QUALITY IMPROVEMENT PROGRAMME

East London NHS Foundation Trust

Violence & Aggression on Female PICU

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Project Team: Rosebank Ward

Project Sponsor: Andy Cruikshank

Background

QUALITY IMPROVEMENT PROGRAMME

Why we chose this project…

- History of violent incidents on Rosebank
- Risk Assessing
- Making better clinical decisions
- Empower staff to challenge and overcome issues of violence and reduce it.
- Most importantly, providing the best care at the most vulnerable time for our service users

What was the problem?

- Impact on Staff- In particular direct assaults to staff
- Team splitting
- Mental health of patients

Project Aim

To reduce violence and aggression by 30% on Rosebank Ward

AIM: To reduce inpatient physical violence at Tower Hamlets Centre for Mental Health by 30% year on year.

Ward Round

Patient Choice and Empowerment

Treatment

Communication

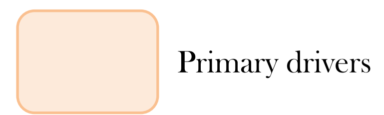
Engagement

Attitude

Environment

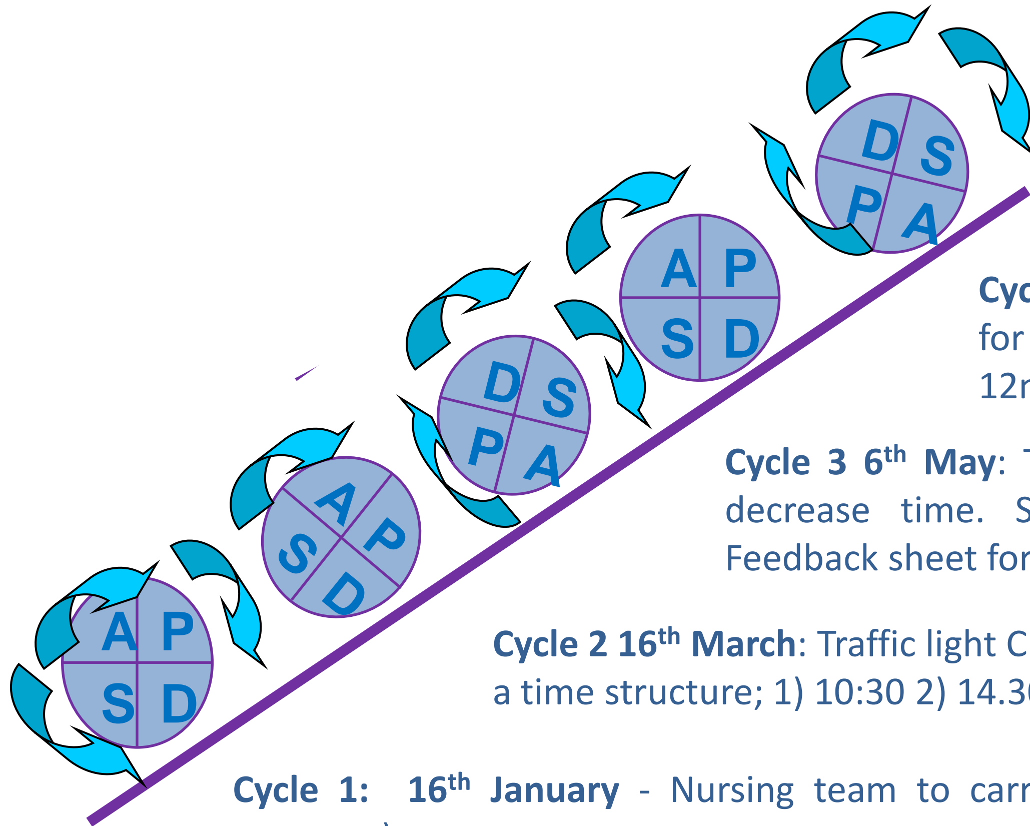
Staff Issues

Training



1. Crisis meetings
2. Safety cross
3. Listening to patients views
4. Post incident debriefs
5. Space to express needs and concerns
6. Carers and visitors to be given reliable and clear information
7. Attentive listening skills
8. Using talking to address patients when you can see that they are stressed
9. Daily feedback from house keepers
10. Sharing concerns with others
11. Group / community meetings
