The Quiet Room: Improving the Acute Care Psychiatric Environment

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Summary
Mental health nurses have a key role in shaping the acute psychiatric environment. However, patients have described these environments as hindering rather than facilitating the development of therapeutic relationships. Pro re nata (PRN) or "as required" medication is a commonly used intervention for nursing staff when they are concerned about patients' safety and their levels of distress. However, studies have shown that nurses tend to resort to PRN medication as a first resort, rather than a last resort (Baker et al., 2007; Usher et al., 2009). This report describes a project that developed the use of a quiet room as an alternative to PRN medication use when caring for patients in a mental health crisis. The methods and approaches were used to clarify values and beliefs, to plan and develop the quiet room with the involvement of patients and to develop the knowledge and skills of nursing staff. The project identified that in an acute psychiatric environment, mental health nurses can provide effective alternatives to pharmacological interventions.

Introduction and Background
Although the central focus of acute psychiatric units is to treat mental illness, meet basic care needs and provide physical health care needs (Bowers et al., 2005), patients have described acute psychiatric wards as "therapeutically superficial" (Hummelvoll and Severinsson, 2001) and an environment not conducive to healing (Thomas and Pollio, 2002). Mental health nurses are in a key position to improve the living environment in a psychiatric setting, especially on acute psychiatric wards. Staff have been perceived as being the primary contributors to the ward atmosphere (Brunt and Rask, 2007). They are responsible for deciding where therapy is conducted, as well as ensuring that space is found to enable healing in an environment where patients are treated with dignity and respect. Caring for people who are acutely disturbed can be difficult for mental health nurses, particularly where risks such as violence to self and others are concerned.

<u>The acute ward environment</u>
The healthcare environment has been found to be important for patient satisfaction with care (Johannson et al., 2006). Although, the design of acute psychiatric wards should provide comfort and protection from negative internal and external stressors, they have been criticised for being noisy, cluttered and institutional (Schweitzer et al., 2004). Thibeault et al. (2010) found that the acute environment has as much potential for destruction as for healing. In this study, patients identified feeling abandoned and said they yearned for a place that was comfortable, comforting, and was a health promoting

physical space. A more recent study, conducted in an acute inpatient ward in Dundee (Stenhouse, 2011), identified that patients found nurses too busy to talk, wanted nurses to make time for them and to initiate interactions, rather than patients always having to ask for help. Bowles et al. (2002) claim that some nurses fail to spend their time in meaningful interactions with patients and that acute psychiatric wards are essentially environments where the use of medication has become the intervention of choice.

Pro re nata medication

Pro re nata (PRN) or "as required" medication is a commonly used intervention for nursing staff when they are concerned for patients' safety and about their levels of distress. Studies have shown that nurses tend to resort to PRN as a first resort, rather than a last resort (Baker et al., 2007; Usher et al., 2009). Findings from other studies have suggested that approximately 80% of psychiatric inpatients receive PRN medication during their admission (Curtis and Capp, 2003; Geffen et al., 2002), however, the clinical effectiveness of PRN medication in mental health settings is yet to be established (Chakrabarti et al., 2007). Therefore, opportunities for mental health nurses to develop new ways of working and enhance best practice in caring for people who feel unsafe, insecure and distressed are needed.

Donat (2005) suggests that encouraging alternatives to medication as a clinical intervention can avoid a reliance on psychotropic PRN medication, and behavioural approaches can provide these useful alternatives. Opportunities for new ways of working or different environments have the potential to influence the practice associated with the administration of PRN medication (Baker et al., 2007).

The ward setting

The ward where the project took place is one of three acute psychiatric inpatient wards within NHS Fife Mental Health Services. The ward is based in Whyteman Brae Hospital, Kirkcaldy. Kirkcaldy has a population of under 50,000 and the ward also accepts admissions from the Glenrothes and Levenmouth areas. At the time of the project the ward had 30 acute beds with 29 nursing staff working a variety of shifts and had a high patient occupancy level. Also significantly, due to a service redesign, another ward was closed and the staff had moved to the project ward. Consequently, many of the nursing staff had only just started working with each other. Although this merger brought some challenges (e.g. different customs and routines) it also brought exciting opportunities, including different perspectives and a higher staff: patient ratio.

