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Nursing care process for releasing psychiatric inpatients from long-term seclusion in Japan: Modified grounded theory approach

Short running title: Releasing from long-term seclusion

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Abstract

Based on the modified grounded theory approach, this study aimed to elucidate the nursing care process used to guide psychiatric inpatients in long-term seclusion towards release from seclusion. Participant observations and interviews were conducted with a total of 18 nurses from three chronic psychiatric wards at two institutions from September 2011 to November 2012, to collect data on the nursing care they provided for psychiatric patients in long-term seclusion. Consequently, four categories and 15 concepts were extracted. The nurses viewed ‘a mature therapeutic environment that utilizes flexible apportionment of care’ as the foundation (i.e., the core category) in guiding psychiatric inpatients towards release from long-term seclusion. The results revealed a care structure in which nurses in such a treatment environment provided care by flexible apportionment of three types of care: ‘care aimed at avoiding mental and physical exhaustion’, ‘standardized care that does not confer a disadvantage to patients’, and ‘immediately responding to prevent problematic behaviors’.

Keywords: chronic psychiatric ward, modified grounded theory approach, psychiatric nursing, schizophrenia, seclusion

Introduction

Seclusion of patients at psychiatric hospitals in Japan is undertaken in accordance with mental health and welfare law (Mental Health and Disability Health Division, 2012a). The policy is to minimize seclusion as much as possible. Nevertheless, the confinement period in seclusion rooms of psychiatric wards in Japan has been lengthening markedly. According to a fixed-point survey of psychiatric hospitals in the nation, while the number of inpatients decreased from 326,125 in 2004 to 308,615 in 2010, the number of seclusion events rose each year over the same period, increasing from 7,673 (2.4%) in 2004 to 9,132 (3.0%) in 2010 (Mental Health and Disability Health Division, 2012b). In a survey of 152 acute psychiatric wards of 24 hospitals in Japan, the average length of seclusion was 12.5 days, whereas seclusion ranged from a few hours to 55 hours in other countries. Moreover, 35.9% of new inpatients in Japan were secluded. These rates are two to four times higher in countries such as Germany, Switzerland, and Australia (Noda et al, 2009).

Despite the existence of such treatment environments, nurses working on acute psychiatric wards are reported to provide care to avoid patients' distress resulting from seclusion by deciding whether to prioritize the patients' will or safety, and to develop rapport with their patients (Enokido, 1998; Fukuda, 2008). Also, nurses support and encourage their patients' strength for recovery (Yoshida et al, 2009). Therefore, we hypothesized that nurses who have substantial experience working in seclusion rooms have developed the requisite skills needed to enable difficult-to-treat patients to be released from seclusion. It would be clinically valuable, therefore, to theorize the care process that leads to the release of such patients from seclusion.

Literature Review

Nurses perceived patient seclusion as a way to maintain safety for patients and nurses (Muir-Cochrane, 1996; Nagai & Kume, 2004). Nurses regarded seclusion as a useful therapeutic method for removing stimuli or recovering patients' self-control (Muir-Cochrane, 1995; 1996). However, patients perceived seclusion as punishment and ineffective (Meehan et al, 2004). Patients placed in seclusion rooms experienced an increase in negative emotions, including fear, anger, sadness, shame, and abandonment (Holmes et al, 2004). Also, nurses were concerned that seclusion infringed upon patients' rights (e.g., freedom, dignity, and autonomy) (Muir-Cochrane, 1995).

Therefore, in order to achieve early release from seclusion, psychiatric nurses must utilize alternative approaches to seclusion and endeavor to foster self-control among patients (Wynaden et al, 2002; Larue et al, 2010). Further, training nurses on preventive measures against violence and abusive language has been found to shorten the length of seclusion and foster consciousness-raising among nurses (Forster et al, 1999; Sullivan et al, 2004). Many other alternative approaches to seclusion have been used in practice, including time-out, special observation, and debriefing, and are reported to be useful in reducing behavioral restraint (Bowers et al, 2012; Stewart et al, 2012). However, some studies have found that these alternative approaches have no therapeutic effects (Rooney, 2009; Needham & Sands, 2010), and therefore they remain controversial to this day.

