NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

IMPROVING MENTAL HEALTH SAFETY
Reducing restrictive practice

Reducing Restrictive Practice

Learning from the collaborative

Introduction/Cooking up quality improvement

Quality improvement works when many small ideas are tried and tested. It's like bringing the ingredients and methods of a recipe together and transforming them into a new dish that has the right balance for the results you want. We've used our experience on the Reducing Restrictive Practice (RRP) Collaborative to bring together the roles and resources that trusts and wards will need (the ingredients), the step-by-step method of what to do and how to bring them together, and the extra ingredients that run through the whole process and are brought to the project by everyone (what's in your store cupboard)

The names of all the wards and units we worked with for this collaborative are listed along the bottom of each page

Contents

Amber Bethlem Bradley Brook

Design phase

When designing a quality improvement project, it's a good idea to look at work that has already been done in the area you want to improve. That's why we've selected resources from the RRP Collaborative that you can use to help design your own project to reduce restrictive practice.

Method

1. Agree who will be in your project team, including a motivated project lead and making sure that these project roles represent your wider multidisciplinary team
2. How will you ensure people with lived experience are involved in the project from the start? People's individual experiences are invaluable in driving change, as outlined by our launch event videos.
3. Ensure you have an engaged senior sponsor – this is a critical role to ensure projects are championed within the organisation and any barriers to the work can be swiftly addressed.
4. Decide how often your project team will meet for the project's momentum to be maintained. We've found that meeting every two weeks works well.
5. Set your aim. Make sure it's measurable – what percentage reduction in restrictive practice will you aim for? Set a realistic timeframe for your project, with an end date – when will you finish the improvement work?

Ingredients

QI project team roles

Launch event videos

> As QI Coaches, we found it helpful to have resources that we could give to teams to assist with the start of their project. We hope that anyone planning to start a QI project to reduce restrictive practices can use this booklet, together with resources from the collaborative, to inspire their QI journey

6. Review good practice: What has already been tried and tested in other mental health services to reduce restrictive practice? You can choose from our final change theory, and make your own menu, with input from your wider team and people with lived experience
7. Develop your theory of change: You can use the driver diagram in our change theory for inspiration, and see the next section about theory of change.

Change theory

Store cupboard

Enthusiasm for the project

Time to devote to the project

Creative thinking

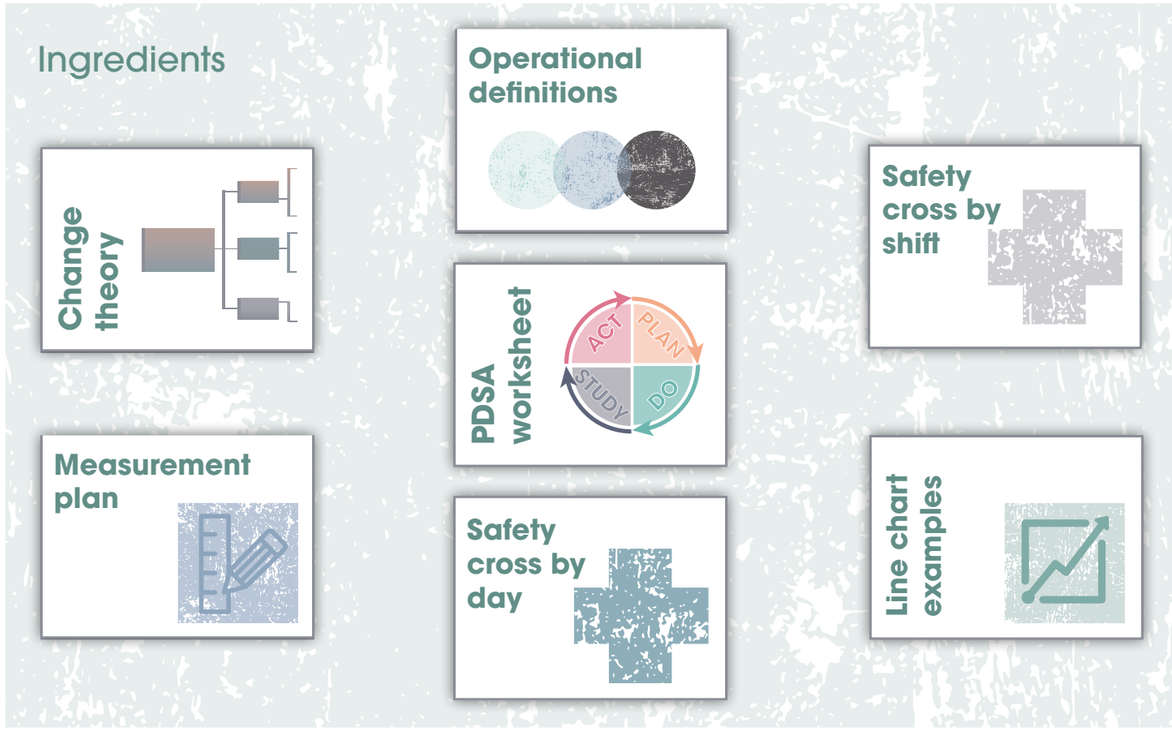
Systematic method of quality improvement

