

To Improve the Management of Violent and Aggressive Patients in Critical Care.

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Quality Improvement Project

The incentive for the quality improvement project was from a trend of increasing incidents of violence and aggression from patients to staff in Critical Care. The number of incidents has not only doubled in the last four years but the severity of injury to staff both physically and emotionally has increased. The patients experience a prolonged Critical Care stay due to being difficult to manage. They cause injuries to themselves, our equipment and the hospital environment. They are a very difficult patient group to manage who often suffer with a mental health history, previous suicide attempts, recreational drug use and abuse of alcohol. With emotional, physical or sexual abuse in their past. They have socialised and grown up in a world where violence and aggression are used to express and protect themselves.

Project Aim :-

To improve the management of violent and aggressive patients in Critical Care.

Effective management is: -

1. The use of a patient screening tool
2. Patient risk documented and discussed at 'TEAM SAFETY' meetings
3. Intervention risk assessments implemented
4. Management guidelines implemented
5. Staff safe holder trained, confident and their safety maintained

We want to achieve a 75% compliance by 30th May 2018

Project focus :-

Our project focused on both quantitative and qualitative evidence that was collected and analysed in the following areas: -

1. The datix incidents over the last four years were all reviewed and analysed
2. Notes were audited looking at elements of care, patient history and patient risk factors
3. Meetings were held with relevant speciality stakeholders to gain information and advice
4. Staff were given a questionnaire to complete and asked to contribute to solving the problem
5. We analysed our current practise and considered our challenges