Aim of the Project

The aim of this project was to build and enable the use of a quiet room for patients within an acute psychiatric ward.

It was anticipated that:

- The room would be a private place that was both comfortable and comforting
- The nurse would be pivotal in providing the emotional support to help the patient feel safe and secure
- This would be a purpose built room where patients and nursing staff could shape the acute ward environment in a way that is therapeutic in nature

- The room would be a space where nurses could engage and connect with patients, whilst realising the patient potential for self-healing

This project was concerned with the development and improvement of clinical practice. Garbett and McCormack (2002) discuss taking a systematic approach to developing practice, using facilitation processes to effect change, improving patient care, and transforming service contexts and culture. This approach was thought by the project team to fit with the aspirations of this project. The following objectives were developed to enable the team to communicate what was expected of the project steering group and the ward staff.

Objectives

- To involve staff and patients in the planning, design and use of the room
- To develop a new room that was comfortable and therapeutic
- To develop guidelines to assist nursing staff to manage and maintain the room in a therapeutic manner
- To understand patients' experience of the room
- To implement a staff learning and development programme to enable nurses the opportunity to discuss and reflect on current practice
- To utilise the Context Assessment Index (CAI) to broaden staff understanding of the ward culture
- To evaluate changes in practice and culture

It was anticipated that by encouraging behavioural alternatives to medication the reliance on psychotropic medication PRN medication would be reduced.

To help focus the project, two evaluation questions were developed by the project team:
1. Does a quiet room make a difference to patient outcomes relating to feelings of safety?
2. Does a quiet room make a difference to patient outcomes relating to the use of PRN medication?

Methods and Approaches

<u>The project group</u>

A small project group consisting of clinicians and managers was formed in January 2011 (see Box 1). Individuals who were knowledgeable, motivated, and influential risk takers were approached to represent the stakeholders of the project. Managers were included to provide adequate resources, high challenge and support, and to provide political expertise.

Box 1. Project group

2 Ward Staff Nurses
Clinical Nurse Educator
Ward Senior Charge Nurse
Ward Charge Nurse
Senior Nurse
Clinical Services Manager

Key functions of the project group were to:

- Clarify values and beliefs
- Set objectives and monitor progress
- Communicate with the stakeholders
- Facilitate necessary changes
- Promote participation of stakeholders
- Develop an evaluation strategy
- Develop and provide staff development programmes
- Provide leadership, organisational and emotional support
- Write the final report and disseminate findings

The group used a broad range of methods and tools to enable the participation of stakeholders and to collect information that would inform the development and evaluation of the project. The team believed that no one approach would be adequate by itself to meet the aspirations of the project and by adopting mixed methods, a more in-depth understanding of what was happening could be achieved, whilst enabling a rich explanation of the results. The following methods and approaches were utilised:

- Enabling stakeholder participation - stakeholder analysis
- Context Assessment Index (CAI)
- Claims, concerns and issues exercise
- Guidelines and monitoring assessment tool
- Staff learning and development programmes
- Observation of practice
- Data collection of PRN medication and feelings of safety

<u>Enabling stakeholder participation - stakeholder analysis</u>

To remain consistent with the team's aspiration to deliver service user centred care, time was spent identifying the people who had an interest and those that would be integral to the success of the project. Interpersonal relationships are challenged with issues of power (Cutcliffe and Happel, 2009) and mental health nursing interventions have been described as "techniques of power" (Roberts, 2005). The project group and the ward staff were keen to ensure that involvement was not tokenistic and although it was a lengthy process, a stakeholder analysis template was completed by the project leaders and explored in greater depth by the project group (see Appendix 1) at a subsequent meeting, demonstrating a genuine intent to include all stakeholders. Once complete, the template provided the project team with a framework to ensure that partnership working was at the heart of the process.

