Nurses’ experiences of seclusion and restraint use in acute old age psychiatry inpatient units

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Background

- Restraint (limitation of person’s freedom through physical, chemical, environmental or psychological means) and seclusion (confinement alone of individual in locked room)
  - harmful to elderly patients; usage controversial (Mohr, Petti, & Mohr, 2003; Moylan, 2009; Patterson & Grant, 2003).
  - Usage contrary to international recommendations (Sailas & Wahlbeck 2005), government reports, mental health service policies, and scholarly literature advocate that, as strategy to deal with disturbed behaviour:
    - Should be used as little as possible or eliminated.
    - Little rigorous assessment of use of restraint and seclusion.
- Cochrane Collaboration reviews of restraint and seclusion (Sailas & Fenton 2009) and containment measures (Muralidharan & Fenton 2009)
  - Concluded non-pharmacological approaches to restraint and seclusion not supported by evidence from controlled studies.
Usage can have adverse effects on elderly patients in particular.

Restraint more commonly used with these patients than seclusion.

Much of focus on minimising or eliminating use of restraint and seclusion

- adolescent and adult psychiatry inpatient settings.

Little research undertaken into its use with elderly patients in acute aged psychiatry units

- Issue is complex.
Aim

- To understand nurses’ experiences of restraint and seclusion in short-stay acute old age psychiatry, with patients aged 65 years and older, and how these experiences underpin resistance to eliminating these practices.
Sample & recruitment

- Purposive sampling: mental health nurses (Inpatient & APATT)

- Inclusion criteria
  - Unit manager, Registered or enrolled nurse, psychologist, social worker, occupational therapist, or psychiatrist.
  - Employed full-time, part-time, or casual.

- Exclusion criterion
  - Nurses working solely at night and at weekends.
Design & method (larger study)

- Mixed methods study
  - Semi-structured, in-depth qualitative interviews
  - Retrospective document analysis of inpatient records relating to use of restraint and seclusion.
  - Survey (3 parts):
    - Demographic section
    - Essen Climate Evaluation Scale (EssenCES) (Schalast 2000)
    - Management of Aggression and Violence Scale (MAVAS) (Duxbury 2003)
Survey summary: Socio-demographic

- Sample size: N=85 (equiv. to 78%)
- Gender
  - Approx. 2/3 females (n=56, 65.9%)
- Age
  - Mean 43 yrs (SD=11.3)
  - Range: 24-62 yrs
    (Note. Missing data n=4)
- Country/region of birth
  - Australia 47.1% (n=40)
  - Western Europe 9.4% (n=8)
  - Western Asia 14.1% (n=12)
  - South-East Asia 28.2% (n=24)
    (Note. Missing data n=1)
Survey summary: Socio-demographic (contd.)

- **Profession**
  - Nurses: Over 88%
    - RN (n=52, 61.2%)
    - Enrolled nurses (n=23, 27.1%)
  - Medical & allied health: Almost 12% (n=10)

- **Duration professional experience MHS**
  - Mean 15 yrs (SD=10.8)

- **Unit distribution**
  - One 30.6% (n=26)
  - Two 25.9% (n=22)
  - Three 43.5% (n=37)
Summary of MAVAS findings

- No significant differences (p>.05)
  - Gender (e.g. overall: p=.27)
  - Country/region of birth (e.g. overall: p=.68)
  - Profession (e.g. overall: p=.56)
  - Duration of work experience (MHS) (e.g. overall: p=.25)
MAVAS and subscales analysis

- Significant differences (p<.05)
  - Age
    - Respondents older than 50 years had statistically higher MAVAS response than those aged 30 to 39 years (Mean 2.3 (SD=0.2) vs Mean 2.0 (SD=0.3))
    - Summary: Age - Respondents older than 50 years scores higher on overall MAVAS than those aged 30-39 years.
  - Education
    - MAVAS (overall), External and Management:
      - TAFE and Tertiary educated respondents gave statistically lower responses than High School educated respondents
      - Summary: Education - High school only educated respondents scored higher on overall MAVAS, external, situational/interactional and management than TAFE and tertiary educated respondents
Place of work