12. Shift feedback
13. Feedback from carer after WR
14. Open appointment with members of MDT
15. Listening skills
16. Explaining sections properly
17. Effective handovers of important information
18. Team meetings to build and encourage support and structure
19. Quicker PICU
20. Family and carer involvement
21. Include what is needed / wanted for the day during the daily planning meeting
22. Community teams to be an extension of the ward team for continuity of care
23. Interacting with patients on a personal level to get to know people.
24. Natural conversations
25. Informal settings
26. Develop service of trauma informed service
27. Constructive feedback give directly from patients to staff
28. Listen
29. Patient code words and traffic lights
30. Physical needs
31. Safety huddle

Sequence of PDSA's – For Safety Huddles



Cycle 4 6th May :Third huddle to be utilised for debrief and handover sheet- Aim for max 12mins

Cycle 3 6th May: Traffic Light checklist re-structured to decrease time. Staff to time huddles max.15mins- Feedback sheet for staff support included

Cycle 2 16th March: Traffic light Checklist created to utilize in huddles. With a time structure; 1) 10:30 2) 14.30 3) 19.00- Measured with a tick sheet

Cycle 1: 16th January - Nursing team to carry out 3 huddles a day (No time structure)

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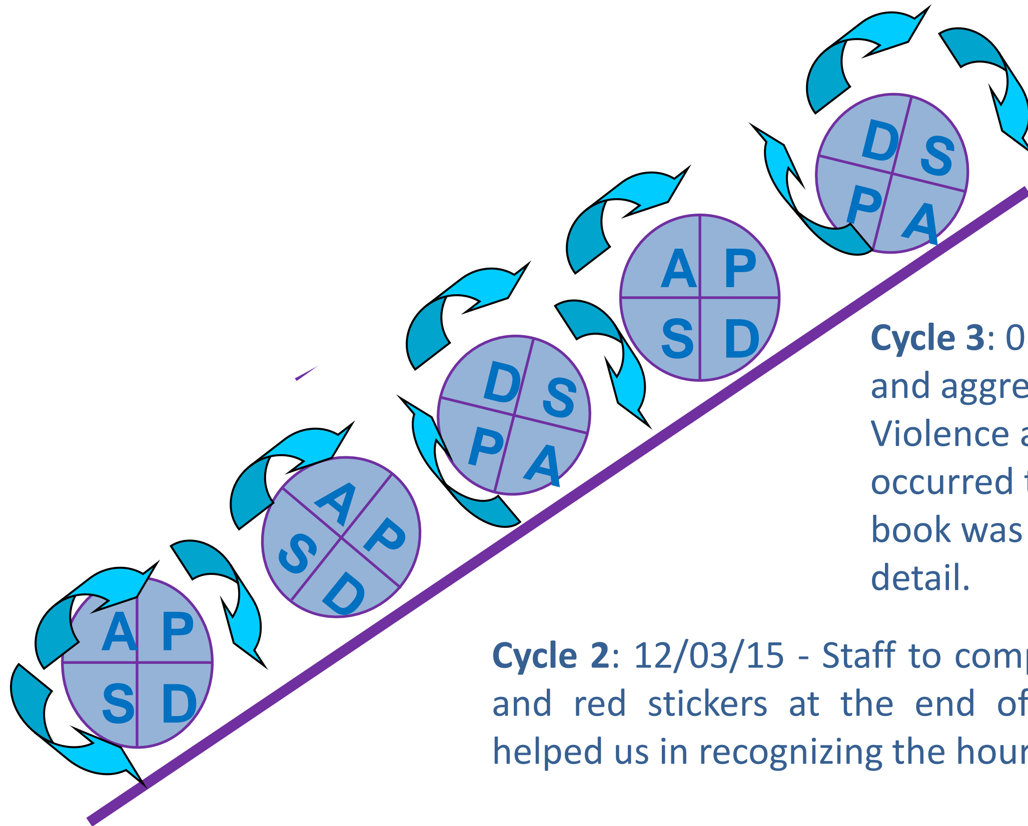
Sequence of PDSA's – For Safety Cross



