Minimising Restraint and Seclusion in Inpatient Services

Removing the restraints on our thinking will help us think of the unthinkable

Harith Swadi, 21 August 2015
BEST PRACTICE IN THE REDUCTION AND ELIMINATION OF SECLUSION AND RESTRAINT: TIME FOR CHANGE
Six Core Strategies® checklist

New Zealand adaption
Strategy One - Leadership towards organisational change.

Strategy Two - Using data to inform practice.

Strategy Three - Workforce development.

Strategy Four - Use of seclusion and restraint reduction tools.

Strategy Five - Service user/consumer roles in inpatient units.

Strategy Six - Debriefing techniques.
Minimise the harm resulting from restraint and seclusion practices

- Use prevention and early intervention approaches
  - All individuals admitted to ward are assessed for triggers for aggression and violence and staff work with service users to minimise triggers and develop individual coping strategies when they do occur
  - Ensure programme of structured/meaningful activities in place, including access to physical exercise
  - Develop and encourage an atmosphere of listening and respect

- Implement routine debriefing
  - Post restraint/seclusion protocol based debrief conducted with service user, families and staff that includes a focus on triggers and psychological harm
    - Immediate debrief with staff involved and service user within 3 hours
    - Formal incident debriefing within 7 days and includes family and wider clinical team
  - Service users & carers who witness a restraint are debriefed with a focus on psychological harm

- Address workforce issues
  - Training plan in place and implemented which specifies learning outcomes covering prevention, early intervention, de-escalation and restraint safety
  - Adequate numbers of staff trained in restraint in place in line with local policy
  - Reviews of any restraints that an individual is involved in is included as standing item within clinical supervision
  - Senior staff trained in the principles of restraint and seclusion reduction

- Develop infrastructures and culture to support reduction initiative
  - Service users involved in every stage of the reduction initiative
  - Protocols in place for use of restraint and seclusion
  - Routinely collect and use key data about restraint and seclusion to enable ongoing learning and reduction in harm
  - Active, committed, high profile leadership supports ward staff to reduce the use of seclusion and restraint and minimise the harm caused when such interventions are used
Summary

- Having in place genuinely predictive strategies in place to avoid the use of restraint

- Any means of physically intervening with a child need to be based on their specific individual personal needs

- Staff must be competent to deliver physical intervention in such a way that children are not hurt
Biases Exist
Of concern is the unacceptable difference in the episodes of seclusion of Māori while they are in acute mental health inpatient units in New Zealand. Evidence from a pilot study of nine district health boards estimated Māori were four times more likely to have been secluded than non-Māori, especially young Māori males (17-24 years) and older Māori females (55-64 years) (McLeod et al., 2013). In similar studies, the use of seclusion on Māori was double the rate of non-Māori (El-Badri & Mellsop, 2002; Tyrer, Beckley, Goel, Dennis, & Martin 2012; Radio New Zealand, 2013).
Supporting seclusion reduction for Māori

“Taiheretia tātou kia puta te hua”

Unite all to achieve the result.
Come together as one and we can achieve anything.
Whanaungatanga was identified by all Māori mental health nurses as the point of difference in their practice from non-Māori colleagues. Adapted from Māori customary principles, this model of practice involves four elements.

1. Recognition (kanohi kitea).
3. Focused engagement (using te reo Māori, karakia, waiata).
4. Relational-centred interventions which include working closely with whānau.
- The use of a culturally relevant physical space
- The use of traditional processes of engagement and participation, particularly pōwhiri, manaaki, karakia, mihimihi, and kai
- The presence of Māori staff
- Appropriate sound cultural assessment
- The fostering of “tino rangatiratanga” or self-determination for tāngata whaiora and their whānau.
SENSORY MODULATION IN ACUTE MENTAL HEALTH WARDS: A QUALITATIVE STUDY OF STAFF AND SERVICE USER PERSPECTIVES
Findings:

- Sensory modulation was perceived as an effective tool for inducing a calm state in the majority of people that used it.

- Sensory modulation supported the rapid building of trust and rapport for both service users and staff members.

