Cornwall Partnership NHS
NHS Foundation Trust

# Implementing a Restraint Reduction and Patient Safety Programme.

Hannah Gethin

*Delivering high quality care*

# How do we improve?

Will → Ideas → Action

# Framework for Clinical Excellence

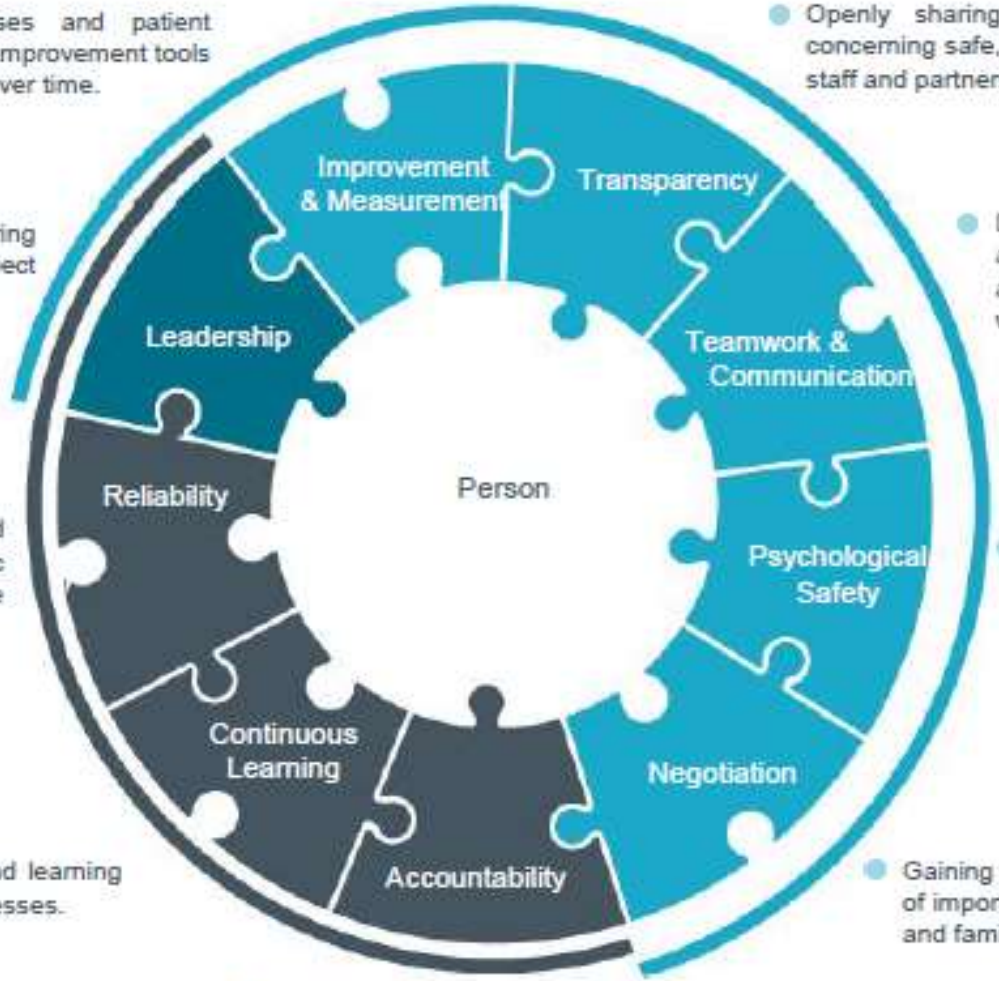
## Patient Safety

- Improving work processes and patient outcomes using standard improvement tools including measurements over time.

- Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.

- Facilitating and mentoring teamwork, improvement, respect and psychological safety.

- Developing a shared understanding, anticipation of needs and problems, agreed methods to manage these as well as conflict situations




- Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.