Study Aim

This study sought to elucidate the process of nursing care that nurses on psychiatric wards provided for psychiatric patients in long-term seclusion to guide them towards

release from seclusion.

Methods

Design

This study was based on the modified grounded theory approach (M-GTA; Kinoshita, 2007), which was developed by adopting the theoretical and content properties of the grounded theory approach (GTA; Glaser & Strauss, 1967), and then adding some modifications with an emphasis on practical applicability. It was founded on the theoretical perspective of symbolic interactionism (Blumer, 1969).

Major differences exist among GTAs. One difference is that raw data are analyzed according to an analytic theme based on the analytic target's viewpoint. The analytic theme and analytic target are decided on the basis of the research question chosen. Therefore, a clearly stated research question is of great importance in setting the analytic theme and analytic target in M-GTA analysis. Another difference is that raw data are not broken down into fragments for coding, making it possible to find the meaning of content that exists at the root of the raw data.

M-GTA was judged to be appropriate for this study because it aims to develop a theory within a limited scope (i.e., a care process for patients in long-term seclusion) and it focuses on the phenomena arising from social interactions between nurses and their patients, their peers (other nurses), and physicians.

Operational definition

"Seclusion" is a means of behavioral restraint where a patient is placed in a private

room from which he/she is not allowed to enter or exit at will. In "open observation," patients are released from seclusion for a period of the day and their symptoms observed. Both seclusion and open observation are implemented under the supervision of psychiatrists.

Participants

We contacted the administrators of the department of nursing at several psychiatric hospitals in one prefecture, and obtained information about the usage of their seclusion rooms. We found two hospitals that met the requirements, and provided information about the research plan to nurses there with more than 5 years of working experience on chronic psychiatric wards with seclusion rooms. Eighteen nurses consented to participate. In addition, inpatients cared for by the study participants were required to have been placed in seclusion rooms for a total of 30 or more days in the 3 months prior to the observation date. In Japan, a "chronic ward" refers to a ward for long-term care. Approximately 80% of patients were diagnosed with schizophrenia and had stable symptoms, and nurses on these wards provide self-care management, recreation therapy, and group therapy with a goal to discharge. Nurses and psychiatrists discuss the need for seclusion at a weekly meeting, and nurses hold a daily nursing meeting to discuss the degree of patient recovery and the possibility of temporary release from seclusion.

Data collection

We conducted participant observations and semi-structured interviews from September 2011 to November 2012. Total participant observation time was 97 hours. First,

we observed the interactions between the nurses and patients, and recorded their reactions to each other's behavior, facial expressions, gaze, and tone of voice among other observations in field notes. We stood behind the participants while observing them interact naturally with the patients. After participant observation, in a semi-structured interview, we asked each participant to look back on his/her interactions with the patients since their first meeting and comment on the objectives for nursing care to achieve the patients' release from seclusion, as well as on the collaborative relationship with physicians when deciding to use seclusion. The interviews were recorded on an IC recorder and later transcribed verbatim.

Data analysis

In this study, the analytic theme was set as the "nursing care process to guide patients towards release from long-term seclusion", and the analytic target was set as the "psychiatric nurses who work with psychiatric patients in long-term seclusion". The M-GTA analysis procedure was as follows:

1. We used an analysis worksheet with four columns: examples, theoretical notes, concept definition, and concept name. We used one worksheet to generate one concept. First, we selected interview or observational data related to the analytic theme and recorded them in the example column. Next, we described the reason we chose these data and how we interpreted the content of the examples, and recorded this information in the theoretical notes.

2. We used comparative analysis to examine other similar/opposite examples.

3. We aimed to find a common meaning among the many examples; for coding, we

described the concept definition and the concept name in a short statement.

4. Once we generated multiple concepts, we initiated the process to examine the inter-concept relationships to clarify their directionality and generate a category under which these concepts fell.

5. We developed a schematized diagram of the relationship between concepts and categories, and formulated a core category.

6. We judged that theoretical saturation had been reached when no additional concepts could be generated and when available concepts and categories were deemed sufficient to explain the phenomena described by the analytic theme.

