Reducing Restrictive Practice Greyfriars

Gloucestershire Health and Care NHS Foundation Trust

Project Team

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About the Project

Nationally there is evidence to show that levels of restrictive practice are higher than appropriate. Patients who require to be nursed within a Psychiatric Intensive Care Unit (PICU), generally present with a higher risk formulation than the general adult psychiatric patent. This can therefore mean that increased levels of restrictive practice is required to ensure the safety of the patient and others on the ward. Due to this the use of restrictive practice within a PICU setting can be considered higher than in other adult psychiatric inpatient settings.

This project will focus on testing change ideas on Greyfriars PICU to reduce the use of restrictive practice.

Aims & Objectives

To reduce the incidents of restrictive practice from 10 per week to 7 in Greyfriars Ward by 31st March 2023

Measurement

Three process measures:

1. Weekly number of Physical Intervention incidents on Greyfriars ward
2. Weekly number of Rapid Tranquilisation incidents on Greyfriars ward
3. Weekly number of Long Term Segregation on Greyfriars ward

Tools, Methodologies Used

How did you involve service users/carers?

Weekly community meetings held on the ward are planned to be used to involve patients in capturing what they see as causes of Restrictive Practice to further inform the project's fishbone analysis. These meetings are also planned to inform the project's driver diagram by seeking change ideas from patients to reduce the number of Restrictive practice incidences .

Project Outcomes, Progress & Impact

Learning and what next?

Due to the length of the project it is clear that we are still in the formative stages, although already the impact of this project is evident within the ward environment.

Having an emphasis and a focus on RRP on the ward has given the staff team an maybe unheard voice in regards to small interventions that can be tested.

From qualitative data collected from staff a driver diagram has been completed highlighting suggestions for several changes in practice, prompting the following change ideas to be tested;

-A de-brief lead team has been set up, this will be a working party looking at optimising post incident de-briefing.

-A updated questionnaire has been created looking at working with patients upon admission to collected information for their individualised positive behavioural support care plan