How It Was Achieved

Driver Diagram

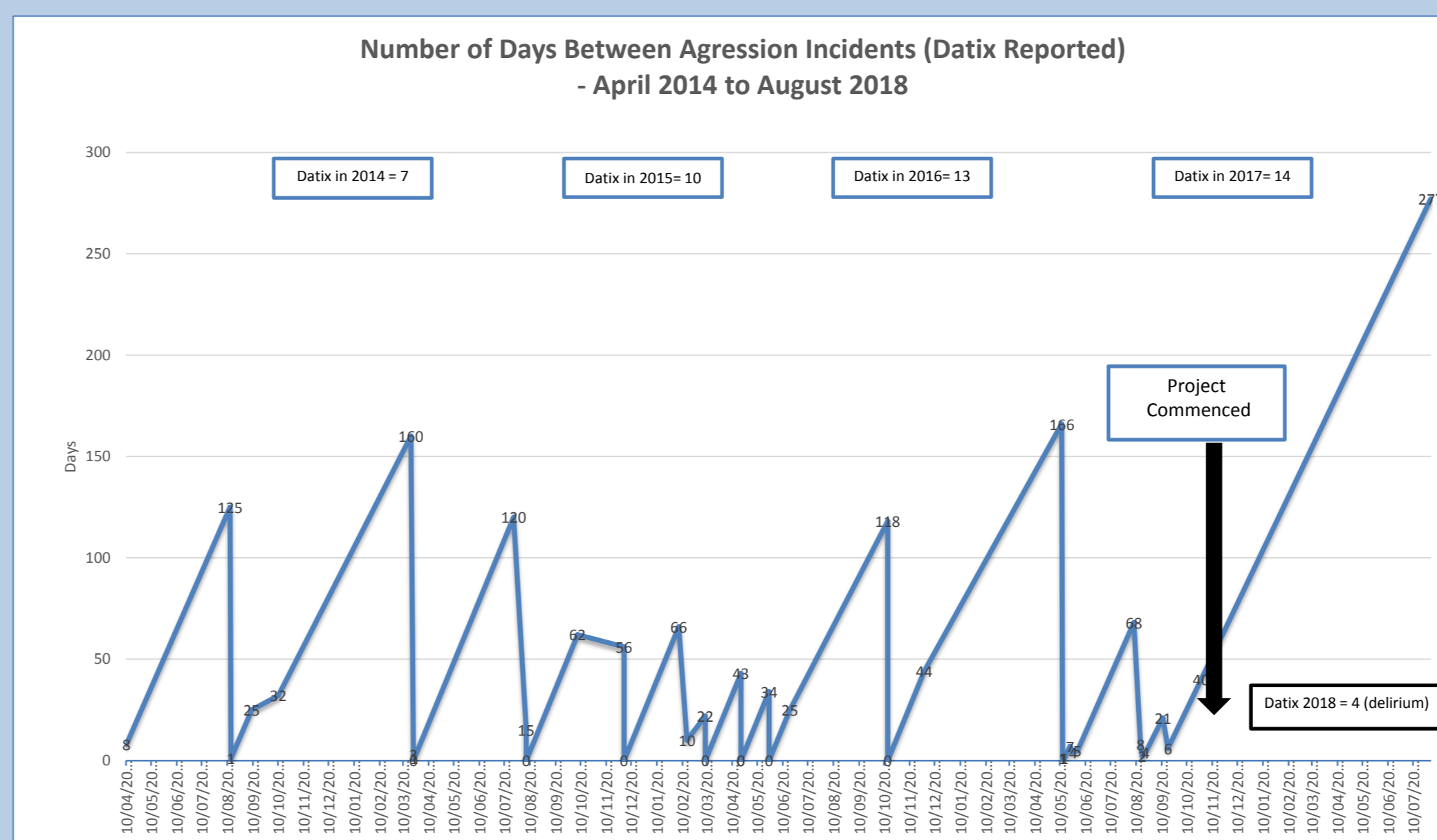
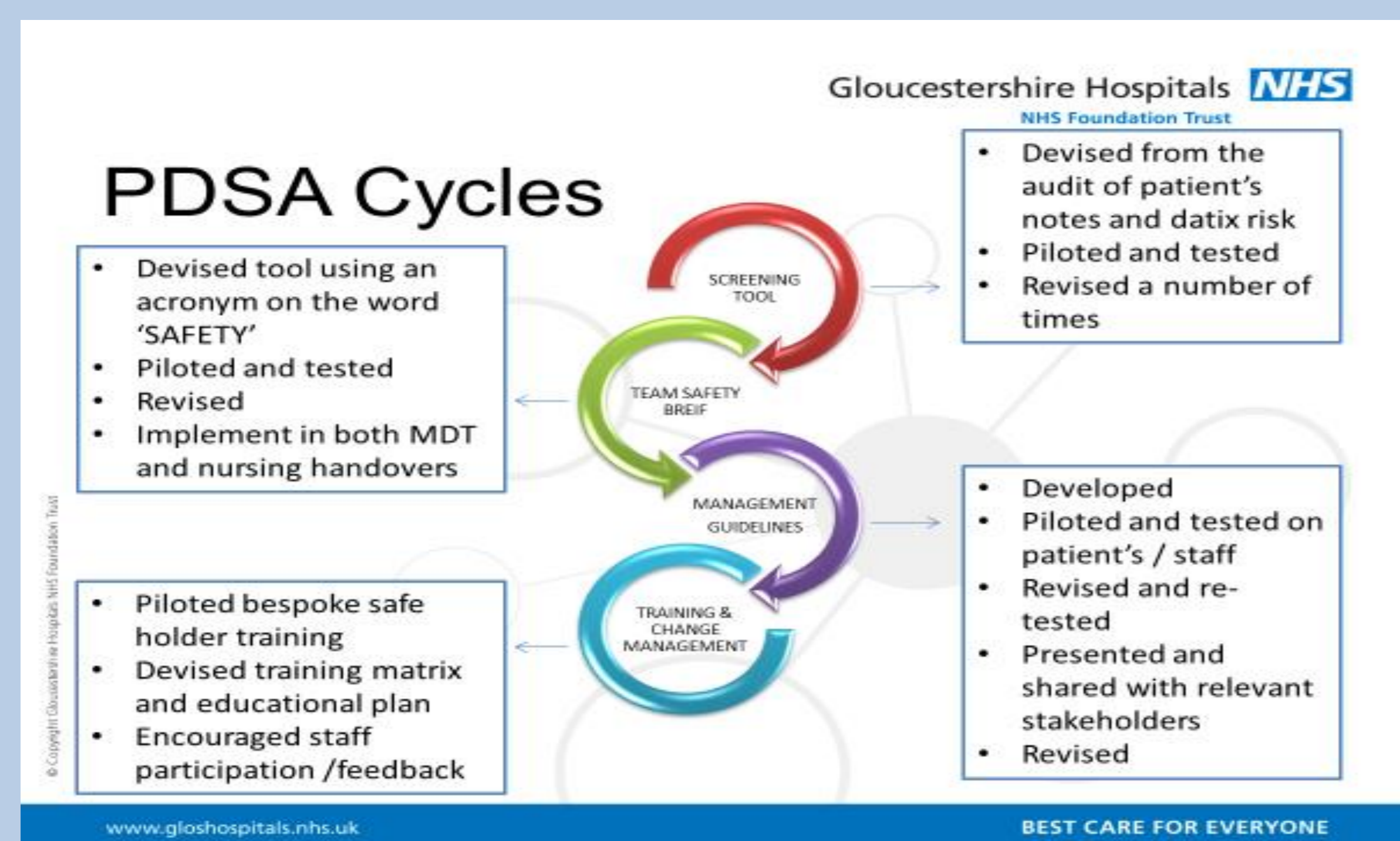
Aim	Primary Driver	Secondary Drivers	Change Ideas
To improve the management of violent and aggressive patients in Critical Care.	Patient Management	Patient Assessment and At Risk Patient Group Identified	Devise a patient screening tool that identifies patients at risk of V & A Devise and implement a MDT Critical Care 'TEAM SAFETY' briefing where high risk patients are discussed Place a V & A alert on nurse handover board
Effective management is: -	Safety - Patient and Staff	Risk Assessments Staff Culture, Change Management and Training	Devise a DCC environmental and staff risk assessment. Promote the use of patient risk assessments Poster for staff feedback on what went well, what didn't go well and what we could do better when caring for these patients Perform a staff questionnaire asking about their experience of V & A in DCC Encourage and support staff to adopt new processes Pilot safe-holding training Devise training matrix and plan for DCC staff
To achieve a 75% compliance by 30th May 2018	Clinical Outcome and Patient Experience	Patient Experience and Care	Devise 'Management Guidelines' for patient group incorporating knowledge from datix, research and mental health team Devise an action card and care plan for mechanical restraint in DCC
	Discharge	Document	Devise decision tree for patients who wish to abscond or self-discharge from DCC Ensure process are in place to communicate issue with patient management on ward discharge, including the Ward sisters and Matrons Produce a DCC patient management record
		Unacceptable Behaviour	Trigger datix