Rigor

To ensure clarity and confirmability (Lincoln & Guba, 1985) of the study process, the entire procedure of the present study—from formulation of the research theme through data analysis—was conducted under continuous guidance from a supervising professor who has expertise in qualitative methods as well as cumulative clinical experience related to the research theme. In addition, various researchers with experience conducting the M-GTA advised on the interpretation of meaning. The study was conducted with the approval of the Medical Ethics Committee of Kanazawa University.

Ethical considerations

Participants were informed that study participation was voluntary and that they could discontinue participation at any time during the study. During participant observation, we decided not to become actively involved with the patients because they were easily upset

due to their symptoms, and had poor self-management and self-determination skills. Therefore, we first obtained consent from their primary care physicians regarding the feasibility of this procedure for the patients. Next, using simple words to inform the patients about our study, we obtained their verbal consent. We discontinued participant observation immediately when exacerbation of a patient's symptoms was anticipated. Participant anonymity was carefully ensured. The study was conducted with the approval of the Medical Ethics Committee of Kanazawa University (Acceptance number 282).

Results

Participant characteristics

Table 1 summarizes the characteristics of the 18 participant nurses. Table 2 summarizes the background characteristics of the patients cared for by the participants. Patients were admitted to the hospitals from 1.5 to 11 years because of poor medication effects, continuing verbal abuse or violence, or persistent difficulties with other patients. One patient had comorbid intellectual disability. Another patient had been secluded twice during the past 3 months, once for 18 days and later for 21 days. Four patients had been secluded for over 30 consecutive days. For the last seclusion episode, the minimum stay was 21 days and the maximum stay was 768 days.

Storyline

First, the storyline will be summarized using the concepts and categories developed from data analysis, then the relationship between the concepts constituting each category will be explained (results are shown in Figure 1). Four categories and 15 concepts were

extracted as constituents of the nursing care process to guide psychiatric inpatients towards release from long-term seclusion. Hereafter, categories will be denoted within single quotation marks.

In guiding psychiatric inpatients in long-term seclusion towards release from seclusion, the nurses viewed **'**a mature therapeutic environment that utilizes flexible apportionment of care**'** as the foundation (i.e., core category).

In this treatment environment, the nurses provided care by flexible apportionment of three types of care: **'**care aimed at avoiding mental and physical exhaustion' (category 1), **'**standardized care that does not confer a disadvantage to patients' (category 2), and 'immediately responding to prevent problematic behaviors' (category 3) through interactions with patients, other nurses, and physicians to achieve release from seclusion. Nurses developed a team-based approach capitalizing on unique roles and constructed an equal footing with physicians. Furthermore, they sought to detect the feasibility of release from seclusion via strengthening tolerance to stimuli among the patients and guiding them towards stability for release.

In category 1, gaps in the intent and timing of care that arose hampered two-way communication, resulting in difficulty controlling behavior due to spiraling demands and repeated experiences of difficult-to-avoid problematic behaviors. Recurrent problematic behaviors resulted in more obstacles against ideas for treatment improvement.

In category 2, nurses estimated the risk of problematic behavior by evaluating the relative risk of harm to others, and resorted to supplementing manpower risks with management by seclusion**.** In addition, using rewards and punishments, problematic behaviors were managed by seclusion to foster experiential self-reflection for strengthening

tolerance to stimuli.

In category 3, nurses attempted to better understand their patients by considering the patients' viewpoints**.** The nurses also helped patients express their wants and needs on their own initiative by devising creative approaches to generate two-way communication. The nurses further strengthened tolerance to stimuli by diverting attention from pathological experiences and building self-determination.

Core category and concepts

Core category: 'a mature therapeutic environment that utilizes flexible apportionment of care'

Nurses provided care by flexible apportionment of three types of care: care aimed at avoiding mental and physical exhaustion, standardized care, and immediate response care. Nurses did so to repress problematic behaviors, minimize seclusion, and preserve their own mental and physical well-being.

A team-based approach capitalizing on unique roles

Each nurse played various roles when interacting with the patients. For instance, they played family roles, including supportive mother, strict father, and amiable friend, which is thought to help improve patients' social skills.

