Restrictive Practice:

a scoping report to understand staff experience

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Oxford Academic Health Science Network
Authors: Katie Lean and Nigel Sims

NHS
Central and North West London
NHS Foundation Trust

Oxford Academic Health Science Network

Contents

Introduction

The Mental Health Safety Improvement Programme set out an aim to reduce the incidence of restrictive practice in inpatient mental health and learning disability services. As part of this programme, Oxford Patient Safety Collaborative collaborated with Central and North West London (CNWL) NHS Foundation Trust to undertake improvement work within a mental health ward in Milton Keynes. The aim of this scoping report sets out to understand the perspective of staff regarding restrictive practice in an acute inpatient mental health unit. For the purposes of the report the use of the term restrictive practice/restraint denotes the following: when a hand is placed on a patient, the use any restrictive manoeuvres, medication, or seclusion to control a situation for the safety of the staff or patients.

Background

In July 2019 NHSE/I launched the Patient Safety Strategy which highlighted safety as the biggest concern for mental health services. An aim was set to reduce restrictive practice by a third by April 2020 and an improvement collaborative formed. Following this, Patient Safety Collaboratives were commissioned to reduce restrictive practice in their regions by 50% by March 2024. These aims focused directly on reducing incidents for patients but what about staff safety? A study undertaken in Australia suggests that mental health nurses when faced with threatening situations, felt only moderately safe and that more research was needed to ensure staff safety (Gerace et al, 2018). They go on to suggest that more experienced staff are less likely to use restrictive practices. Additionally, when surveyed, many practitioners felt uneasy with the use of restrictive practice, particularly when trying to balance patient safety with patients' rights and less invasive procedures (Duxbury & Whittington 2005, Duxbury 2015). There are certain predictors that can increase the use of seclusion and restraint including, perceived anger among team members, more incidents of self-destructive behaviour in patients and insufficient safety measures in the workplace (De Benedictis et al, 2011).

Improvement work commenced in the ward in 2021 to reduce the incidence of violence and aggression which may lead to restrictive practice. Early January 2022, Oxford AHSN was asked to undertake a scoping exercise around staff perceptions on restrictive practice in their ward area. The aim was to understand the perceptions of staff surrounding violence and aggression and the impact that undertaking restrictive practice has on them.

Methodology

A mixed methodology for the evaluation was agreed by Oxford AHSN and CNWL NHS Foundation Trust.

Understanding the views of staff

To understand the key elements facing staff currently, data was collected from semi-structured interviews and an on-line survey.

Semi-structured interviews

All staff within the ward were sent an email inviting them to take part in semi-structured interviews. To reduce bias, coercion and preserve anonymity they registered interest directly to the lead evaluator at Oxford AHSN. This was followed up with an email from Oxford AHSN introducing themselves to participants (Appendix one). Four semi-structured interviews were undertaken with a range nursing staff (Appendix two).

Online survey

Intelligence gathered from the semi-structured interviews formed the questions used for the online survey and was shared with all staff (Appendix three). This was tested by the interviewees and agreed by the ward manager prior to circulation. The survey was sent via the ward manager and response rate of 42% was achieved over four weeks.

Findings

Who took part?

Between February 2022 and April 2022, a total of four staff were interviewed (12%) and fourteen completed the online survey (42%). There was a mix of staff who agreed to be interviewed ranging from salary grade 3 – 7. The online survey participants ranged from salary grade 1-3 (43%) to grade 6-7 (21%), as well as staff grade doctors (7%) (figure one).