As part of the design phase, it is important to develop your theory of change – that is, a shared theory of how you will achieve your aim, what changes you might make that will lead to improvement - and a plan for how you will measure the impact of those changes. We've developed several resources over the course of the RRP Collaborative that can help you develop your own theory of change for similar improvement work. What's your theory? is another helpful resource, which explains how to use driver diagrams and describes the theory of change.

The final change theory that we developed over the course of the 18-month collaborative can be seen on pages **6 and 7**

Method

1. Ensure that people who use the service are part of the system or process you intend to change, as well as staff who provide the day-to-day care within that system. This is essential, so that you can effectively identify what matters most to the people who are delivering and receiving care.
2. Set your aim – spend some time on it, and make sure that it is SMART:
   - Specific
   - Measurable
   - Achievable (but also aspirational)
   - Relevant
   - Time-based



3. Develop a driver diagram – identify the main areas you're going to focus on to so that you can achieve your aim. Ask yourselves what changes you are going to need to make, and in which areas of the system or process.
4. Your driver diagram will then inform your measurement plan and your testing (PDSA worksheet). Once you have established your aim, plan how you're going to measure whether the changes you make are leading to improvement or not. The measurement plan should include details of:
   - the outcome measures you'll use and the frequency of measurement
   - operational definitions for each outcome measure (so that what you are measuring is clear and consistent for everyone involved)
   - any measurement tools you intend to use (such as safety crosses and line charts).

Store cupboard

Genuine co-production from the start

Understanding of SMART objectives

Protected time

Innovative ideas

End of programme change theory

Reduction of the use of restrictive practice (physical restraint, seclusion, rapid tranquilisation)

Patients

- Active participant in care
  - Recovery focus; patient involvement in care planning and schedules; family & carer involvement
- Increased participation in activities
  - Focus on hours with more incidents; new and innovative groups based on interests; activity boxes; activity coordinators
- Person-centred care
  - Personalised care plans; positive behaviour support plans; therapeutic and sensory interventions; sleep hygiene

Staff

- Engagement between patients and staff
  - Safety bundles; RRP champions and peer support; increased staff presence & support; proactive (preventative) and least restrictive strategies
- Engagement in quality improvement
  - Coproduction; regular protected time; visual displays of data; MDT involvement & community meeting agenda items
- Good communication & transparency
  - Floorwalkers/coloured lanyards; visual displays of routines, preferences & staff allocation; newsletters & welcome packs
- Channels of communication between staff
  - Safety huddles; RAG rating & support plans; MDT meetings; improved handovers
- Training & the use of tools
  - Trauma-informed care training; simulation training; staff skills training at all levels according to identified need; use of data to promote learning; DASA/Broset/PMVA
- Supervision & wellbeing
  - Trauma-informed; regular supervision; reflective practice; staff support groups & wellbeing tools

The ward

- Physical environment
  - Trauma-focused environments; improved indoor & outdoor space; smoke free
- Reviewing blanket restrictions & ward rules
  - Reduce blanket restrictions and unnecessary rules; personalise care planning; focus on community, mutual expectations, trust and shared responsibility
- Ward routine
  - Increased focus on patient preferences and needs; morning groups/breakfast/tea or coffee; changes to increase staff availability

Learning Sets

If more than one team will be taking part in your quality improvement project, we recommend using a collaborative system to create a learning community. Learning sets are a great way to bring representatives from each team together to collaborate, share knowledge and ideas, learn together and build connections.