Cycle 4: we are yet to define violence an aggression for our safety cross; to discuss at our next Away Day.

Cycle 3: 01/05/2015 – differentiation between violence and aggression when an incident occurred. 'V' for Violence and 'A' for Aggression was written if an incident occurred to categorize it. To support this, a safety cross book was displayed for staff to note the incident in brief detail.

Cycle 2: 12/03/15 - Staff to complete the safety cross by displaying green and red stickers at the end of general observations, every hour. This helped us in recognizing the hours of feeling safe – focusing on the good.

Cycle 1: 01/02/15 Initiate hourly safety cross on the ward and recognize hours of incidents and unsafe environment, to gather this data daily of hourly observations and record on spreadsheet to analyze data at the end of the month.

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Data Collection

DATE	SAFETY HUDDLE 1	TIME	SAFETY HUDDLE 2	TIME	SAFETY HUDDLE 3	TIME
	10:30- 11:30		14:30-16:00		18:30-19:30	
18th March	X	30	X	25		
19th March	X	30				
20th March			X	UNKNOWN		
21st March	X	20	X	30	X	20
22nd March			X	30		
23rd March						
24th March	X	UNKNOWN	X	UNKNOWN	X	UNKNOWN
25th March			X	UNKNOWN		
26th March	X	UNKNOWN	X	UNKNOWN		
27th March	X	11				
28th March	X	25				
29th March						
30th March	X		X	UNKNOWN		
31st March			X	UNKNOWN		
01-Apr	X	UNKNOWN	X	UNKNOWN		
02-Apr	X	30	X	UNKNOWN		
03-Apr	X	11	X	UNKNOWN	X	UNKNOWN
04-Apr	X	60	X	30		
05-Apr	X	15	X	15		
06-Apr	X	30			X	UNKNOWN
07-Apr	X	UNKNOWN	X	UNKNOWN		
08-Apr	X	15	X	UNKNOWN		
09-Apr	X	UNKNOWN	X	20		
10-Apr						
11-Apr						
12-Apr						
13-Apr						
14-Apr			X	UNKNOWN		
15-Apr	X	UNKNOWN				
16-Apr						
17-Apr						
18-Apr	X	UNKNOWN	X	UNKNOWN	X	UNKNOWN
19-Apr	X	UNKNOWN				
20-Apr	X	UNKNOWN	X	UNKNOWN	X	UNKNOWN
21-Apr	X	UNKNOWN	X	UNKNOWN		
22-Apr	X	UNKNOWN	X	UNKNOWN	X	UNKNOWN

Time = Minutes taken for huddle to be completed

Huddles not taken place

60- INTERRUPTED HUDDLE

Traffic Light Huddle Structure

Safety Huddles Checklist

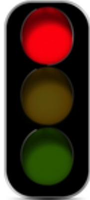
For the duration of the huddle please ensure there is someone on the floor.

PART ONE: Traffic Lights

STAFF PLEASE USE A TIMER- PART1= 12 MINUTES

PART2= 3 MINUTES

Follow the traffic light system when discussing service users! RED FIRST!



RED

- Any safety or risk issues?
- Any medication issues?
- Any physical health issues?

AMBER

- How has............. been this morning/afternoon/evening?
- Any events coming up for this service user?
- Any physical health issues?
- Any medication issues?

