MDT

Standardisation

Documentation

Measurement

Staff education, training, induction + support

Managing resources

- What resources will you need to maintain performance
- Examples include staff, funding, equipment, paper

Standardisation

Documentation

Measurement

Staff education, training, induction + support

Managing resources

Socialising the change

Q+A SESSION

Bethlem ward

South London and Maudsley NHS Foundation Trust

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Now it's your turn …

- Use the implementation plan worksheets provided
- Choose a change idea that you would like to implement into the day to day routine on your ward
- Plan how you will do this against each of the 6 steps to implementation

Close