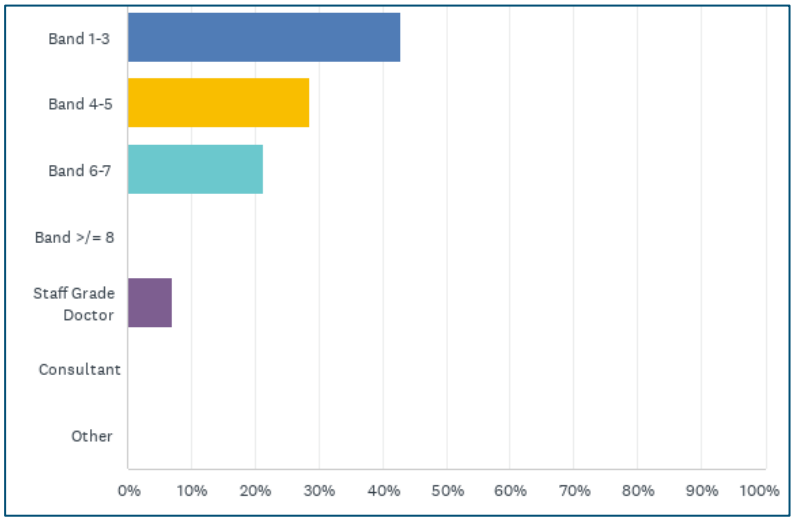


Figure One:
Salary grade of staff who completed the survey

Restrictive practice – before, during, after

All the interviewees had been involved in some form of restrictive practice. Breaking down the various types of practice, the survey demonstrated that 79% had been involved in physically restraining a patient, 71% in administering medication for sedation and 93% in the use of seclusion. In the previous two months to the survey being undertaken, 50% of staff had physically restrained a patient and 36% had administered sedation between one to three times (table one).

	% of staff involved in number of incidents in the **previous** 2 months		
Type of restraint	0 incidents	1-3 incidents	4-6 incidents
Physical	29%	50%	21%
Medication	50%	36%	14%
Seclusion	7%	64%	29%

Table One:
Number of incidents in previous two months

When staff need to use restrictive practice, 43% of staff surveyed noted that it was only sometimes clear who was leading the team opposed to 7% who stated it was always clear. A comment was noted that if there is not clear leadership in these situations then "staff can start to blame each other". Most staff agreed that these situations could be improved with clear leadership, role definitions and communication in the planning and implementation of the restraint. Following an incident staff can feel a mixture of emotions including sad, stressed, tired and numb (figure two).

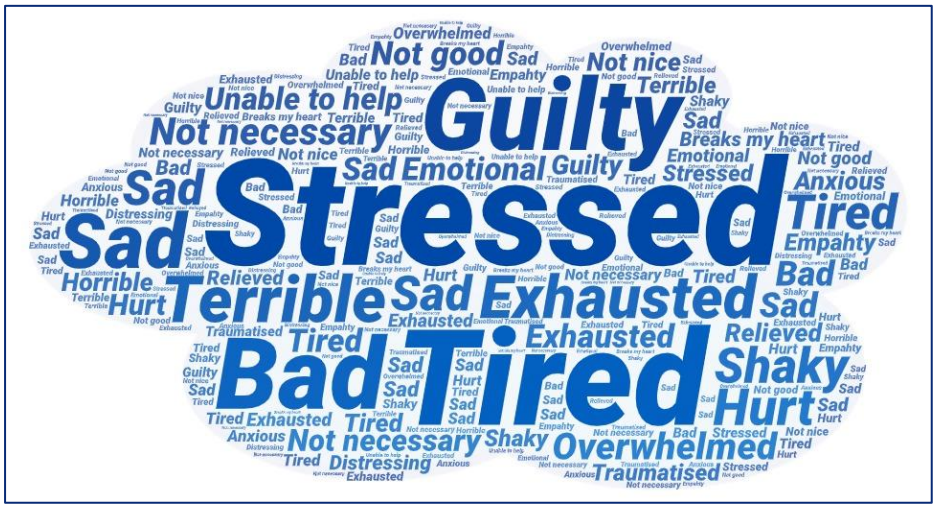


Figure Two:
Staff feelings post restraint incident

NICE (NG10) and hospital policy recommend that a post-incident review should occur within 72 hours of the event, with the main purpose to understand how to improve future practice. This was found to be erratic in occurrence. Fifty percent of staff noted that they rarely happened with the other percentage split between always (14%), Usually (29%) or sometimes (7%). Staff generally found these sessions of benefit for learning as well as an opportunity to check in with how staff are feeling. However, it was felt that it could be improved upon by removing any blame culture and including the individual who had been restrained.