GREEN

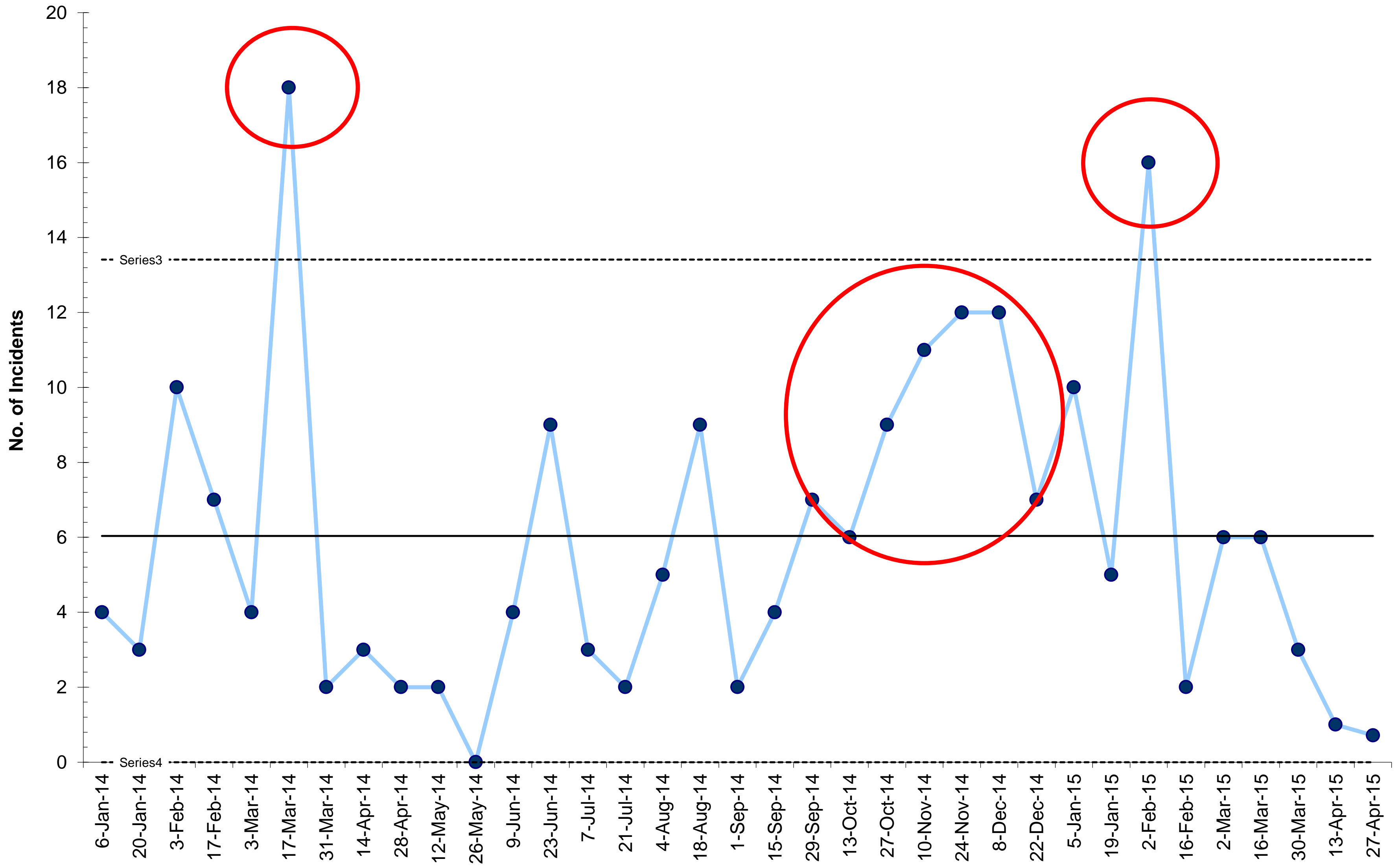
- Does this patient remain stable?
- Any events coming up for this service user?
- Any physical health issues?