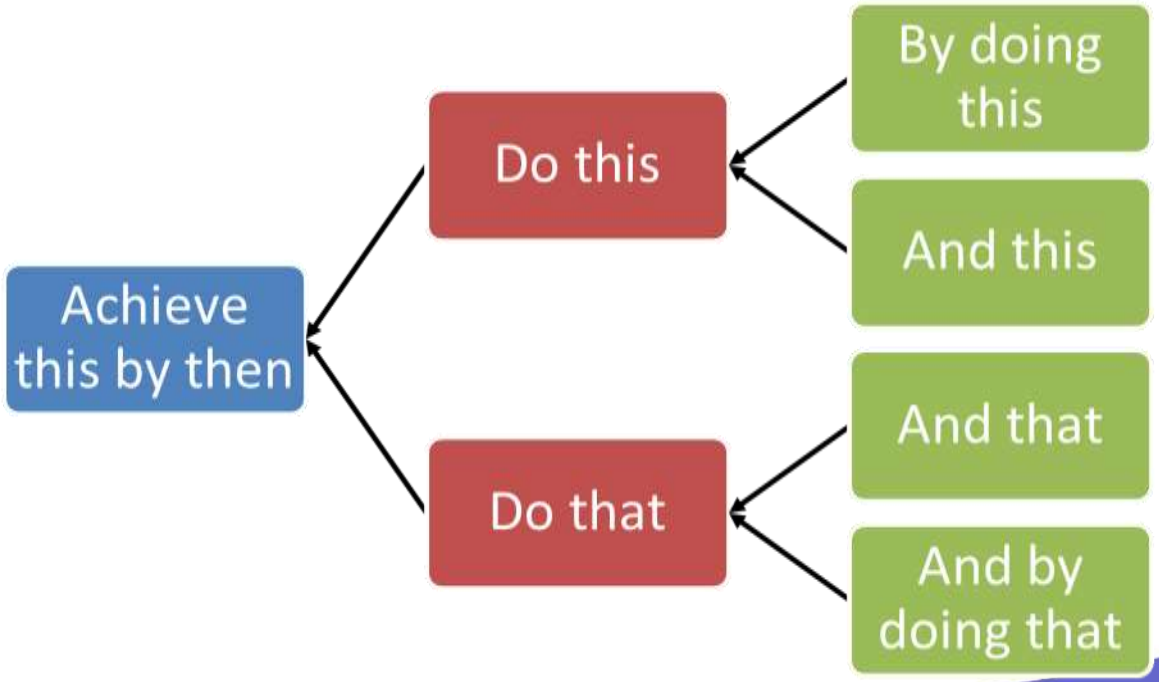
- Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.

- Regularly collecting and learning from defects and successes.

- Gaining genuine agreement on matters of importance to team members, patients and families.

- Being held to act in a safe and respectful manner given the training and support to do so.

# Driver diagram



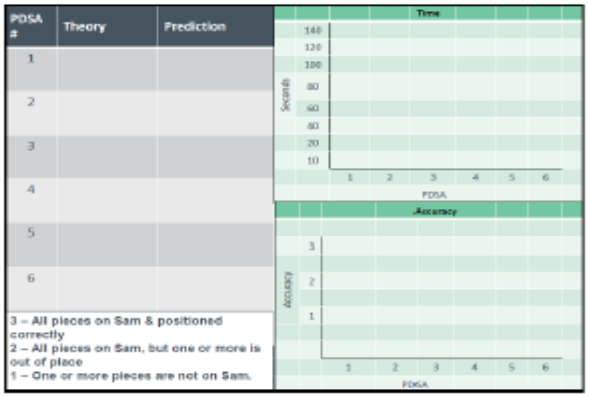
# Model for Improvement

# Please choose 3 individuals:

1. **Note taker**
   To fill out ------→

2. **Timekeeper**
   Need a watch with a second hand
   (or equivalent)

3. **Quality Assurance Individual**
   Evaluates the quality of Mr. Potato Head

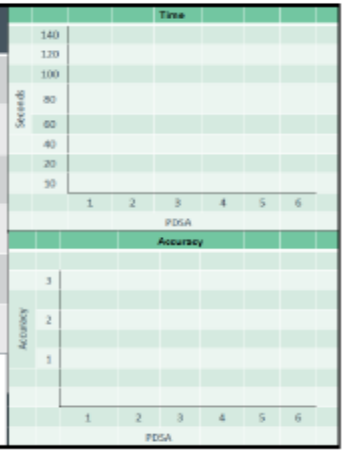


# Making a Prediction

- What is your **theory**?
  - What process will you use to improve time and accuracy?
- What do you think will **happen**?
  - What is your prediction about time?
- **Think ahead to future tests**
  - ….and how they might be shaped by the current small test.

| PDSA # | Theory | Prediction |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |

3 – All pieces on Sam & positioned correctly
2 – All pieces on Sam, but one or more is out of place
1 – One or more pieces are not on Sam.