"It can be a valuable learning opportunity as a team"

"For some it helps and for others they have their own coping mechanisms"

"Brings closure at times"

Reducing restrictive practice

Whilst observing what could be better when restrictive practice is necessary, all staff interviewed and surveyed agreed that their goal would be to continue to reduce the incidence. There was unanimous agreement that a reduction would ensue if there were more activities, staff to support the activities and structure to a patient's day. This was followed closely with time to talk, building meaningful relationships, listening, and ensuring consistency of staff rather than agency (figure three).

Figure Three:
How to reduce incidence of violence and aggression

There was a genuine desire to improve the situation in the ward environment for the benefit of both patients and staff. 36% of staff felt that they had little influence to make changes whereas 64% felt that they had some opportunity to improve the environment. No one felt that they were able to make none or every change. Whilst staff may feel energised to be part of positive change, they also feel exhausted, frustrated, disheartened, and stuck in a system where things remain the same.

"People are so busy getting the minimum done"

"We need to do the quickest thing rather than the best thing"

"No opportunity to move things forward in the service"

Key Themes

From the interviewees and the staff who participated in the survey the following key themes have been identified (Appendix four).

Communication

There is some evidence that improved communication may increase patient safety, yet certain communication tools are reliant on clear and effective interpersonal skills (Muller et al, 2018). Good communication skills can also help the patient become an active partner in care planning (Baby et al,

2019). Throughout interactions with staff, it became evident that there were three areas where communication could be improved.

Communication from staff to staff

Due to the current pressures in the ward the staff is often a mix of agency and contracted employees. It was felt that this may lead to miscommunication when understanding local policies and procedures. Common agreement was held that there was often a lack of leadership in a restrictive practice situation. This lack of communication can lead to staff starting to blame each other and brings confusion into the situation. De-brief sessions post incident although sporadic, were thought to be a beneficial learning opportunity for the team.

There are dedicated supervision sessions which each member of staff has on a regular basis. The majority felt these to be rushed or cancelled due to poor staffing levels. For a large proportion of the staff their supervisor is a direct line manager which can feel like they are being performance managed. A safe space with an independent supervisor was felt to be a more psychologically safe relationship.

Communication with medical staff was highlighted as something that could be improved to ensure a clear plan is documented and carried out for the patient. One idea for improvement was that there could be a more relaxed doctor presence on the ward with open communication.

Communication from staff to patients

There was a unanimous voice around the need to communicate and build relationships with patients. All highlighted the importance of having time to build a therapeutic relationship, plan and undertake activities with patients. It can become a challenge to provide these with multiple agency staff and staffing shortages, yet all agreed that with these in place, violence and aggression incidents would be reduced.

Communication to and from senior management

There was an undertone that senior management did not understand the ward environment and made changes without the input of staff who work there day in day out. If any ideas were offered, they were often rejected as "not possible". There was felt to be a burden of paper work which takes time away from patient care without much understanding as to why it was introduced or why it is necessary. A member of staff shared how difficult it was to get any time or response from senior managers. They noted that they were solution based but needed senior input.

"It would be nice to hear a genuine well done"

"Try to find some common ground with the patient – this comes from knowing them"

"I never go to anyone with a problem unless I've got a solution"

Create Space

Due to a variety of workload pressures whether it being a shortage of staff, increased agency staff presence or an increase in the complexity of patients; staff are under pressure. A mixture of responses were captured including feeling rushed, struggling, firefighting, no time to think and powering-through. This lack of space to think compounded the feeling of being under pressure. Staff who were interviewed were grateful of the space to share what they thought would work, wouldn't work and just time to breath. There was also a belief that patients needed space to explore what works for them in a safe environment including the use of sensory activities.

"If I had a few hours in the afternoon, I'd plan more activities – to do what they want to do, basketball, cinema …. we have a great big garden to use"

Conclusion

Improving patient safety through minimising the use of physical restraint, seclusion, or medication, means considering how the current system works and what changes are needed to reduce harm or injury to the patient (Bowers et al, 2015). Protection of staff's physical and mental health in such scenarios should not be overlooked as some can experience stress, lack of confidence and physical injuries (LeBel 2011). Some of these symptoms are already present in the ward staff interviewed/surveyed and a large proportion of staff are exhausted.