Context Assessment Index (CAI)

To understand the culture and context of care on the ward the CAI was used. Studying the workplace culture is not new and studies have revealed that to work effectively and improve the quality of care, certain attributes are essential (Kramer and Schmalenberg, 2004).Manley (2004) identified practitioner empowerment, practice development and a number of other workplace characteristics encompassed by the term "transformational culture". The culture of the workplace is seen as vital to enable teams and people to flourish, therefore it is worthy of investigation. The aim of a CAI is to enable health care professionals to assess the context within which care is provided in clinical areas (McCormack et al., 2009). The CAI assesses three elements; culture, leadership and evaluation along a continuum from 'weak' to 'strong' (0%-100%). To determine a baseline, the project CAI was first distributed to the ward staff in December 2010. Copies of the CAI were placed in sealed envelopes and put in the internal mail to all nursing staff working on the ward. A box for collecting completed questionnaires was kept in the ward office. A letter was sent out accompanying the assessment tool offering a guide to help complete the form. Of the 35 CAIs that were sent out, 18 were returned. The procedure was repeated in November 2011. 31 forms were sent out and 16 were returned. The results were analysed by both project leaders and the results reported to the charge nurses and project group.

Box 2. Results of CAI

December 2010	**November 2011**
Culture: 70.1%	Culture: 70.8%
Leadership: 69.4%	Leadership: 71.9%
Evaluation:71.2%	Evaluation: 73.4%
Overall Context: 70.2	**Overall Context: 72.2%**

Results from the first assessment suggested that the staff who responded perceived the context to be relatively strong. To the project group, this suggested indicators of an environment receptive to change and transformational leadership styles. This was encouraging, and the project group/lead explored the results with the senior charge nurse and requested these results to be disseminated to all the staff on the ward. The repeat assessment in November 2011 indicated a small increase in the overall strength of the context; however it was difficult for the project team to view this as a significant increase or to attribute this directly to the project. The project group however, believed that the results demonstrated a context that values patients and staff.

Claims, concerns and issues exercise

It was important for the project group to understand what the ward staff thought about the project. To address this, an exercise called claims, concerns and issues (Guba and Lincoln, 1989) was used to explore staff views and to capture their experiences of being a part of this project. On the 21st April 2011, one of the project leaders facilitated this exercise, with the charge nurses managing the release of staff from clinical practice. It was crucial for the project group that opportunities for nursing staff to engage and participate in the project be used fully. This exercise enabled everyone to listen to each other's claims (positive statements about the project) and concerns (negative statements about the project) and provided opportunities to challenge individual thinking in a

constructive way. This session allowed the team to understand the project goals whilst clarifying the role of the mental health nurse in the use of the proposed quiet room. This method identified that staff wanted guidelines to help them use the quiet room as an intervention. The claims, concerns and issues exercise was repeated after the implementation of the room, on the 6th January 2012 to understand staff views and perspectives at the end of the project. The results of these workshops will continue to be benchmarked against further claims, concerns and issue sessions. A comparison of the first two sessions can be seen below in Box 3 (statements are how they were written by staff).

Box 3. Comparison of claims, concerns and issues

21st April 2011	**6th January 2012**
Claims: Having quiet area on ward for patients Hopefully reduction in use of PRN medication Chance for patients to use skills they have learned in groups e.g. relaxation A room where staff/patients are not disturbed Somewhere "nice" on ward	Claims: Reduction in medication used Privacy when distressed Gives people ideas for own home environment Soothing environment Another diversional option, reinforces same Alternative to meds - give people space of their own Space to practice relaxation Safe haven
Concerns: That room will be vandalised or left in a mess People using room for wrong purpose (sleeping/music etc.) Medical will staff want to use room for meetings etc. Staff development and training Room may not be monitored well, people barging in on each other Ventilation of room Staff will use it as somewhere to go for break?	Concerns: Out of sight-area within room Under used? People abusing the contents e.g. removing items Different judgements re risk etc. made by different staff No buzzer It takes more time Potential of use for self-harm
Question/Issues: Appropriate evaluation tool Training Clear guidance on use of room and adherence Equipment/furniture	Questions/Issues: Is it being under used? Why? What will the statistics show in next 6 months? Under use of nursing assistants-need education? Why are some staff using it more than others - is it just circumstances or is it due to possible lack of education/information?

