RRP Catch Up with Dr Renarta Rowe

30/07/21

On Tuesday the 23rd of March 2021, Birmingham and Solihull Mental Health Foundation Trust saw the launch of the Reducing Restrictive Practice Collaborative, a 12 month project, supported by the QI team and the Institute for Healthcare Improvement (IHI) that aims to reduce restrictive practices on our in-patient wards.

As the collaborative is a few months in, we thought that we would take the time to have a chat to Dr Renarta Rowe, Forensic Psychiatrist and Collaborative Lead, about how the RRP collaborative is progressing and her experiences of using QI on such a large scale.

Thanks for taking the time to speak to us Nat! For those that don't know, what is the Reducing Restrictive Practice Collaborative and who's involved?

The RRP Collaborative is a Trust wide year long process, supporting all inpatient areas to work together to reduce restrictive practices such as restraint, seclusion, rapid tranquilisation and blanket restrictions. The Collaborative builds on the work of the PPCEP from recent years and also national learning. Dr Hilary Grant is the Executive Director for the Collaborative and I am the Clinical Lead. Other key people include Sam Howes, the AVERTS Lead, Cath Richards, Improvement Advisor for the Collaborative, the rest of the QI team, and two Experts by Experience, Mustak and Rhea. There are lots of other people involved (too many to name here!) and we are also working really closely with IHI, our Quality Improvement Partner organisation.

Why is this collaborative important? And what's it been like utilising the Model for Improvement on such a large scale?

We know from the work of the PPCEP that just having ideas or evidence of what might work to reduce restrictive interventions can be difficult to implement in areas with high staff turnover, lots of clinical activity and of course during a pandemic. The great advantage about this approach is that really small tests of change can be carried out with individual service users, to give staff an opportunity to be clinically creative- this is more empowering for staff, service users benefit and because we are actually measuring the outcomes, we can demonstrate what is working, so we can share this learning. We have 15 wards involved, which includes a huge amount of clinical expertise, rather than just a small group on one ward.

What is the aim of the collaborative? And how are we measuring success?

The aim is to reduce restrictive practices in our organisation, using quality improvement methods, but there are some additional aims associated with this- one is to improve the experience of service users and staff as a result of using less restrictive interventions. Another is to support staff to really understand how QI works in practice, so that many more people feel competent and confident in using this approach in the future.

In terms of measures, we have a number of measures that are the same for all QI project teams, including numbers and rates of restraint, seclusion and rapid tranquilisation. But there are lots of other measures for individual teams, depending on the details of their project- for example service user experience, staff experience, staffing levels etc. The key point is that we are always collecting data for any change that we introduce to see if there is a change in the data after the new idea has been introduced, and if so, is this an improvement.

How has Expert by Experience involvement influenced the project?
Mustak and Rhea have been fundamental to the Collaborative so far and we are hoping that more EBE and also service users will be able to be involved. Mustak and Rhea both shared personal stories at the first Learning Set (a day when all teams come together to think about why we are actually doing this and to share learning), both of which were really powerful and inspiring. Having service users who have actually been in these real-life situations makes us all think differently about every interaction we have with a service user, to try to make sure that we are really thinking about the best way to approach difficult situations, even if that is not the easiest or quickest way. We could not do this without them.

What lessons have you learnt so far in carrying out this collaborative?
The first lesson is that this is a lot more work than we had anticipated! Developing the infrastructure of the Collaborative has been quite tough and trying to juggle so many aspects along with our "day jobs". We have all learnt about team working and personally I have really enjoyed working closely with new people, for example the QI team, the QI project team that I am coaching and lots of other people. But is it also really rewarding- when a team sends us a completed safety cross (a really easy, visual way of recording what is happening each day on a ward) or their data from one of their tests of change, that is just great! It is very exciting, and I am so pleased to be able to be part of it!

How has COVID affected the collaborative? Have there been any challenges or opportunities?
Like everything, COVID has affected how we work, in terms of additional tasks that have to take priority, staff being re-deployed last year, and not being able to run training or other sessions in person. However, the Teams meetings have been great to allow busy staff on the wards to have very quick catch ups with their QI coaches and Improvement Advisors, which would not really be practical in person.

What's been the most exciting part of being involved in this work for you?
Lots of things! New people, new ways of looking at data, seeing actual change take place, and seeing staff and service users who are new to QI experience the benefits of this approach. For me, the Collaborative is a great way for me to combine my passion to reduce restrictive practices with my passion for QI - perfect!

What's next for the collaborative?
So we will run the Collaborative until probably late Spring/early Summer next year, and then maybe think about running a second cycle. We are linking in within the West Midlands with other providers and organisations, to share our learning but also see what others are doing. There will also be lots of learning internally that we can think about as a QI team and a Collaborative and maybe we can use this approach in future for other aspects of patient safety and quality, eg physical health. Watch this space!

Thank you for taking the time to speak to us. If you could put it into one or two sentences, what would you say Quality Improvement means to you?

For me, it is a refreshing way of looking at tricky problems that we have not been able to solve using the traditional ways, of changing policies, or changing training. I think that when anyone actually experiences a change in practice from this approach, you would not want to use anything else.