Method

1. Decide how often learning sets will take place and the how long the sessions will be.
2. Structure learning sets to include storytelling and sharing of experiences. There are more learning set resources on our RCPsych page to help you think about this.
3. Think about how you will engage people in learning sets.
4. How you will keep learning sets interactive? What tools and resources to use? Consider having presentations, interactive breakout sessions, team tasks, posters, audio and visual methods.
5. Consider teams that have already carried out projects in the area/topic you are looking to improve and provide those teams the opportunity to share their work.
6. Build a space for teams to network with one another - decide whether you do this as a whole learning community or whether you will create break out groups based on the type of ward/service.
7. Develop feedback forms to aid your development of future learning sets.

Ingredients

Tools and resources to aid sessions

Presentations

Audio and visual

Store cupboard

Imagination and creativity

Enthusiasm for the learning sets

Time to dedicate to attending learning sets

Learning sets bring quality improvement collaboratives to life. Regularly bringing together the teams enables everyone to share ideas, and we saw many ideas gain traction across the collaborative.

For example, early on in the RRP Collaborative, a ward presented on how they had introduced a 'Here to help' floorwalker lanyard, so that a member of the team could always be easily recognised as being available to help patients on the ward. Subsequently, 'Here to help' lanyards were introduced on many wards across the country and were found to have a positive impact on patients and staff. Another example is of a ward replacing their metal key for observation windows with a plastic one, to reduce the noise the key made and so reduce the disturbance to patients in the night. It's important to keep learning sets engaging and to be creative, through a mixture of presentations given in various mediums and breakout sessions. Semi-structured activities are great for problem solving and generating discussion, and to help you can choose from a menu of liberating structures – activities that foster participation and lateral thinking in novel and creative ways. A number of teams gave presentations with their patients, and were also creative in how they shared their ideas, including showing videos that had been directed by patients.

Another significant benefit of learning sets is that teams can network, discuss ideas and experiences, and share their contact details to keep in touch with each other. When reflecting on the RRP Collaborative, a staff member from one ward spoke about how learning sets break down barriers and hierarchies, noting that in their role as an occupational therapist, they could be sitting at a table with a consultant psychiatrist, director of nursing or nurse consultant, and that everyone was equal as they shared the challenges they faced, listened to and offered advice to each other, and shared stories.

> ‘The learning sets are very helpful and inspiring. Above all, having the opportunity to share our experiences and learn from the work that others are doing is invaluable.’ – taken from learning set evaluation form

> All the QI Coaches on the learning set days were encouraging, uplifting and supportive. We’d sometimes attend the days feeling somewhat stuck in regard to change ideas and ward progress, however a day spent with the QI coaches ensured we left feeling positive, motivated and inspired to discuss new project suggestions and ideas with our team. It also prompted some interesting debate and passionate discussion about restrictive practice, on our train journey back to West Yorkshire.’ – Nostell ward (South West Yorkshire Partnership NHS Trust)

> ‘The learning sets have been great; they suit my style and give me time-out to think about the project work. It is a great chance to network.’ – taken from learning set evaluation form

Skilled, close improvement support

Skilled improvement support, often provided by QI coaches, plays an important role in supporting services to improve quality of care. They design various tools and facilitate sessions with project teams to help them apply QI methodology to their projects, so the project teams can generate, plan and test change ideas within their service.