PART TWO: Staff support plan

- How is everyone feeling? Any injuries?
- Does anyone have any issues?
- Do you feel supported by your team?

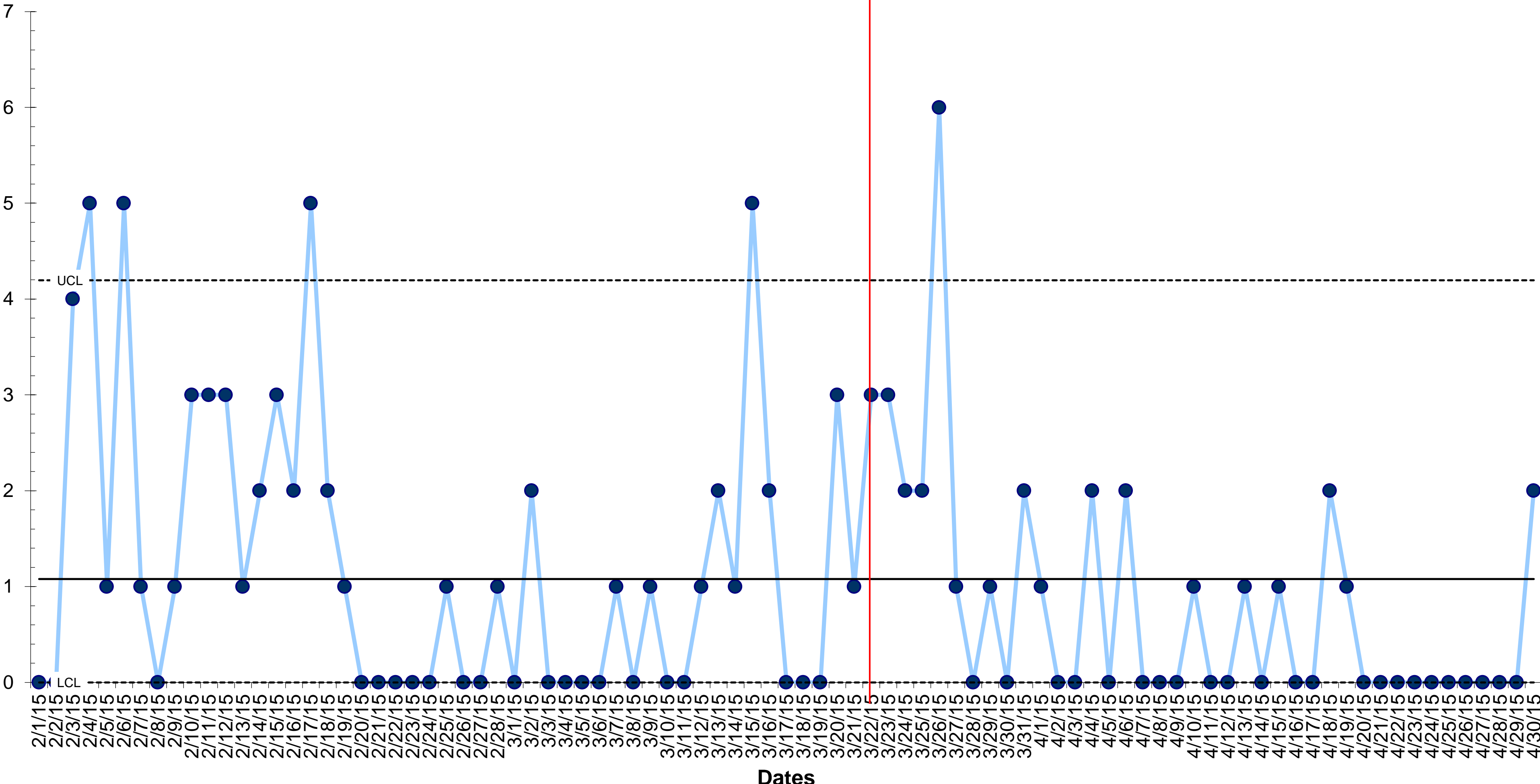
Mark X when completed ***PLEASE PUT HUDDLE TIME STARTED AND ENDED***