	How do we change culture/include all staff Is everyone clear about correct/acceptable use of room?

In comparing these sessions the project leaders got a sense that the use of medication was a strong factor in the aspirations (claims) of the project. Privacy was also an assertion that was important. It is significant that none of the concerns mentioned in first sessions were repeated in the second. One of the reasons for this could be that each of these concerns was addressed directly. It is interesting that staff highlighted the issue of evaluation at both sessions. This was pleasing, as it suggested that staff were genuinely interested in the success of the project.

Guidelines and monitoring assessment tool

To support the development of the project and to assist nurses to make decisions in relation to the quiet room, the project leaders, following critical dialogue, drafted guidelines that were presented to the project group. They were also sent out to the nursing and medical staff for consultation. The guidelines were intended to minimise variations in practice and to promote effective nursing practice. To raise awareness of the guidelines (see Appendix 2) they were also disseminated to patients by posting them on notice boards in the sitting room area. Central to the guidelines was the requirement for staff to use the Tidal Monitoring Assessment Tool (see Appendix 3) prior to using the quiet room as an intervention. This is a unique feature of the Tidal Mental Health Nursing Model (Barker and Buchanan-Barker, 2005). The ward uses the Tidal Mental Health Nursing Model as a nursing framework. The purpose of the Monitoring Assessment Tool is to provide a measure to assess the level of risk, whilst identifying what needs to be done to help reduce the level of risk.

Staff development

Implementing a nursing staff development programme to address learning needs was viewed as a high priority by the project group. It was also identified in the claims, concerns and issues exercise, as an ingredient for success for the project. Improving patient care without staff development can be an impossible task (Walker, 2008; Carradice and Round, 2004). One of the project leaders is a hospital based Clinical Nurse Educator, responsible for the educational activities relating to the project. The Clinical Nurse Educator utilised a range of teaching and assessment strategies to support learning throughout the project, including the use of specific development workshops (see Box 4). The workshops were about an hour long and accommodated six members of staff at a time. The workshops were facilitated by the Clinical Nurse Educator and provided an excellent opportunity for the nursing staff to engage in reflection and critical dialogue around specific issues whilst providing a forum to challenge individual thinking in a constructive way.

Box 4. Development workshops

Workshop Title
• PRN medication • Alternative coping strategies • Use of quiet room guidelines • Monitoring assessment: Tidal Model • Claims, concerns, issues • Personal security planning

Developing and designing the room

The proposal for developing the quiet room was placed as a standing agenda item on the existing community meetings, which are held every Tuesday morning in the ward sitting room. This time was spent capturing staff and patients' views, as well as keeping everyone aware of progress and re-articulating the aspirations for the room. It was also an opportunity to raise issues and concerns. At these meetings catalogues and material swatches were reviewed by staff and patients to discuss furnishings for the room. Two suggestion boxes were also placed in both ward sitting rooms to collect suggestions from patients to further develop the room. Suggestions for the design and decor were made by patients, carers and staff. These included; colours of paint, design of curtains, style of pictures for the walls, types of furniture, brightness/levels of lighting and layout of furniture. Many of these ideas were used. A picture was donated by a patient and now hangs proudly in the room. A contracted company from the estates department carried out the painting and building work. Photographs of the new room are now displayed in the ward waiting areas and have been included in the new patient leaflet currently waiting to be approved. The room became operational on the 3th May 2011.