# Getting the Most out of the Exercise

- This exercise is designed to teach how to perform a test of change.
- During the simulations, observe
  - the conversations that occur
  - the generation of ideas
  - any disagreements
  - the team dynamics
  - the interactions between individuals.
- Think about what is happening and how it might apply in a clinical setting.

# Rules

- Fill out PDSA prior to every Potato Head Assembly and use the PDSA form
- Answer ALL the questions prior to beginning the test
- Formally debrief after EVERY Potato Head assembly
- **DOCUMENT** your Aims, Results, Theories, Predictions
- Perform a few Potato Head Assemblies
- Listen for periodic announcements or questions from Instructor
- **NOTE to START: All parts of Mr. Potato Head must be inside to start with the bottom part on.**

# Time

- **Start:** When time keeper says go.
- **Stop:** When teacher indicates last piece is in place AND removes hands from Mr. Potato Head.

# Accuracy

1. One or more pieces are not on Mr. Potato Head
2. All the pieces are on Mr. Potato Head, but one of more is out of place
3. All pieces are on Mr. Potato Head and are positioned correctly

| PDSA # | Theory | Prediction |
|---|---|---|
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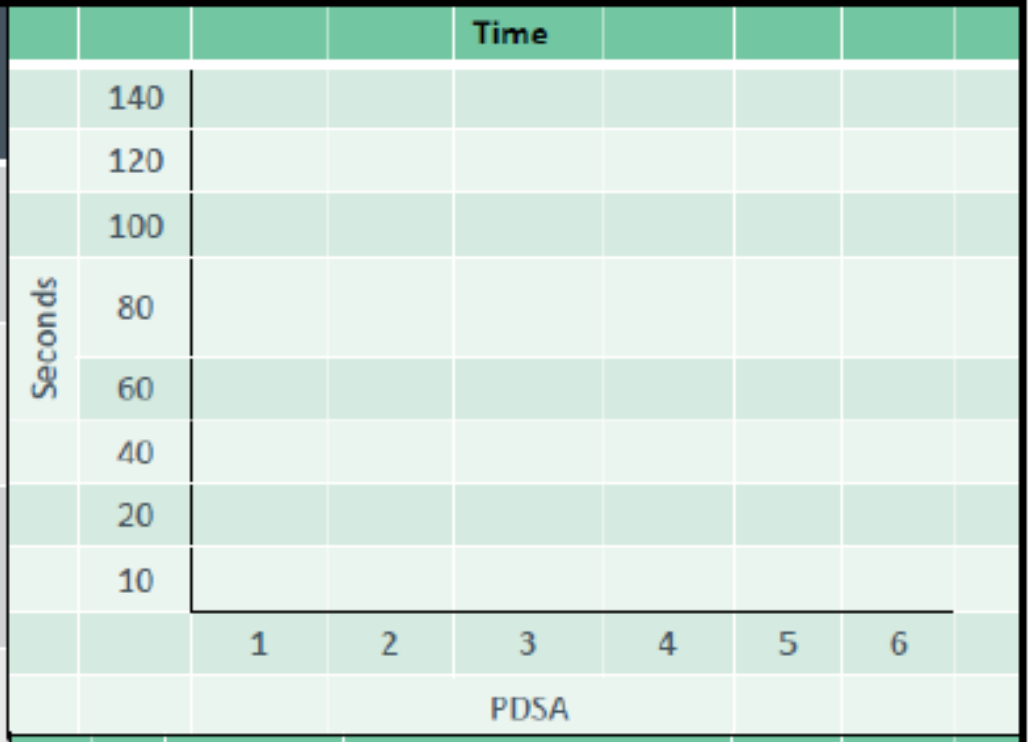
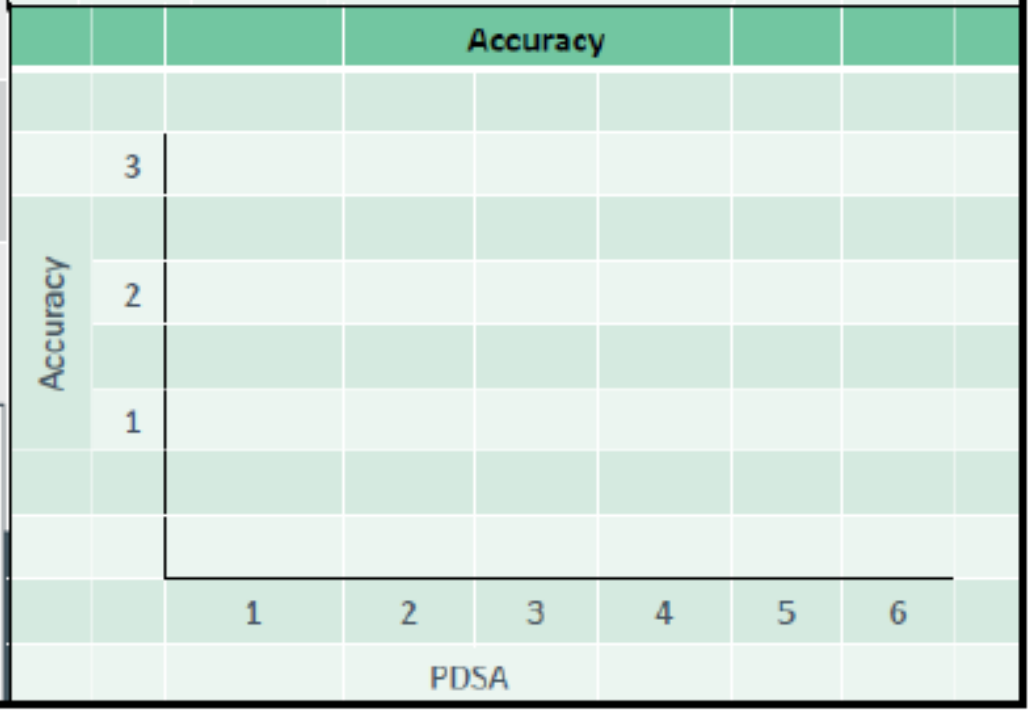
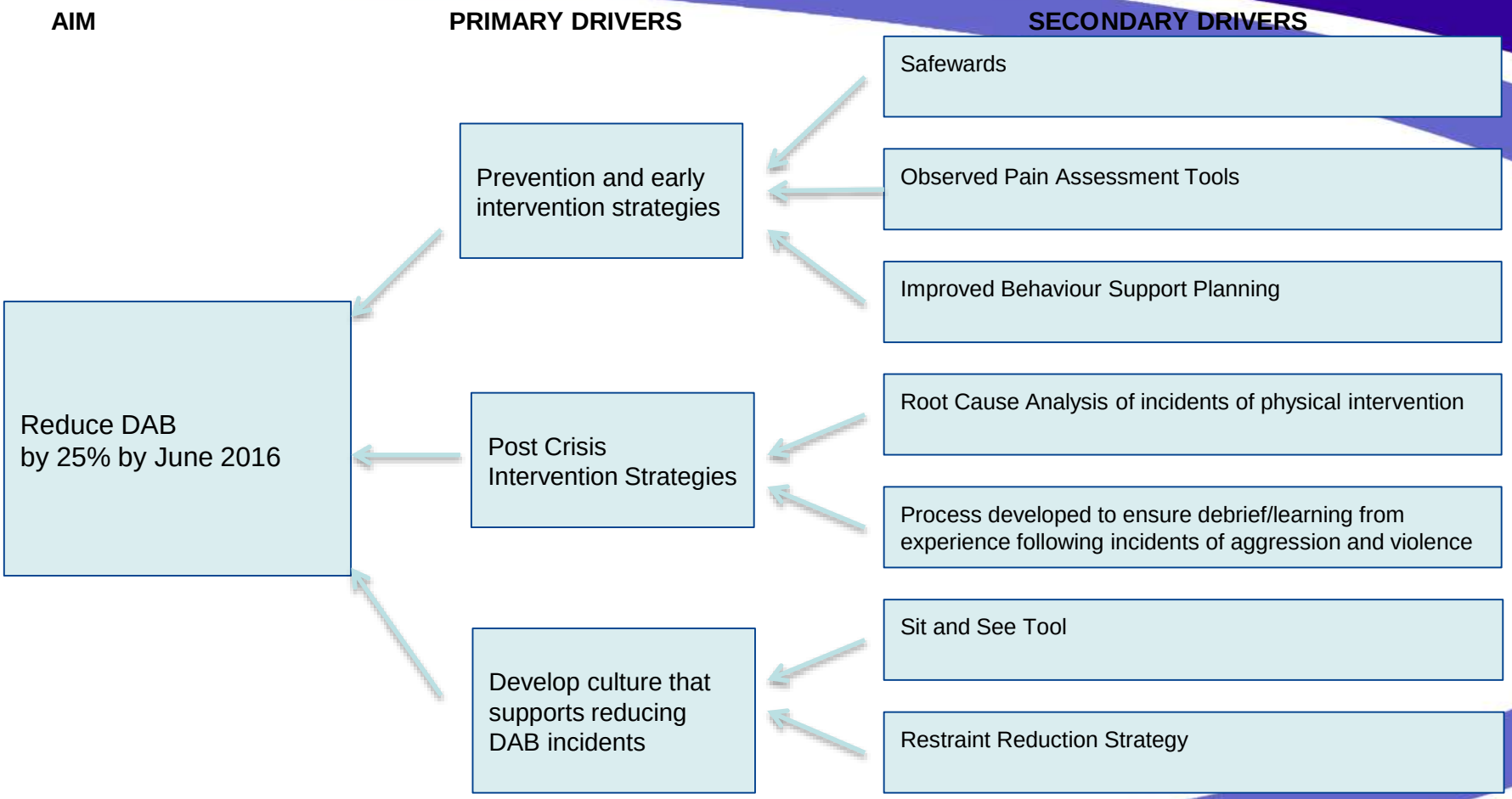
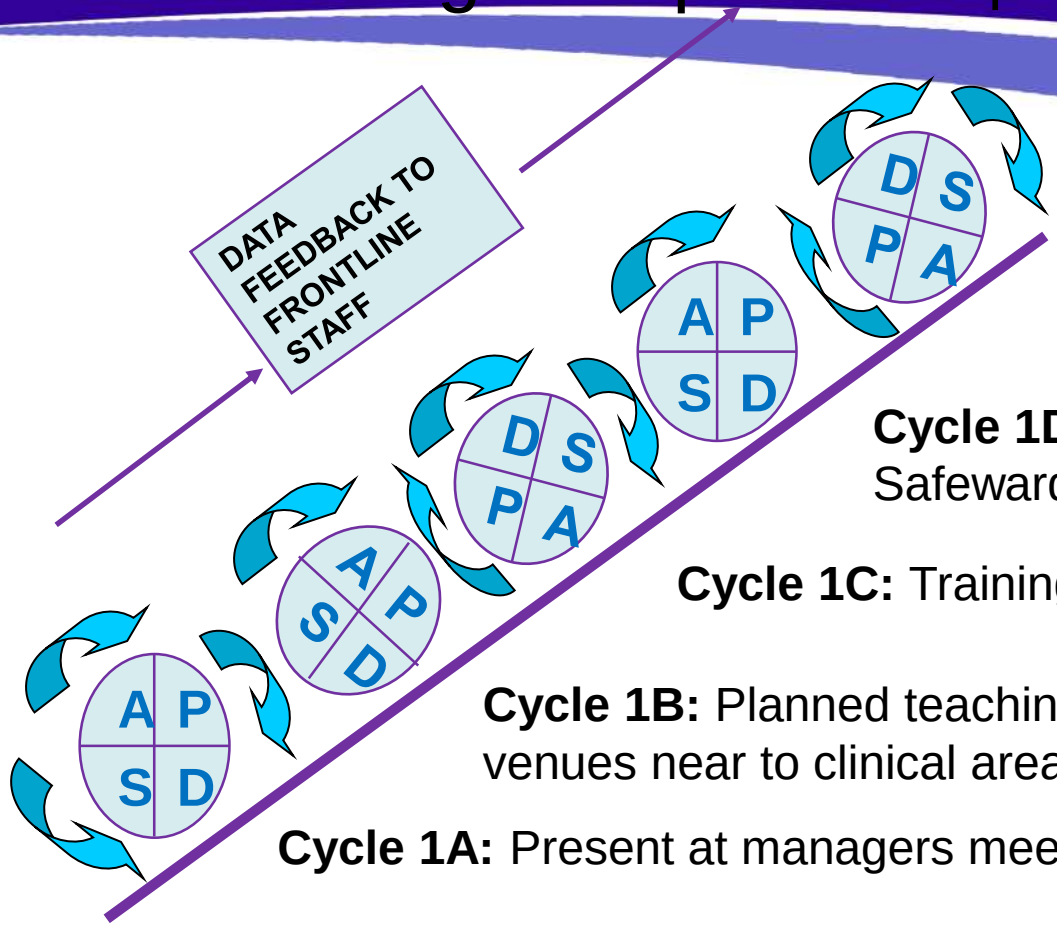