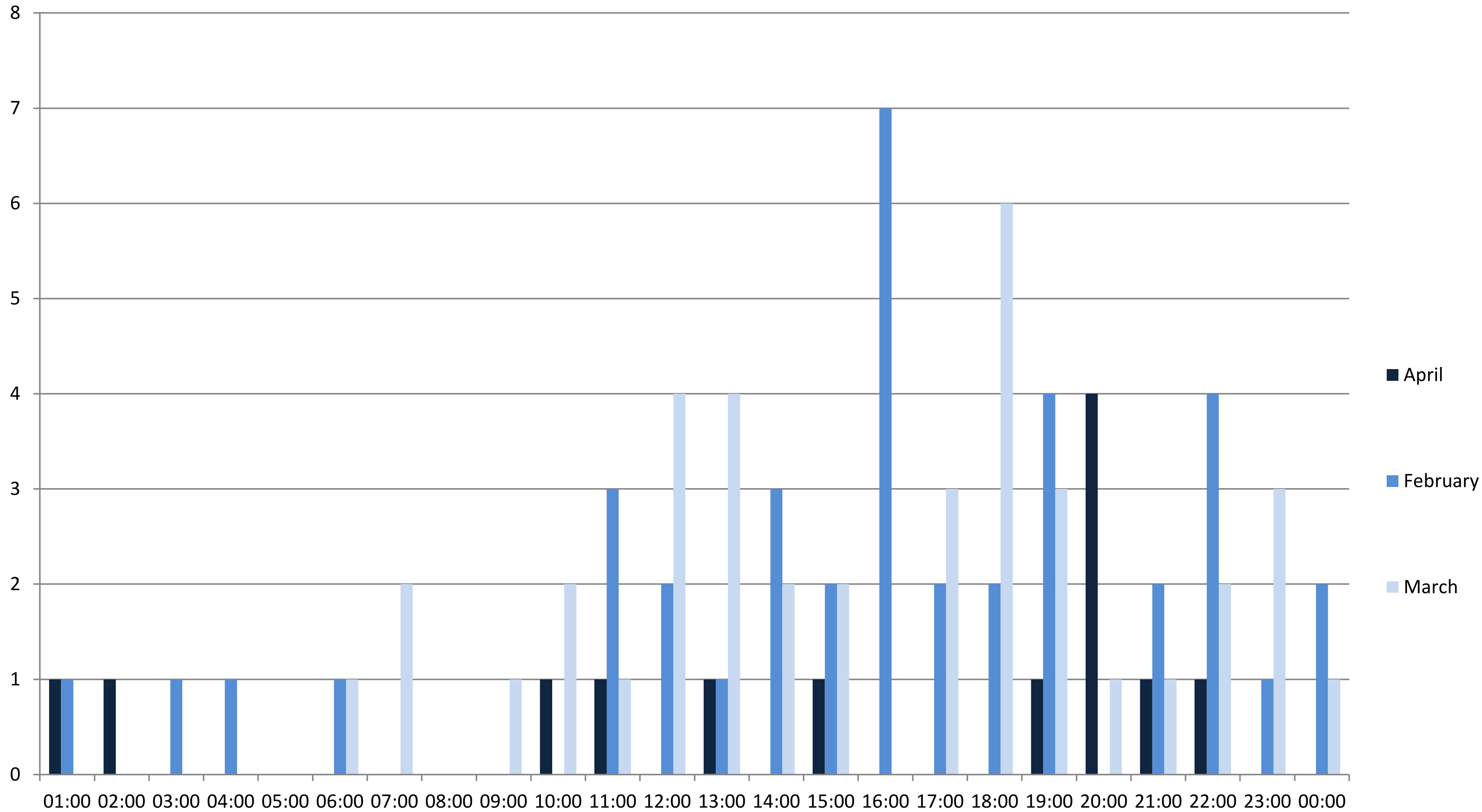
Date	Safety Huddle 10:30-11:30	Safety Huddle 14:30-16:00	Safety Huddle 18:30-19:45	Any extra Safety Huddles
13th May				
14th May				
15th May				
16th May				
17th May				
18th May				
19th May				
20th May				
21ST May				
22nd May				
23rd May				
24TH May				
25th May				
26th May				
27TH May				
28th May				
29th May				
30th May				
31st May				
1st June				