Whilst this may be the case it is not without hope and all who took part had ideas to improve the current situation (Appendix five). Working day to day in the ward environment gives staff the insight needed to see how to better manage situations and collectively own and understand the "why" behind each decision. What is lacking is space. Space to build relationships with patients and colleagues, to think about what the best course of action is and how to implement it.

Most participants valued the opportunity to talk to someone outside their workspace which highlighted the importance of supervision and such like being undertaken by a neutral person.

Improvement methodology can support small and large changes for the benefit of the staff and patients. However, it is less likely to sustain without the understanding and support of both.

Appendix One – Emails to staff

Dear Colleagues,

Your opinion matters

You may be aware that X ward is working to reduce the number of restrictive practice incidents. It is hoped that this will make the environment better for staff and patients. As part of this, an independent evaluation of staff's thoughts, concerns and ideas will be undertaken. This will capture what you feel is important and how these incidents effect you both personally and as a team.

Your ward manager has agreed for me to approach you to understand your thoughts around how you feel about the current working environment, and to gather your thoughts on what may work better. This would involve about 30 minutes of your time to talk honestly about what you think works well and not so well. This meeting will be confidential and held virtually.

We are looking to talk to a variety of people including clinical and support staff as all views are important. If you would be willing to spare 30 minutes of your time to talk to me, please contact me katie.lean@oxfordahsn.org, including your job role [support worker, AHP, nurse, doctor] and I will contact you directly. Your thoughts are valued so please do get in touch so that your voice can be heard.

Thank you for your time in considering this, it is very much appreciated.

Best Wishes

Email to staff who respond

Dear (insert name),

Thank you for agreeing to talk to me about restrictive practice in X ward.

Through talking to you it will help to gain an understanding of what works well, what does not and how it may affect you personally and as a team.

The call will be informal via Microsoft teams (if you have access to a computer) or by telephone and will take about 30 minutes. During the call I will ask you some questions but feel free to add in whatever you want around your thoughts on the service.

There are a few things I would like to let you know about regarding the final report and confidentiality of our conversation.

- Your response will be completely anonymous
- I would like to take notes during the conversation to ensure accuracy – this will be deleted at completion of the evaluation
- The summary of our conversation will only be seen anonymously by other members in the evaluation team and not shared any wider
- Your feedback will be included in a report which will be shared within your hospital and NHS England for wider learning. We will not name anyone in the report and will only refer to the number of people in total
- The report will describe the themes coming out of the conversations and we may use quotes, but again these would remain anonymous.

Please can you let me know what time and date is best to call you and would you prefer that call via Microsoft teams or telephone (if telephone please provide a number for us to call which will not be shared wider).

Thank you again for your time, we value your input

Best Wishes

Appendix Two – Semi-structured interviews

Introduction to interviews

Thank you for taking the time to talk to me about restrictive practice in Hazel ward. Your feedback is very valuable, and it will help us to understand how it affects you and the work you do. The Oxford AHSN team will review your feedback and use it towards a report that will inform your team around improving the environment for you and patients.

There are a few things I would like to go over with you about the interview, final report, and confidentiality of your interview.

- Your response will be completely anonymous
- I would like to take notes during our conversation to ensure accuracy, these will be deleted at completion of the evaluation
- The content of our conversation will only be seen anonymously by other members in the evaluation team
- Your feedback will be included in a report
- We will not name anyone in the report – we will just refer to the number of staff interviewed
- The report will describe the themes coming out of the interviews and we may use quotes from the interviews, but again these would remain anonymous.

Questions within the interview.

We want to ask all staff via a survey about restrictive practice. To make sure we are asking the right questions it's important for us to understand your experience of restrictive practice.