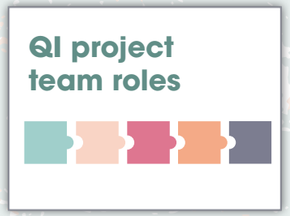
A QI coach should have the skills and knowledge to:

- ☑ provide specialist direction and leadership for planning and carrying out quality improvement projects
- ☑ share specialist knowledge of improvement methods and tools, and how to apply these in daily practice
- ☑ maintain regular contact with your team(s), both remotely and in-person, to give guidance and feedback on each team’s progress
- ☑ develop a culture of quality improvement, and work in partnership with stakeholders to develop structures and processes that support staff to undertake QI projects
- ☑ design opportunities for project teams to share and learn from each other across the collaborative

Method (responsibilities of a QI coach)

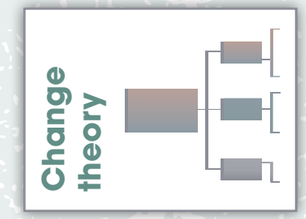
1. Identify the project team(s) that you'll be coaching
2. Support teams as they identify their area for improvement and create a theory of change (see Systematic method of quality improvement on page 4)
3. Help your team identify the early tasks that will need to be completed, such as forming a project team, identifying a project lead and setting up regular team meetings (see early tasks checklist)
4. Plan how you will run – and support the team to run – effective team meetings
5. Plan how you will support teams to communicate and work together effectively
6. Teach teams the use of QI concepts, methods and tools, and help them apply them to daily practice
7. Help project teams to develop measures and plans for data collection, and to analyse the data

Ingredients



> We would like to highlight how helpful our QI coach has been. You continue to encourage us and ensure that we are on track to achieve our aims and goals. Without your guidance, patience and understanding of the clinical pressures we are facing whilst trying hard to make the changes to improve the ward and patient experience we would not have had the success we have had. Your knowledge on QI has kept us engaged and you have been so approachable throughout, making this project enjoyable ☺ - Irwell ward (Greater Manchester Mental Health NHS Foundation Trust)

8. Support project teams to apply QI methodology, so they can generate, plan and test change ideas, including PDSA cycles and use of real time data (see change theory and 'Generating Ideas – A 4-step process' document about the nominal group technique)
9. Support project teams in their work with stakeholders including patients, frontline staff, and carers, friends and families
10. Update the sponsor on the team's progress, highlighting any areas that need additional support
11. Facilitate collaborative-wide communication and idea sharing, such as through planning learning sets, hosting phone clinics and producing materials such as newsletters
12. Think about how you'll maintain regular contact with your project teams and be accessible to them when they need support. You can give support by phone, email, teleconferencing, videoconferencing and in-person visits to the team



Store cupboard

Project team(s) from an organisation to coach

Ability to use previous QI experience in your team

Knowledge of QI concepts, methodology and tools

Ability to work with all types of stakeholders

Creative thinking

Presentation skills

Maple (Solent) Maplewood LSU Marina Nostell

Storytelling

Stories have the power to transform the way we see the world. We can connect with them on an emotional and an intellectual level, and they let us imagine alternative perspectives. In healthcare and quality improvement work, storytelling can be used to engage with the experiences of people using and working in services. This helps to identify improvements needed or deficits in the care that's being provided more vividly. A story has the power to motivate people, and so they can be influential in facilitating change.

Throughout the RRP Collaborative, we used storytelling in various ways. It was a central part of how we communicated and engaged with project teams, as we shared stories (about staff and patient experience, quantitative and qualitative achievements ward teams were seeing, and innovative new ideas) in regular newsletters, meetings and at learning sets. We also presented our work to a wider audience and stakeholders, and public communications through the media.

We've gathered some stories from the RRP Collaborative here. We hope you find them engaging and motivating for your own improvement work.

The story of the steel-capped boots

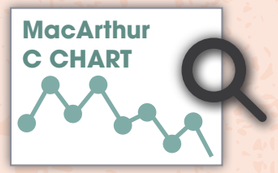
MacArthur PICU, Black Country Partnership NHS Foundation Trust

MacArthur Psychiatric Intensive Care Unit (PICU) was a ward that, for the first 12 months or so of the collaborative, had been struggling to see improvement in their data due to extremely challenging circumstances on the ward and significantly low staffing levels/high number of vacancies. Even though they weren't yet seeing data improvement, they had noticed several small cultural changes on the ward: people were thinking differently about the use of restrictive practice.