Informal observation of the use of the quiet room

Once the quiet room was being used, the project leaders listened to some nursing staff concerns regarding the use of the room (e.g. the door had been kept closed, linen left in front of entrance, no tissues in the room). Observation of care is a formal method that encourages nurses to stand back and observe their workplace environment. However, observations of care are not just about "watching" behaviours, but also includes that which is ascertained via the other senses of the observer e.g. what is heard (Bowling, 1997). This is an activity that is carried out with the consent of the team involved. However, as both project leaders work in the ward, they used this opportunity to make informal observations of the use of the quiet room, when the ward was quieter. Staff were unaware that these observations were happening. On reflection, the project leaders felt nursing staff should have made aware of the observational practice to keep the process transparent. Formal and informal conversations were also held with the nursing team over time. Through these observations and conversations several issues were identified:

- The door to the room was often blocked by the laundry trolley
- The quiet room door was often closed (it was agreed by the senior charge nurse that it should remain open at all times)
- Frequently there was no evaluation sheet in the room
- Frequently there were no tissues in the room
- Staff were not encouraging feedback from people using the room

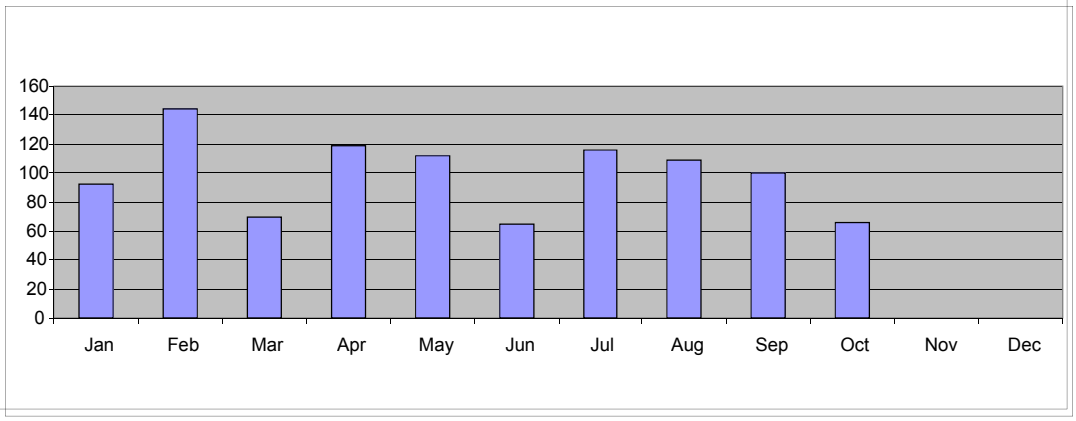
These issues were communicated by the project team to staff via the Charge Nurses and through challenging these issues on a daily basis, they gradually improved.

Review of PRN medication and feelings of safety

Information about the administration of PRN medication and medication interventions was collected and recorded each night by the night nursing staff. PRN medication interventions were recorded for five months (Jan 2011-May 2011) pre-introduction of the quiet room and compared with a five month period post-introduction. This data was analysed by the project leaders for trends in type of medication, dose and time administered. Close attention was also paid to polypharmacy, namely when two or more drugs are administered at the same time.

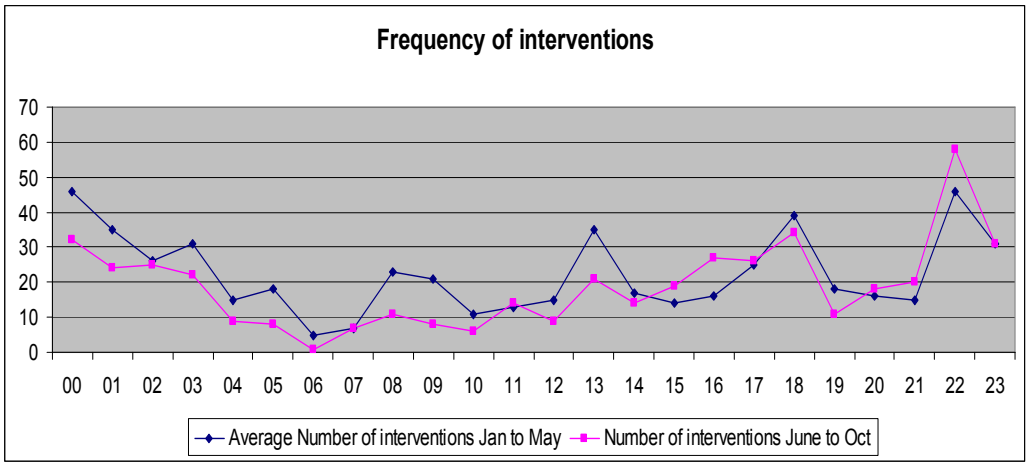
The room was implemented on the 30th May 2011. PRN medication was administered on 537 occasions during the pre-introduction period and 456 in the post-introduction period.