- Sensory modulation facilitated the development of service users’ self-management, increasing their awareness and ability to regulate their own emotional levels.
Mediating Mechanisms:

- Creating a sense of safety
- Soothing through the sensory input
- Distracting attention from distressing thoughts, emotions and perceptions
- Stabilising or ‘grounding’ through the sensory input
- Creating positive associations
- Creating a sense of control
- Supporting expression and release of thoughts, emotion and energy.
Sensory approaches include the use of:

- assessment tools,
- sensorimotor activities,
- sensory modalities,
- environmental modifications,
- and assistance in learning how to self-regulate.
The Isolator

By HUGO GERNSBACK

MEMBER AMERICAN PHYSICAL SOCIETY

The author at work in his private study aided by the Isolator. Outside noises being eliminated, the worker can concentrate with ease upon the subject at hand.
Youth Inpatient Unit

10 years of data
50 patients out of 391
Psychotic disorders 38%
Maori twice as likely
Most common time in evening
Average 90 minutes per day

60 admissions out of 716
Rate 8.4% of admissions 12.8% of patients
others 15.3%
76% of seclusions start in first week
Median length is 7.5 hours
10 minutes per patient per day
## Seclusion Episodes

<table>
<thead>
<tr>
<th>Interventions prior to seclusion*</th>
<th>Seclusion Episodes n = 328 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1 or nurse ‘specialling’</td>
<td>136 (42%)</td>
</tr>
<tr>
<td>PRN medication</td>
<td>188 (57%)</td>
</tr>
<tr>
<td>Low stimulus environment</td>
<td>95 (29%)</td>
</tr>
<tr>
<td>Distraction</td>
<td>39 (12%)</td>
</tr>
<tr>
<td>Room boundaries/ ‘open seclusion’ or HDU</td>
<td>109 (33%)</td>
</tr>
<tr>
<td>Calming/verbal de-escalation</td>
<td>39 (12%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical indications for seclusion*</th>
<th>Seclusion Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault</td>
<td>37 (11%)</td>
</tr>
<tr>
<td>Aggression</td>
<td>140 (43%)</td>
</tr>
<tr>
<td>Destruction of property</td>
<td>25 (8%)</td>
</tr>
<tr>
<td>Deliberate self harm</td>
<td>13 (4%)</td>
</tr>
<tr>
<td>Personal safety</td>
<td>78 (24%)</td>
</tr>
<tr>
<td>Over stimulation</td>
<td>38 (11%)</td>
</tr>
<tr>
<td>‘Agitation’</td>
<td>39 (12%)</td>
</tr>
<tr>
<td>AWOL (absent without leave) risk</td>
<td>25 (8%)</td>
</tr>
</tbody>
</table>

*Most episodes had more than one prior intervention or indication documented.
Figure 1. Frequency histogram of the timing of seclusion.
What did we learn?

- The first seven days represent the highest risk
- We use physical restraint
- We rely too much on medication
- Evening risk
What changed?

- Heightened awareness especially evening - staffing
- Restraint minimisation plan for every patient
- Sensory modulation room
<table>
<thead>
<tr>
<th>Date</th>
<th>07.03.2015</th>
<th>Assist patient to deescalate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues /Problems</td>
<td>Restraint minimisation</td>
<td></td>
</tr>
<tr>
<td>Treatment /Intervention</td>
<td>- Make a plan with [redacted] at the beginning of each shift, allowing him to have input into how his day (shift looks), factor in 1-1 time, relaxation time, time for escorted walk, meeting times, sensory room times, time to do his art, time to talk to parents/siblings, offer chaplain time etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>When becoming agitated (signs, pacing, becoming tense, raising voice) - Spend 1-1 time with [redacted], - Listen and validate his concerns,</td>
<td></td>
</tr>
</tbody>
</table>
CAF Inpatient Unit

24 patients out of 108 (22% of those admitted) used the sensory modulation room

- **Before:** 3.2 per 100 treatments days
- **During:** 1.8 per 100 treatment days
- **After:** 1.4 per 100 treatment days
February – July 2015

- 1,575 Treatment Days
- 34% used sensory modulation room vs. 22%
- Seclusion Rate 3.4 per 100 treatment days
  1.0 (excluding time out)
Number of seclusion hours per year
Number of aggression incidents per year
What Options do we have?

Service Level - Alternatives to inpatient care

Unit Level – Environmental Manipulation and Design
  Alternative framework for reducing restraint and seclusion

Staff Level – Shaping Practice
  Preventing escalation
Service Level - Alternatives to inpatient care

- Crisis Resolution Teams
- Home based Treatment
- NGO provider partnerships
- Day Care
Unit Level – Environmental Manipulation and Design
Design Guide for the Built Environment of Behavioral Health Facilities

by James M. Hunt, AIA, NCARB and David M. Sine, ARM, CSP, CPHRM

Distributed by the National Association of Psychiatric Health Systems

www.naphs.org
Comfort rooms
Sensory items
Quiet zones
In-out flow
Safe Zones
Chill out rooms
e.g. Outdoor Areas:

Outdoor areas (e.g. enclosed courtyards, fenced areas adjacent to the treatment unit, or simply an open campus) are considered to be of great therapeutic benefit.