These qualitative changes were illustrated by a phone call the team project lead received from ward-based staff who were in distress about a man who had been newly admitted and was wearing steel-capped boots. He had kicked out at a member of staff and was threatening to continue if staff tried to remove his boots. The staff were seeking advice because they felt they had no choice but to restrain him; however, they also knew they should try to think of alternatives. The project lead asked if the man had any other shoes to wear? He did not, and this was one of the reasons for his distress at being made to remove his boots. The project lead asked the staff whether he would calm down if they allowed him to keep the boots on, at least for a temporary period. He would. The project lead quickly advised them to do this, put the phone down and went straight to Primark. She bought him a pair of comfortable slippers and took them to him on the ward. The man was completely delighted with the offer of warm, comfortable slippers and happily agreed to remove his steel-capped boots.

This story and its message, like others, travelled through the collaborative community, more widely within the Trust and to broader audiences interested in the work of the RRP Collaborative. The message is that, by thinking differently about 'what matters most' to the people in their care, personalising care and responding to individual communication, the ward staff were able to avoid what would previously have been seen as a 'necessary' use of restraint.

MacArthur PICU gained a lot of encouragement from the recognition of the changes they had made, and not long afterwards their ongoing commitment and an improvement in staffing led to a quantitative improvement in their data as well. To date, they have reduced their use of restraint by 66%, their use of rapid tranquilisation by 61% and their aggregate data (restraint, seclusion, and rapid tranquilisation) by 45%.



Working collaboratively

Westferry, East London Foundation Trust (ELFT)

Having been sectioned under the Mental Health Act, James found himself an inpatient on Westferry ward. When he was unwell, he experienced seclusion. He often feared being restrained and would tell staff he would walk to seclusion rather than be placed under any kind of physical restraint. While he was on a different ward at East London Foundation Trust (ELFT), James felt there were many unnecessary restrictions, such as patient access to the ward lounge.

James made a recovery and was discharged from hospital. However, as person with lived experience he was keen to do what he could to help improve services, especially in the trust whose care he had received. He went on to work with Westferry Ward and shared his interest in becoming a project team member of the RRP Collaborative. James helped the team understand the impact of restrictive practice on his own journey as someone who had used the service, and he helped create change ideas that the team then implemented. He also regularly took part in team meetings for the collaborative. James presented at one of the RRP Collaborative's learning sets, where he used role play with QI coaches to demonstrate to teams across the country what blanket restrictions were experienced like for him and other patients on the ward. James was instrumental in changes made on Westferry Ward, such as 24-hour access to the ward lounge for current patients.

James was able to bring ideas to the team that might not necessarily have been thought of without the input from those with lived experience. Using his voice had a powerful effect and demonstrated how wards can learn so much from people with lived experience, and about the importance of collaboration.

Using a Quality Improvement approach

Hawthorns 1 PICU, Southern Health NHS Foundation Trust

Staff working at Hawthorns 1, a Psychiatric Intensive Care Unit (PICU), felt the ward was a good place to work and that morale was high. The team had embedded a person-centred approach to their care on the ward, and they were engaged with the RRP Collaborative. The team were keen to promote the work they already did well on the ward, and their focus was often on performance and assurance. They struggled to shift their focus to generating and testing new change ideas for improvement, finding this process frustrating.

With support from their QI coach, the team saw that they could adopt elements of their person-centred approach to care on the ward for the RRP Collaborative, and they shifted their focus away from using their measures and data to demonstrate the good work they were already doing.

The team found ways for the whole ward community staff and patients to share the project, creating a ward culture in which everyone felt confident to share and test change ideas. This in turn helped the project team to use qualitative measures and incorporate feedback from everyone on the ward into their change ideas – for example, by discussing the RRP Collaborative in community meetings and by including a patient representative in project team meetings. Through co-production, the team were able to shift their thinking towards change ideas, which then helped them collect more useful data by leading them to use both qualitative and quantitative measures for improvement.

This story illustrates the utility of data in QI work, and, importantly, it's not used to determine whether a ward or team are 'good' or 'bad', but rather as a way to learn about the impact of changes that they are making. It also demonstrates the importance of using data that is helpful to your aim. In the example above, the ward were focused on using data to show they were doing well, but this made it harder to think of things to improve. By focusing on changes they wanted to make, and then using data to show improvement and as a learning tool, the team embraced the culture of QI. By the end of the collaborative, Hawthorns 1 had reduced their use of use of seclusion by 57% and their aggregate data (restraint, seclusion and rapid tranquilisation) by 58%.