What The Project Achieved

100% of all patients admitted to DCC had a V & A risk score

'TEAM SAFETY' Brief takes place in all MDT & nursing handovers, 'high risk' patients are discussed

All 'high risk' patients with Mental Health and Substance abuse use care plan or relevant elements



What are the key measurements
Outcome - Reduction in the number of critical incidents triggered from violence and aggression.
Process - Compliance with effective management
 • Use of patient screening tool
 • Patient risk documented and discussed at 'Team Safety'
 • Management guidelines implemented and followed
 • Staff safe holder trained, confident and safety maintained
Balancing - Number of specific patient group admitted.

Conclusion - This project has been effective not only in improving staff safety but also improving the journey of this vulnerable group of patient's. It has achieved this by understanding their physical condition, mental health and psychological needs. The networks this project has opened within the trust has greatly benefitted.

Feed back - The implementation of this project has dramatically reduced the incidence of violence and aggressive episodes. Staff feel empowered and supported in their care of these complex patients. The project and documentation raises awareness, promotes best practice and discussion amongst the whole MDT. (Critical Care Sister and Mental Health Link Nurse, Annette Whiteley)

Next Steps - To implement in Cheltenham Critical Care, share with the wider trust and support other areas as required. To present and share with Southwest Critical Care network and publish the training in a Critical Care journal. To continue to monitor and audit practice to further improve the project and documentation.