I strictly told him, "You must not be violent! Because you are violent with others, you cannot go out. Some of them were injured!" After that, he looked very sorry. (Participant A)

He embraces nurses who are familiar with him. He is only open to nurses who are like

real friends to him. (Participant B)

When he needed me, I wanted to meet his demands. I think it is important whether I can respond in a timely manner. (Participant C)

Equal footing with physicians

Nurses were building an equal relationship with physicians. Nurses discussed the need for a patient's seclusion based on sufficient data they obtained from their continuous observation.

I sometimes tell physicians, "We discuss such things at the nurses' meeting. What do you think of our idea?" Physicians have never said, "It is useless." They understand that nurses continue to observe all the time. (Participant G)

Strengthening tolerance to stimuli

Nurses brought about the capacity to adapt to the surrounding environment by exposing patients to environmental stimuli. Thus, nurses try to expand time for open observation.

We make time for observations in order to increase a patient's capacity to gradually tolerate surrounding stimuli. I want to try to open the door, but without being unreasonable. (Participant F)

Guiding to become stable for release

Nurses expanded those aspects of patient behavior and social function leading to release from seclusion.

Her mood was a little different. At the open observation when we were taking her to the shop, she spoke to other patients. It seemed somewhat social. (Participant Q)

Categories and concepts

Category 1: 'care aimed at avoiding mental and physical exhaustion'

The nurses were mentally and physically exhausted by the patients' problematic behaviors. As a result, nurses resorted to distancing themselves from the patients while maintaining treatment interventions. Because nurses often experienced patients' violent and problematic behaviors, they would meet the patients as they entered and exited the seclusion room.

Gaps in the intent and timing of care

The patients' condition did not coincide with the time period during which the nurses wanted to intervene. Nurses would encourage the patients to participate in some activity, but often at a time when the patients were unresponsive.

He hardly ever expresses his opinions and emotions. He would only say something like, "I don't care." And I believe that if he expressed himself a little more, he would make more progress. (Participant H)

Difficulty controlling behavior due to spiraling demands

Nurses recognized that patients' demands could become excessive, for example, while going for a walk and when wanting a preferred item, which required more intensive involvement from the nurses.

He regarded me like a mother because he thought that I would accept whatever he said. So, he would persist with a request. (Participant B)

Repeated experience with difficult-to-avoid problematic behaviors

Nurses repeatedly faced difficult situations that they needed to prevent in order to avoid problematic behaviors. Nurses felt it was difficult to detect signs of imminent problematic behaviors.

He could not understand the borderline between reality and delusion. When he was delusional, he became violent towards someone. Even if nurses were talking to another patient, he would say, "You were verbally abusive!" and proceed to use violence against another patient. (Participant G)

Other obstacles to developing ideas for improved treatment

Because of the patients' repeated problematic behaviors, nurses could not generate new ideas for expanding open observation in a safe therapeutic environment.

Actually, we believe that we should not seclude patients. We believe seclusion is a last resort, but we have no choice but to seclude patients. (Participant I)

Category 2: 'standardized care that does not confer a disadvantage to patients'

This category describes nursing care involving uniform assessments and interventions within the medical team, to calm the patients and prevent them from being disadvantaged in their social relationships.

Relative evaluation of risk of harm to others

Nurse assessments are always implemented relative to other factors because the risk of harmful action depends on the corresponding nurse and the presence of other patients.

When other patients started to eat, he stole food from them even if he was eating himself. We routinely stay with him because of the risk that he will take away their things. (Participant P)

Use of rewards and punishments

Nurses make it clear to the patients that problematic behaviors have consequences, and they strengthen adaptive behaviors. The purpose is to give preferred things for adaptive actions and to use seclusion for problematic behaviors.

He is especially motivated by food. Such things are a weapon for us. Using food leads to self-care or adaptive behaviors. (Participant A)

When problematic behaviors occurred, we didn't do an open observation for two days in order to allow him to reflect on what he did and to alleviate his symptoms. (Participant A)

Supplementing manpower risks with management by seclusion

Nurses continued to seclude patients at times when they lacked enough manpower to adequately observe them.

When he was excited and more impulsive, we cannot help but ask for another ward's staff. We must keep in check four or five people. (Participant B)

Category 3: 'immediately responding to prevent problematic behaviors'

Under this category, the nurses detect what patients want early, and adapt themselves to the requirements of the moment to maximally meet the patients' needs in order to prevent problematic behaviors.