Incidents of Physical Violence (Rosebank ward) - C Chart
No. of Incidents
20
18
16
14
12
10
8
6
4
2
0
Series3
Series4
6-Jan-14
20-Jan-14
3-Feb-14
17-Feb-14
3-Mar-14
17-Mar-14
31-Mar-14
14-Apr-14
28-Apr-14
12-May-14
26-May-14
9-Jun-14
23-Jun-14
7-Jul-14
21-Jul-14
4-Aug-14
18-Aug-14
1-Sep-14
15-Sep-14
29-Sep-14
13-Oct-14
27-Oct-14
10-Nov-14
24-Nov-14
8-Dec-14
22-Dec-14
5-Jan-15
19-Jan-15
2-Feb-15
16-Feb-15
2-Mar-15
16-Mar-15
30-Mar-15
13-Apr-15
27-Apr-15

Incidents of Violence & Aggression (Rosebank Ward) – Safety Cross (01/02/2015 – 30/04/2015





Incidents Per Hour (01/02/2015 – 30/04/2015)
8
7
6
5
4
3
2
1
0
01:00 02:00 03:00 04:00 05:00 06:00 07:00 08:00 09:00 10:00 11:00 12:00 13:00 14:00 15:00 16:00 17:00 18:00 19:00 20:00 21:00 22:00 23:00 00:00
April
February
March

Learning

Patients view:

"Safety Cross is on the wall, it's for every hour, green when there's no incidents and red when there is an incident."
(Community Meeting on 14/ 05/2015)

'Felt things have been calm, and staff have been helping patients'.
(Community Meeting on 02/04/2015)

'Thinks it's down to people getting leave and going home.'
(Community Meeting on 19/03/20)15).

'Due to sharing on the ward, also now new staff are friendly and respectful'.
(Community Meeting on 19/03/20)15.

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Learning

The effect on staff:

- Staff more confident about clinical work.
- Teamwork
- Staff awareness and conscious of how to keep a safe and therapeutic environment.
- Discussing the important issues and concerns that may highlight risks and escalation.

Challenges faced:

- Ward culture – trying to embed this into our ward culture and facing resistant
- System forgotten in a fast paced service
- Interpreting whether the change we made (PDSA's in place) improved the ward environment or just generally.

What we benefitted from this project:

- *Good evaluation of the day and reassurance to staff*
- *Better risk assessing and managing situations*
- *Reduction of violence and aggression on Rosebank Ward, period.*
- *More staff pursuing QI projects*
- *Improvement of embedding this system into our ward culture*

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What next?

- Next PDSA cycle: Definition of violence and aggression at our next team meeting day.
- Continue to have a low threshold for violence and aggression to minimise incidents and encourage safe ward environment.
- Maintain a log of all incidents (safety cross book; who, what, why) for data purposes and future trends.
- Continue safety huddles within time limit as it plays a pivotal factor in maintaining the ward a safe environment.
- And continue to encourage staff, so it is completely embedded into our culture.
- Educate staff about the benefits of QI and how to support projects
- Analyse data for Safety huddles to find trends