# How to achieve



# PDSA Testing Ramps for: Implementation of Safewards




**1E:** Collate information review PDSA

**Cycle 1D**: Champions group formed and Safewards meetings commenced

**Cycle 1C:** Training went to the ward areas

**Cycle 1B:** Planned teaching drop in sessions for staff in venues near to clinical areas

**Cycle 1A:** Present at managers meeting

Process Change PDSA: Implementation of Safewards

# PDSA Testing Ramps for: Use of the Sit and See Tool

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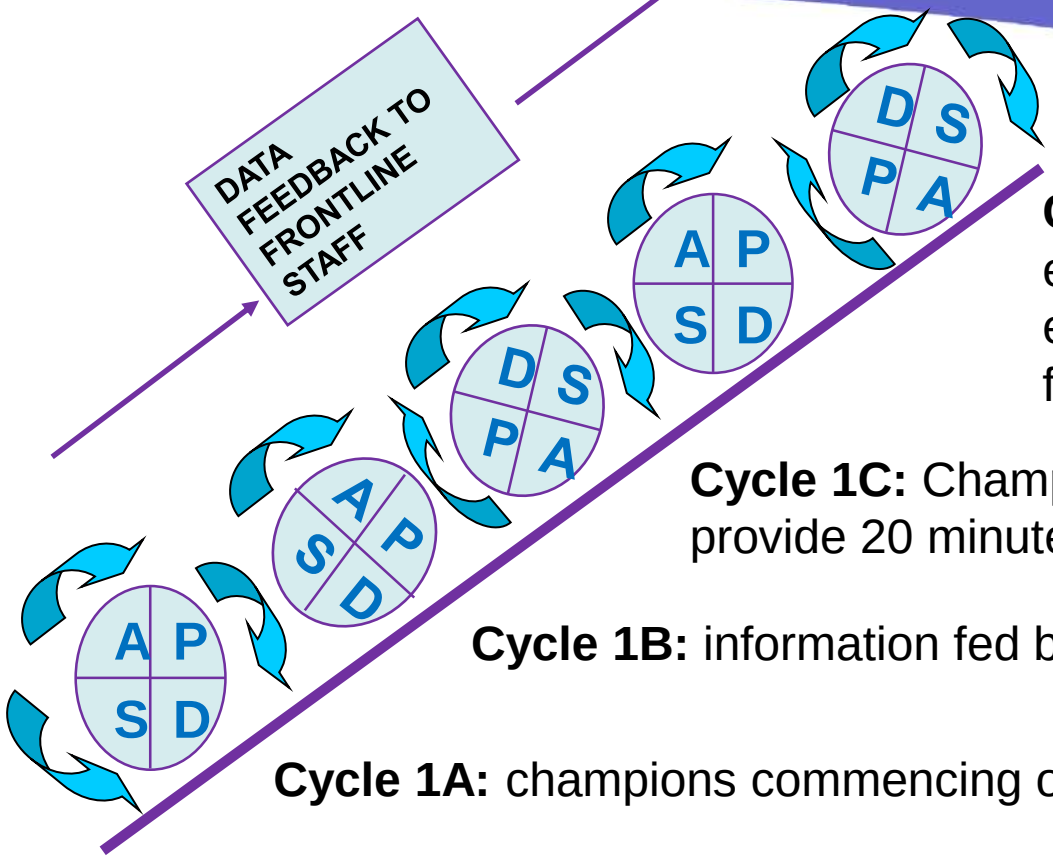



**1E:** Collate information review PDSA

**Cycle 1D**: Information fedback by email for dissemination to team and each ward will have a Sit and See file to keep paperwork