Box 5. Number of PRN medication given Jan-Oct 2011



Box 5 shows that most PRN medications were given in February 2012 and that there is a gradual decrease in PRN medication administered after June 2011, which was shortly after the room was introduced. This is an early indication and data is being collected on an on-going basis to establish PRN administration practices. Box 6 identifies the differences in times that PRN medication was administered. Of significance are the peak PRN administration rates pre and post-introduction at the usual regular medication administration times of 0800, 1200, 1800 and 2200hrs.

Box 6. Times of PRN medication administration: pre and post room introduction



More PRN medications were administered from the afternoon onward, which coincides with the later shift coming on duty at 1300hrs. PRN medication was at its peak between 2100-2200hrs which is just after the night shift duty begins.

The trends of PRN medication were of particular interest to this project. The peak times were similar pre and post room intervention and they all correlated to the administration of regular prescribed medications. The PRN drugs that emerged as most used were Haloperidol and Lorazepam.

Polypharmacy of drugs (typically 5mg Haloperidol and 1 or 2mg Lorazepam) is one formulae used by staff to achieve rapid tranqullisation. Rapid tranquillisation is the administration of tranquillising drugs over a short period of time. The aim is to achieve rapid, short term control of extreme agitation, aggression and potentially violent behaviour that puts individuals at risk of physical or psychological harm. Rapid tranquillisation should only be used for patients when other interventions have failed to contain the behaviour and/or to calm a patient who is acutely disturbed. The use of these drugs includes either oral or intramuscular administration.

The results collected identified a 41% reduction in the combination of Haloperidol 5mg and Lorazepam (either 1 or 2mg) administered at the same time, either orally or via the intramuscular injection route, from the time the room was introduced.

<u>Log book</u>

A log book was developed and utilised to identify how many people used the quiet room. The log book collected details of; the nurse supervising the patient, the length of time spent in the room and assessment of the level of safety experienced by the patient. The Tidal Monitoring Assessment tool which utilises a likert rating scale was used as a method of data collection to evaluate patients' feelings. This information was collected pre and post-introduction of the quiet room.

A total number of 31 patients have used the quiet room since it was implemented. Analysing the log book the project group could identify that:

- 15 patients reported that they felt safer after using the room

- 4 patients identified no change
- 1 patient felt worse
- On 11 occasions the Tidal Model Assessment rating scale was not used (people had asked to use the room when they were not distressed, however, they still wanted to rehearse coping strategies or they clearly identified a therapeutic need)

This last point has been seen as a significant development of the room. Although not planned, staff and patients suggested that the room should not just be seen as a place where people go when they are distressed. They wanted the room to be available for people who wish to continue on their recovery journey, even in the absence of psychological distress. Consequently it was felt that a risk assessment was not required for this group of people.

The longest time a patient spent in the room was 110 minutes and the shortest time was 10 minutes. It is important to remember that all patients using the room were supervised by, and connected to a nurse for the whole duration of their stay in the room.