- Statistically significant differences between means:
  - Units 2 & 1 (Mean 2.4 (SD=0.3) vs Mean 2.2 (SD=0.2))
  - Units 2 & 3 (Mean 2.4 (SD=0.3) vs Mean 2.2 (SD=0.4))
    - No significant difference (at 95% Confidence Interval level) between means: Units 1 & 3

- Summary: Unit 2 respondents scored higher on overall MAVAS, external and culture/gender than other units
Focus of this presentation

- Semi-structured, audio-recorded, in-depth qualitative interviews with 39 mental health nurses
- Duration of interviews: 30-45 minutes.
- ‘Aide-memoire’ (Burgess 1984) or interview guide
  - Broad questions asked initially; responses probed
  - Sample of interview questions:
    - Tell me about your involvement with the use of restraint and/or seclusion.
    - What factors increase/decrease the likelihood of restraint and/or seclusion being used in aged psychiatry units?
    - What are the barriers to reducing or eliminating restraint in aged psychiatry units?
    - What practical and safe alternatives can be used to restraint and seclusion in aged psychiatry units?
Data analysis

- Smith and Osborn’s (2008) interpretative phenomenological analysis approach to analyse data
  - Data transcribed verbatim; read and re-read.
  - Transcripts coded and tentative transformation of codes into conceptual themes undertaken.
  - Preliminary themes clustered into groups of themes
    - those insufficiently grounded in data omitted.
  - More focused analytical and theoretical ordering of themes undertaken.
Results
Overview of themes

-One overarching theme: *lack of accessible alternatives to restraint and seclusion*

  - Three related themes:
    - *adverse interpersonal environment contributing to use of restraint and seclusion*
    - *unfavourable physical environment contributing to aggression and restraint and seclusion use*
    - *practice environment influencing the adoption of restraint and seclusion*

- Reflected participants’ experience of restraint and seclusion in units.
Lack of accessible alternatives to restraint and seclusion

- Decision to use restraint and seclusion not taken lightly
  - found these practices difficult to implement
  - often felt conflicted about their involvement
- Restraint and seclusion in their unit did not need to be improved:
  - “because we are doing a good job of it” (Interviewee 3.7).
- Believed had no better, accessible alternatives.
  - “It is necessary in controlling them [patients]. … for the time being, it’s the only thing to protect the staff and other clients” (Interviewee 1.11).
  - “I don’t know why we have to improve because we don’t like using them [restraint and seclusion], but there’s nothing we can do” (Interviewee 1.3).
Adverse interpersonal environment contributing to restraint and seclusion

- Adverse interpersonal environment — behaviours of, and relationships between, patients and staff — important consideration with restraint and seclusion.

- Patient aggression identified as main reason for restraint and seclusion:
  - “this is like a prison; if there are aggressive and violent people, there is a need for it” (Interviewee 3.10).

- Patients and staff regarded at risk from aggression and, therefore, need protection from harm through restraint and/or seclusion use:
  - “It prevents patients from hurting other people and staff” (Interviewee 3.5).
Adverse interpersonal environment contributing to use of restraint and seclusion (contd.)

- Poor staff-to-patient interpersonal relationships contributed to patient aggression
- Failing to listen to or meet patients’ needs may result in patients resorting to aggression in order to be heard:
  - “When a patient is angry, we, as nurses, are not listening, we must find out what is happening” (Interviewee 1.8).
- Staff responding inappropriately or insensitively to patients
  - leads to escalation of behaviour:
    - “Even some [staff] are not the best in talking to [patients] and they can escalate the situation” (Interviewee 2.2).
- Cultural differences and insensitivity leading to misinterpretation of patients’ behaviour as aggressive:
  - “We might have a nurse from another country and we have an Italian patient that uses his hands in explaining something and the nurse can perceive it as being violent. … Staff are not tuned into different cultures” (Interviewee 2.2).
Unfavourable physical environment contributing to aggression and restraint and seclusion use

- Influenced initiation or exacerbation of aggression and decision to adopt restraint and seclusion.
- Units described as noisy, crowded environments with patients being unable to avoid noise and stimulation:
  - “The layout of the unit is not good; it’s too noisy, with the TV, radio and dishwasher going at the same time.” (Interviewee 2.2).
- Some patients requested seclusion in order:
  - “to be left alone from the others” (Interviewee 2.1).
Unfavourable physical environment contributing to aggression and restraint and seclusion use (contd.)