**Cycle 1C:** Champions used planned meeting to provide 20 minute observations to clinical areas

**Cycle 1B:** information fed back, using a variety of methods

**Cycle 1A:** champions commencing observations

Process Change PDSA: Implementing the Sit and See tool

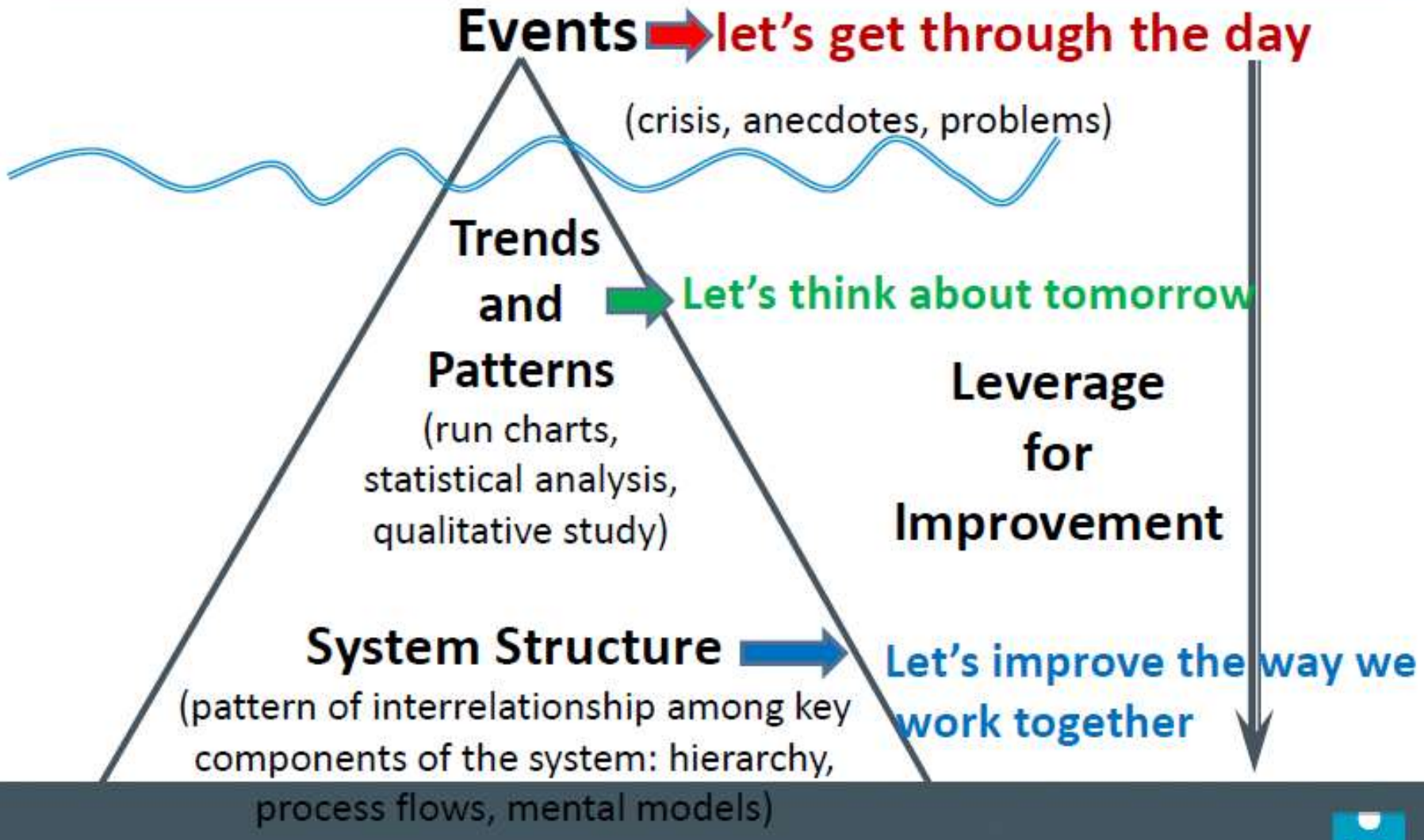
# Psychological safety

- Comfortable:
  - Asking questions
  - Asking for and receiving feedback
  - Being appropriately critical
  - Being innovative

# Teams

| | The associated behaviors |
|---|---|
| PLAN FORWARD | Brief (rounding, huddle, pause, timeout, check-in) |
| REFLECT BACK | Debrief |
| COMMUNICATE CLEARLY | Structured Communication<br>SBAR and Repeat-Back |
| MANAGE CONFLICT | Structured Critical Language |

# Systems: Leverage for Improvement



# Attribution Error

*A fault in the interpretation of observations, seen everywhere, is to suppose that every event (defect, mistake, accident) is attributable to someone (usually the one nearest at hand), or is related to some special event. The fact is most troubles with service and production lie in the system.*

*- Deming (1986),p. 315)*

# Take a moment to reflect on your own work. What will you incorporate from this session into your plans?