1. Tell me a little bit about yourself and how long have you worked in mental health care?
2. Thinking about restrictive practice – can you tell me a bit about your experience of restrictive practice
3. When you notice an escalation of a behavioural situation with a patient how does this make you feel?
4. Have you ever undertaken physical intervention techniques (restraint +/- rapid tranquilisation)? (Think about de-escalation, seclusion etc.)
5. How do you feel having undertaken physical restraint +/- rapid tranquilisation?
6. Do you think staff respond differently to different sorts of patients? e.g. when a member of staff has been involved in an aggressive situation with the same patient
7. Do you think different sorts of staff respond differently in a de-escalation situation? e.g. worn down tolerance threshold due to work or home
8. In your experience have you been involved in any sort of post incident review – tell me a bit about it? (what works/doesn't work)
9. What do you think works well at the moment and why? (Think team and personally)
10. If you could change anything to do with restrictive practice just now, what would it be and why?
11. Do you feel that Covid-19 has had an impact on restrictive practice?
12. Are you aware of any current work on your ward around restrictive practice? Can you tell me a little bit more about it and how you feel about it?
13. Is there anything else we haven't covered that you think is important?
14. Would you be happy to test the survey for me before I send it out to your colleagues?

Appendix Three – Survey questions

Introduction

Oxford Academic Health Science Network are working with your hospital to reduce the use of restrictive practice in Hazel ward. (We are using the term restrictive practice to mean when you put your hand on a patient, use any restrictive manoeuvres, medication, or seclusion to control a situation for the safety of the staff or patients).

It is important to understand how you feel now so that any changes that may be made are informed by your views. The following questions have been designed around the feedback from informal chats with some members of your team. We hope to capture more of the team's thoughts through this short survey which should take no longer than 10 minutes to complete.

The information we collect from this survey is anonymous. If you have any questions, please email katie.lean@oxfordahsn.org. Once the survey has closed, the information will be aggregated into an anonymised report which will be shared with the team and Central and North West London NHS Foundation Trust.

1. Have you ever been involved in physically restraining a patient? Y/N
2. Have you ever been involved in administering medication to sedate a patient (to control an escalating situation)? Y/N
3. Have you ever been involved in the use of seclusion with a patient (to control an escalating situation)? Y/N
4. In the last two months how often have you been involved in physically restraining a patient? (enter number)
5. In the last two months how often have you been involved in administering medication to sedate a patient (to control an escalating situation) (enter number)
6. In the last two months how often have you been involved in the use of seclusion with a patient (to control an escalating situation)? (enter number)
7. On a scale of 1-7 in your usual working day do you feel that you have enough time and resources to support patients?
   (1 = none of the time and resources, 7= all of the time and resources I need)
8. What do you feel would help you to be able to better support patients? (free text)
9. In your view would any of the below help to reduce the incidence of violence and aggression on the ward? Place in order of priority 1 = most important practice, 4 = least important (only use each number once)
    - Planned activities throughout the day
    - Spending more 1:1 time with individual patients
    - More doctor time/presence on the ward
    - Making a plan for the day with each patients

10. Are there things that would help to de-escalate a situation rather than use restrictive practice? (free text)

11. During a restraint situation, is it clear who is leading the team?
(Always, usually, sometimes, rarely, Never)

12. Is there anything that would make the situation better? (free text)

13. How do you feel after restraining a patient? (Free text)

14. Do de-brief sessions take place after restrictive practice?
(Always, Most of the time, Sometimes, Never)

15. What do you find most valuable from a de-brief session? (free text)

16. What do you find least valuable from a de-brief session? (free text)

17. Do safety huddles take place on your ward? (Y/N)

18. What do you find most valuable from a safety huddle? (free text)

19. What do you find least valuable from a safety huddle? (free text)

20. On scale of 1-7 how able do you feel to make changes to improve your ward environment? (1=I feel able to make changes, 7= I can't make any)