- Having space where patients could go, either of their own volition, or being placed there for a short time by staff, such as in a low stimulation area (LSA) or high dependency unit:
  - identified as effective alternatives to restraint and seclusion.

- Absence of alternatives approaches affected adversely nurses’ use of these practices
  - Reduced nurses’ options for addressing aggressive behaviour:
  - “My reaction to seclusion is actually to separate them [aggressive patients] from other patients, but there’s no other place to send them” (Interviewee 2.3).
Practice environment influencing the adoption of restraint and seclusion

- Practice environment influenced decision to use restraint and seclusion.
  - Included policies about use of these measures,
  - low staff-to-patient ratios,
  - level of care need and gender mix
  - emphasis on providing a safe environment for patients and staff.

- Claim that restraint and seclusion used infrequently and as a last resort, in accordance with government policies:
  - “Restraint and seclusion ... is the last resort option; we make a lot of decisions about options before we seclude” (Interviewee 1.12).

- Within this framework, participants generally believed they were using these measures appropriately and no changes needed to their practice (as highlighted earlier).
Practice environment influencing adoption of restraint and seclusion (contd.)

- Ability to manage patients within framework of using restraint and seclusion as last resort dependent on:
  - Staff-to-patient ratio
  - Staff education
  - Staff clinical experience

- Having sufficient numbers of well-educated and experienced staff important in reducing usage:
  - “We don’t use seclusion here often; we try not to. Not because there are few aggressive clients but because we seem to manage well. We have very good experienced staff in the unit” (Interviewee 1.10).

- Conversely, shortage of staff, insufficiently educated and experienced staff could increase usage:
  - “The disadvantages are shortage of staff and less experienced staff. That is part of the reason that we use restraint if [patients] are disturbed” (Interviewee 1.8).
Practice environment influencing adoption of restraint and seclusion (contd.)

- Patients’ level of care needs affected usage.
  - Higher level need patients seen as inappropriately admitted to units, or too many admitted, when units were deemed unsuitable for caring for these patients within constraints of physical environment and staffing levels:
    - “[Restraint and seclusion use] could be [because of] staff pressure when short of staff and there’s many clients with challenging behaviours” (Interviewee 1.15).

- Patients’ age and diagnosis influenced usage.

- Reluctant to use these measures on frail elderly or those with dementia:
  - “If you reflect on the situation, I don’t think any staff should lock them up in the room; they are elderly and frail” (Interviewee 1.11).
Providing safe environment central to participants’ understanding of their practice
- restraint and seclusion regarded as vital tools to meet this goal:
  - “Safe environment is the top priority” (Interviewee 1.4).

Conversely, participants aware of potential for usage to have adverse impact on patient and staff safety.
- Could increase potential for physical injury to frail, elderly patients and to staff:
  - “Sometimes there could be injuries to clients and staff” (Interviewee 1.11).
- Adverse physical, emotional and psychological impact of usage on the patient, staff and other patients:
  - “It causes physical and emotional trauma for the individual and staff” (Interviewee 1.11).
Limitations

- Findings cannot be generalised to other old age psychiatry inpatient units
  - however, themes are applicable in similar situations (Polit & Beck 2010).
- Recruitment of staff working during weekdays
  - however, most staff accessible during these time periods because of rotation between day and night and between weekday and weekend work.
- Sample did not include inpatients/former inpatients (not well enough) or family carers
Conclusions

- Study provides new insights into contentious issues of restraint and seclusion
  - provides in-depth exploration of contextual influences underpinning resistance to reducing or eliminating these practices.
  - Contextual influences need to be addressed if there is to be meaningful and sustainable reduction in, or elimination of, these practices.

- Findings highlight policies advocating minimal use or elimination of these measures cannot take place in vacuum
  - need to be accompanied by appropriate education and support,
  - consideration of ethical and workplace cultural issues concerning these practices
  - introduction of comprehensive initiatives to address aggression.

- More research needed to evaluate effectiveness of alternatives to restraint and seclusion
Thank you.