Levels of staff supervision for patients using outdoor areas may vary widely between facilities or even between different groups using the space at any given facility and should be carefully reviewed by the facility and be dependent on the acuity and assessment of the most acute patients using the area.
Promote a Safe hospital Environment

Encourage and Promote Courteous Interactions
Pay Attention to Behavioural Warning Signs
Develop and update personal safety plans
Consider Objects That Could Be Used as Weapons
Practice and Promote a Team Approach
Assess Your Environment
Introduce Safety Protocols and ensure they’re followed
Unit Level - Alternative Framework
Unit Level - Alternative framework for reducing restraint and seclusion

Innovations: Child & Adolescent Psychiatry: Use of Collaborative Problem Solving to Reduce Seclusion and Restraint in Child and Adolescent Inpatient Units

Ross W. Greene, Ph.D.; J. Stuart Ablon, Ph.D.; Andrés Martin, M.D., M.P.H.

http://dx.doi.org/10.1176/ps.2006.57.5.610
The most common antecedent for assaultive behaviour in child inpatient units is some type of redirection or limit setting by staff.

Ryan et al 2004

Table 5. Reported antecedents for assaults of staff by patients at a state inpatient psychiatric hospital for youths (N=215 assaults)

<table>
<thead>
<tr>
<th>Antecedent</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Hands on” for escort or restraint or redirection</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Request, direction, or command potentially viewed by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the patient as limit setting or as coercive</td>
<td>147</td>
<td>68</td>
</tr>
<tr>
<td>Frustration identified but seemingly unrelated to staff’s</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>commands, requests, or limit setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer-provoked aggression seemingly displaced onto staff in the area</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>(no staff redirection noted before the assault)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For “no reason” or “out of the blue”</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>Unclear or not specified</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>
Cognitive Behavioural Approach based on the theory that:

Young people engage in aggressive behaviour due to

1. Lack of flexibility
2. Lack of ability to tolerate frustration
3. Lack of problem solving skills
Shifting the emphasis away from “You have to comply” to “We have a problem”

Behaviour Managers vs Active Participants
Objectives

- Identify the cognitive factors that contribute to aggressive behaviour
- Be mindful of the three options (impose, remove, collaborate) and their impact on behaviour and relationship
- Become proficient in solving problems collaboratively
Example

Work with **Interests** instead of **Positions**

1. Generally, behind every interest there is more than one solution that will satisfy it.

2. In identifying underlying interests, we may be able to uncover more shared interests between the parties than conflicting ones.

3. Shared interests are not obvious when working with opposing positions.
In the process of identifying interests, look for what Fisher and Ury call the "bedrock concerns which motivate all people".

These are basic human needs and include:

- Security
- Economic well-being
- A sense of belonging
- Recognition
- Control over one’s life
Example

**Understand** the other side’s **Perceptions**

Perception is . . .

Our interpretation of our world and our experiences

Impacted by our values, beliefs, fears, and desires

Unique to everyone
Understanding perceptions is important

It is the differences in people’s perceptions that cause conflict

Understanding how people perceive themselves and the world around them is the key to understanding their behaviour

Understanding people’s perceptions will help open ways to finding solutions.
We can help others tell their stories by using effective communication and reflective listening skills to draw out all aspects of the situation as they perceive it. For example:

Is it accurate to say that your priorities are . . .

Am I understanding you correctly when I say . .

Is there something you feel I don’t understand?
At Staff Level – Shaping Practice

“Listen to the patients, they’ll tell you what you need to know.”

-- J.J., Safety Officer,
Greystone Park State Psychiatric Hospital,
New Jersey
Children’s views on restraint
Reported by the Children’s Rights Director for England
‘There’s no such thing as the best way to do it’

‘Talking winds me up’

‘Only do it carefully’

‘There should be sanctions, not restraint’

‘There’s no such thing as the best way to do it’

‘Things build up and get out of control’

‘It’s just supposed to calm you down, not hurt you’

‘If you can smash something then you can do something worse’

‘You can break something if you do it slightly wrong’

‘If you know the situation is going to wind a young person up, then don’t create the situation’
- Separate young people from each other.
- Staff should not scream at children.
- Let young people walk away to calm down on their own.
- Understand the different ways to calm each young person down.
- Keep talking calmly, in a calm voice, and try to communicate well.
- Persuade them to calm down.
- Reward good behaviour.
- Talk with the child (perhaps over a cup of tea).
- Send a child to another room for time out.
- Try to solve whatever problems are leading to the need for restraint.
- Disengage from the situation so that it does not escalate.
- Help children to express their feelings in different ways.
- Give children time.
- Use activities to help people calm down.
- Let the child talk to their keyworker or social worker.
- Let a friend try to calm the child down.
- Let the child walk away from the situation.
What types of restraint shouldn’t be allowed?