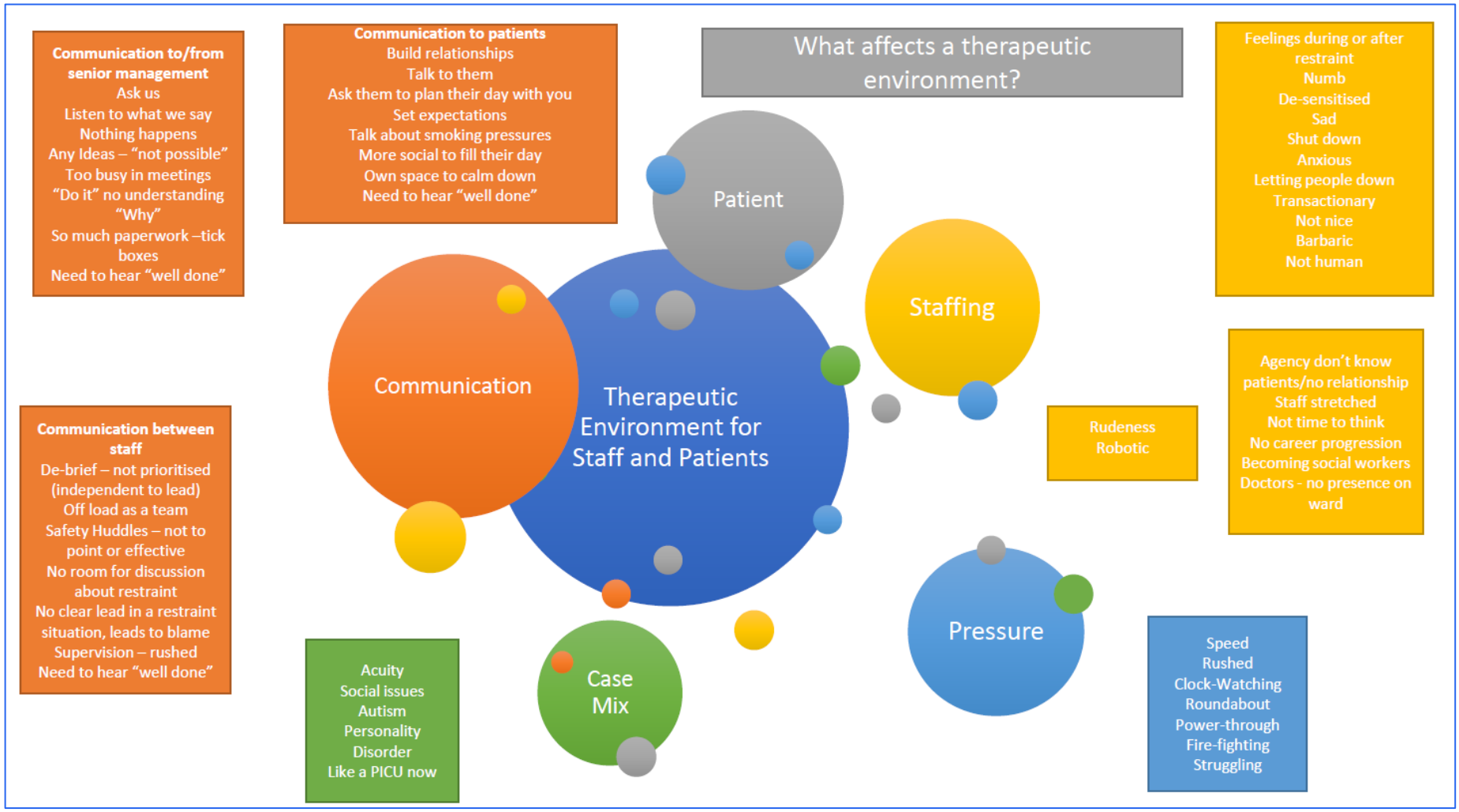
21. What three words currently describe how you feel in your place of work?
(Please enter as many words as you want to)

22. Is there anything else that you would like to add?
(free text)

23. What is your current job grade?
Band 1-3, Band 4-5, Band 6-7, Band ≥8, staff grade, consultant, other

Thank you for your time in this survey.

Appendix Four– Semi-structured interview themes



Appendix Five - Ideas to improve current ward situation

- Staff communication board
- Discharge coordinator and ward supporting patients jointly (3 days follow up)
- Protected time with psychologist (mandated)
- More doctor presence on ward – group session
- Informal ward rounds – more holistic
- Independent person to lead de-brief post incident not manager
- Develop ward video on restrictive practice through a patient's experience – interviewing staff to capture how it feels for staff and why it may happen
- Plan the day with patients – something to look forward to
- Use the gym more or garden
- Targeted skills drills – improve communication in a restraint scenario
- One page profile of the patient so that everyone knows what they like/dislike, what to do if they are distressed – humanise them. See outside of the diagnosis.
- Re-introduce plan of the day that patients attend to work with them and build a plan together.

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