A communication template was developed by the project group to capture the patients' experience whilst in the room. The template was seen as important by the project group to evaluate and improve patient care, improve communication with patients, identify recommendations and to trigger communication between staff. The tool was made visible on a table in the quiet room. Eleven comments and six suggestions for improvements were received. The major theme stemming from the comments was of a positive and relaxing environment:

"Peaceful and relaxing"(23/6/11)
"A safe haven" (27/08/11)
"Great time out zone love the lighting 10/10" (24/08/11)

Not all comments were positive:

"Boring Yawn"(no date)

There were other suggestions for improvement including; two requests for a clock, a lock on the door, some nicer pictures and some black out curtains. These suggestions will be addressed by the project group and fed back to patients if and when suggestions are actioned.

Discussion
The findings indicate that this has been a successful project. Patients have used the room and a significant number of those have described feeling safer after its use. The project group have collected evidence that suggests that the objectives outlined earlier in this report have been met. The CAI tool suggests that the workplace was ready for cultural change, to support the change in practice and to increase the likelihood of the projects success. Claims, concerns and issues workshops have been a very useful approach to enable staff to express their thoughts and to bring the necessary attitudes and behaviours to the fore. The most recent feedback from the workshops indicates that staff

are acknowledging a decrease in medication use, however, some feel that the room is still underused. There remains scope for helping staff to develop a clearer understanding of the purpose of the room and this re-enforces the notion that there is still a lot of work to be done. Given that the room has now been used therapeutically by patients who are not distressed, guidelines will need to revised. Concerns have also been raised by some staff that certain nurses have never used the room. An audit of the log book identified that a few nurses have used the room more frequently with particular patients. This could be because some patients are more willing to try alternative strategies before receiving PRN medication. Alternatively it could be that some staff are more prepared to spend time with patients before resorting to PRN medication. The project group will continue to review this trend. Monitoring of the log book will be done by the charge nurses within the ward.

Auditing the administration of PRN medication has been a significant contribution to the evaluation of the project and helped to engage night nursing staff in the process. Identifying the use of Haloperidol as the most widely used drug was concerning. Contemporary literature suggests that older antipsychotics (e.g. Haloperidol) should be a last resort to treat acute behavioural disturbance (Baker et al., 2007), and preference should be given to benzodiazepines (e.g. Diazepam, Lorazepam etc.) and the newer antipsychotics. It is very encouraging therefore that the data collected showed a reduction in its use, and the project leaders suggest that the learning and development workshops have provided the opportunity for staff to reflect on and discuss the different ways of working with patients and this has contributed to the reduction. Questions still exist as to why PRN medication peaks at regular medication times and the project group will support the ward staff to ascertain reasons for this and to explore what happens in the ward environment at these particular times.

Using a variety of methods and approaches has taken up a lot of time and resources. The project team have needed to arrange rooms, organise and protect staff time, develop learning materials and utilise administration resources to support the work. However, investing in time for the nursing team to explore the issues and having good management support on the project group has been influential to enable this to happen. On reflection the project group feel the project may not have been as successful without this high level support. Ensuring the managers were involved in the project group ensured they were kept up to date with the project whilst helping to troubleshoot resource issues.

Conclusion

Facilitating change is not an easy process. Staff verbal feedback, observed feedback from members of the project group (particularly charge nurses) and results from the CAI, have demonstrated to the project lead that the methods and approaches used have been empowering and helped to engage staff in the project objectives. Evidence presented suggests that a quiet room can help to reduce the amount of PRN medication administered and as a result improvements in patient safety have been identified by staff. The ward can "hold its head up high" as it has achieved a number of goals. However, issues described by staff reveal that there is still a long way to go to sustain the improvements in practice. Issues raised on the 6th January 2011 suggest that staff want to know why the room is under used and there are on-going issues about further education.

The challenge will be to continue to explore these issues and to provide work-based staff development opportunities, as well as engaging in audit and quality initiatives.

This is the first project (that the project team are aware of) that has investigated the impact of a recovery focussed purpose built room on the experiences of patients on an acute psychiatric ward. The project group acknowledge that these results are unlikely to be generalizable. This was just one ward within one hospital site. No demographic details or ward occupancy levels were obtained; consequently the findings reported need to be interpreted with this in mind. However, the project group and the ward staff believe that the results reported are positively correlated to the introduction of the quiet room.