- The ‘single wrap’ or ‘sleeper hold’ because they can stop the child breathing
- Holding the child face down on the floor
- Holding the child face down on the floor with knees on their back
- Hurting by holding the wrists
- Dropping a child to the floor with a foot behind their knee
- Dropping a child on to their back – they are likely to hit their head, especially dangerous on a hard floor or stairs
- Holding around the neck
- Grabbing arms and pulling them painfully across you
- The ‘basket hold’ – because it hurts and still allows the child to kick or head butt the person restraining them
- Putting your full weight on to a child
- Sitting on a child
- Using handcuffs
- Moving a child around on the floor
- Putting a child’s arm up their back
- Grabbing a child’s hair
- Anything involving the child’s face
- Restraining anywhere where it is dangerous to do it (for instance, near to the top of the stairs)
- Any sort of restraint that leaves marks on the child
- Restraint that involves touching people’s private parts
- Restraint that involves holding a child too tightly
- Restraint that damages the child’s dignity
- Use of things like pepper spray
Are there any children who should never be restrained?

- disabled children
- very young children
- children who have mental health issues
- children who had only just come into care
- children who have been sexually abused
- children with some medical problems

no one thing works for everyone – it all depends on the individual
At Staff Level - Preventing escalation

- De-escalation techniques are not natural.
- We are driven to freeze, fight or flee when scared; in de-escalation, we can do none of these.
- Reasoning with an enraged person is not possible.
- The core objective is to reduce the level of arousal so that a discussion becomes possible.
Safety Precautions

- Take a position just outside the individual's personal reach (out of arm's reach) on the non-dominant side.
- Maintain an open posture.
- Keep the individual in visual range.
- Make certain the room's door is readily accessible; avoid letting the individual get between you and the door.
- Summon help if the individual's aggression escalates to violence.
- If other patients are in the vicinity, ask them to leave the room to decrease distractions and protect the person's dignity.
Assess the situation promptly. If you see signs and symptoms of a person entering into crisis, intervene early. Maintain a calm demeanour and voice. Use problem solving with the individual -- ask "What will help now?" Be empathetic. Reassure individual that no harm will come to him or to others. Avoid an argumentative stance. Offer to help. Engage the individual. Use stress management or relaxation techniques such as breathing exercises. Don't crowd the individual; give him or her space. Be aware of yourself -- your look, your tone. Offer choices. Use open-ended questions. Give the individual time to think. Decrease the tension with relaxation techniques. Ignore challenges; redirect challenging questions. Tell them what you can do to help them.
Allow venting.
Allow pacing.
Don't say "you must."
Avoid power struggles.
Set limits and tell them what the expectation is.
Be careful with your nonverbal behaviours.
Be aware of the individual's nonverbal behaviours.
Be clear; use simple language.
Language -- follow the rule of 5 (no more than 5 words in sentence, 5 letters in a word -- eg, "Would you like a chair?")
Use reflective technique -- "Am I hearing you?"
Agree to disagree.
Be willing to break the rules.
Consider using sensory modalities such as weighted blankets or calming rooms with stress reduction tools.
Contrary to what many individuals believe, decreasing the rate and duration of seclusion and mechanical restraint use in psychiatric hospitals does not lead to more staff injury; in fact, it may actually reduce staff injuries.

When the use of seclusion and restraint is high, injuries tend to be high because the act of applying restraints is itself physically dangerous to staff members and because the coercive nature of the measure tends to elicit a more aggressive response.
Final thought

- Harm in restraints and seclusion are well documented; positives are not substantiated
- Biases exist in the system based on gender, ethnicity and diagnosis
- Restraint and Seclusion are not evidence-based practice
- The worst punishment possible in prisons is seclusion/solitary confinement
- There are very promising alternatives
- Significant culture and thinking change is required to achieve a zero target
- Can we do it?
TOMORROW IS A NEW DAY.
WE CAN DO IT! YES WE CAN!