**Request for Information – Feedback Summary Sheet**

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| **Request made by:** | Michelle Platt | **Responses to be sent back to:** | Kerry Wright |
| **Date request made:** | 03/05/2018 | **Date sent out:** | 03/05/2018 |
| **Details of Request:** | 1. The amount and kind of incidents involving aggression, violence and harassment (AVH) in Critical Care from patients and visitors towards staff. We would like to know if other areas have any measures in place to mitigate the risk to both staff and the patients please.2. If any other Critical Care areas adopt any strategies to reduce delirium in Critical Care patients to combat the issues of AVH? E.g., commencing recognised delirium drug therapies pre-sedation hold on high risk patients, security measures etc. |
| **No.** | **Response Received From:** | **Details of Response:** |
| 1 | Allyn DowICU/PPU managerFurness General Hospital | We have not done any particular work to combat this on ICU and generally just manage extreme situations with a security company contracted to deal with these issues. This is rarely done however.The wards and ED tend to have more incidents than we do on ICU so it is few and far times when we have needed to call them for ICU. All incidents are reported and reviewed by our local security manager, in some extreme cases patients or relatives have legal restrictions placed on them.All staff have conflict resolution training and we have a trust security policy. |
| 2 | **Dr Michele Platt, RN, BSc(Hons), MSc, PhD**Network Manager,**East Midlands Spinal Network** (No longer in post since scoping exercise- replaced by Martin Mauracheea) | KMH have done lots of work around delirium – not specifically aimed at reducing violence etc. but good work nevertheless. This includes sedation holidays (as part of the network’s ventilation care bundle work) and CAM-ICU. They have also implemented the sleep hygiene bundle and ABCDEF bundle shared with them by NUH. At Follow Up Clinic I used the PHQ9, GAD7 and IPAT tools to assess progress.Furthermore, the Network did quite a lot of work around delirium last year – I presented some of the work we had done at KMH on delirium for the EMAHSN and was subsequently invited to put in a bid for some SI monies. I worked with the Clinical Psychologists from Notts Healthcare and developed a course in psychological skills for the MDT across the MTCCN. This course was delivered over 18 months and included a study day and some associated group clinical supervision (some of your colleagues at NUH attended). The psychologists trained staff on the use of a number of tools that enabled teams to identify psychological issues early in the course of the patients’ recovery and prioritise patients for referral to clinical psychology (in a resource-limited environment). |
| 3 | Mandy Coggon (SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST) | We have had a few incidents recently where staff have been kicked punched and or spat at. Nothing was done to my knowledge other than a Datix form. Staff tend to accept that the patient is not well but I personally would struggle with the spitting incident . We have security but they seem a bit heavy handed and often fuel the aggression . |
| 4 | *Claire Horsfield – Quality Improvement Lead Nurse and Chair of Critical Care National Network Nurse Leads Forum (CC3N)* | Our network is looking to develop a delirium bundle as a means to reduce the incidence of delirium. We have worked on promoting protected sleep time along with developing an infographic to raise staff awareness of delirium and its prevention. I can share any of our resources and they are available on our website [www.lscccn.org.uk](http://www.lscccn.org.uk) I agree we need to do more around treatment though as it is a challenge for staff and there are many reports of violence and aggression towards staff although I don’t have specific numbers. |
|  | **Mary Meeks**Clinical MatronCritical CareRHCHHHFT | We had a spat of incidents to staff of violence and aggression from delirious patents this prompted us to introduce Team delirium. They together with our Clinical psychologist have done a huge amount of work on updating delirium awareness, and relaunching CAM-ICU, the attached pathway was put together by our Clinical psychologist with pharmacy input. We have our Clinical Psychologist for 8 hours a week, cross site ( so for both Critical care units) we share her with another service. Our psychologist comes every week at a set time unless we need her for something specifically., We have a referral form but can contact her immediately by phone if required,  she is very flexible and will come when we ask for particular patients/families, and staff debriefs etc. We have certainly seen a reduction in reported violence/aggression, we have yet to audit delirium patients again, I think we will pick ore of those up! |