Finally, this report has raised implications for practice. Changes in the ward environment and implementing a structured risk assessment can promote patient safety, and help shift practice away from a culture with an overemphasis on PRN medication. It is hoped these implications will encourage others to develop practice initiatives that will improve the working and living environment on acute psychiatric wards. Furthermore, researching alternative interventions used already by nurses to assess and manage risk when patients are acutely distressed and/or request PRN medication should be a notable area of interest for the future. For the project group and the ward staff this is just a first step and on-going evaluation will be needed to measure the impact on practice if the project has achieved its true therapeutic and cost effective value.

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Appendix 1

Identifying stakeholders and facilitating collaboration, inclusion and participation

Name of stakeholder/stakeholder group and role (if relevant)	Level of: • Power • Interest	Ideas on how stakeholders can best be involved/engaged	Level/intensity of CIP	What are the consequences of their level of CIP?
e.g. CEO	High power/low interest	• Share information • Consider open invitation to meetings • One to one meetings at key points	• Collaborative relationship Low level of inclusion & participation	• Potential for strategic support • May be able to influence other stakeholders • Support with dissemination • Potential for project resource provision

Appendix 2

Guidelines for Use of Quiet Room

PURPOSE

- To improve the patient experience within Ravenscraig ward by creating a positive, warm, hopeful, calming and recovery orientated therapeutic environment.
- We hope that the provision of a quiet room within Ravenscraig ward will reduce the use of pharmacological interventions and patients will be enabled to utilise and develop their own coping strategies e.g. relaxation.

DESIRED OUTCOME

- Patients and staff work together to promote recovery whilst minimising distress and crisis.
- Patients can replicate environment at home and utilise skills learnt on discharge.

ASSESSMENT

- Discussion between staff and patient takes place outside the quiet room so as clear purpose and desired outcome can be identified.
- Monitoring assessment tool should be used before using the room to provide a measure of risk and for staff and patient to jointly identify ways in which risk can be reduced.
- Patients' strengths and coping mechanisms should be identified/reiterated and these should be included within the individual's personal security plan.

FACTORS INDICATING USE OF QUIET ROOM

- Patient requests to use the room and clear purpose and desired outcome can be jointly identified.
- Patient reports or is observed by staff to be experiencing distress.
- Patient appears to be over stimulated by ward environment this may include friction with other patients.
- To provide privacy in order to maintain a patient's dignity during time of crisis.
- To enable patients to practise alternative coping strategies learnt within ward or prior to admission. If the patient is not distressed a Monitoring Assessment Tool is not necessary.
    - Nursing staff should take into consideration other space that may be available within ward environment, time out-with ward as an alternative as well as current activity available within the ward.

WHILST IN ROOM

- Nurse to remain with patient for initial period, encouraging them to identify personal strengths and coping strategies.
- Patient may refer to their own personal security plan and safety box.
    - If patient has not already developed personal safety plan this should be done as soon as possible after leaving room.
- Staff to determine the need for removal of potentially harmful objects from within the room.

- When patient is in the room on their own they should be observed by nurse at regular intervals.
- Changes in patient to be reported and use of other therapeutic interventions to be considered.
- Patient and nurse jointly determine when to exit room following discussion of desired and actual outcome and review of monitoring assessment tool.

DOCUMENTATION

- Use of room to be clearly documented within nursing notes this must include desired and actual outcome.
    - This may be documented as a one to one session which will include patient input to identify “what is different now”.

MAINTENANCE OF ROOM

- Patients and staff are responsible for leaving the room clean, tidy and ready for use.

Appendix 3

Tidal Monitoring Assessment Tool

Monitoring Assessment

Persons Name……

Unit No/CHI…….

How I am feeling

How safe and secure I feel? (0-10)

What helps me at this moment in time?

What chance is there that I may come to harm? (0-10)

Could I be helped to feel more secure? (0-10)

What might be helpful?

How confident am I? (0-10)

How confident are you?