Considering patient viewpoints

Nurses endeavored to consider patients' reactions to surrounding stimuli from the patient's perspective in order to understand the patients' thoughts and feelings.

We forgive a little noise from a patient, but he could not forgive. Because he is serious, when he wants to take a rest, he would become irritated. (Participant H)

Creative approaches to generating two-way communication

Nurses created an atmosphere conducive to allowing patients to express their needs and hopes easily.

I started with the simplest care, such as using nail clippers. The relationship was established gradually. What she says sounds like word salad, but I think she has been telling us something she wanted to express. (Participant Q)

Diverting from pathological experience

Nurses explored how patients can be diverted from pathological experiences.

When we did gymnastics, she was able to concentrate on it. Under these conditions, I could guide her to be with the other patients. (Participant N)

Fostering self-choice

Nurses set up encounters that gave patients the freedom to choose at will as much as possible in order to increase the patients' self-determination and self-representation.

First, I asked him, "There is the day room or that room, where would you like to eat?" Today, I had the impression that he could answer my question. (Participant K)

Discussion

One study found no relationship between staffing, rates of violent behavior and/or language, and the use of behavioral restraints (Bowers & Crowder, 2012). In the present study, even nurses with substantial experience working in seclusion rooms carried out 'care aimed at avoiding mental and physical exhaustion', and they used seclusion as 'standardized care' to supplement manpower risks. They worried that the patients' problematic behaviors could lead to a crisis situation in the ward. Especially at night, seclusion was needed to compensate for having only two staff nurses to care for 60 patients, as required in Japan. Our findings are supported by previous studies showing that nurses considered seclusion necessary to maintain the safety of patients and nurses (Muir-Cochrane, 1996; Nagai & Kume, 2004). However, some studies have suggested that nurses have ethical concerns about the use of seclusion dependent on nurse staffing levels (Muir-Cochrane, 1995; Kono & Kamigori, 2006). Also, in a care situation akin to category 1, Duxbury (2002) reported that patients recognized that poor communication with nurses caused aggressive behaviors. In this study, categories 1 and 2 included the issue of maintaining long-term seclusion to alleviate low manpower.

On the other hand, as in category 3, nurses with much experience working in seclusion rooms carried out bold ideas for improving patients' problematic behaviors and social skills. In this study, the nurses shifted from management-oriented care that places high value on nurses' viewpoints to a perspective that supports patient autonomy. One intervention study reported decreased rates of seclusion when using a novel approach that emphasized patient well-being and recovery (E-Morris et al, 2010). Other studies have found that nurses utilize positive alternative approaches other than seclusion to help patients regain self-control (Wynaden et al, 2002; Bowers et al, 2012; Larue et al, 2010; Stewart et al, 2012). The present study suggests that when nurses attempt to better understand their patients by considering their viewpoints and providing them abundant social opportunities, they come to recognize their patients' positive qualities, and gradually shift to care aimed at exploring the feasibility of release from seclusion.

The most intriguing finding of this study is that highly experienced nurses created a mature therapeutic environment that utilized the flexible apportionment of three kinds of care aimed at release from seclusion. A previous study in Japan suggested that nurses could not argue with physicians or senior nurses on equal terms (Kono & Kamigori, 2006), yet we found that highly experienced nurses could create a ward culture where staff members relate to each other on equal terms. Thus, the treatment environment can facilitate release from long-term seclusion.

Study limitations

This study investigated nursing care for patients placed in seclusion at the time of observation; it did not analyze the entire care process from the beginning to end of

seclusion. Future studies need to modify the scope of data collection in order to elucidate the care process to guide patients towards complete release from seclusion.

Conclusions

This study identified nurses who provided care by utilizing flexible apportionment of three types of care: standardized care, immediate response care, and care aimed at avoiding mental and physical exhaustion. Nurses did so in order to contain problematic behaviors, minimize seclusion, and preserve their own mental and physical well-being.

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Contributions

Study Design: YN, MH

Data Collection and Analysis: YN, MH

Manuscript Writing: YN, MH

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Figure legend

Figure 1. Nursing care process for releasing psychiatric inpatients from long-term seclusion in Japan.

‘ ’: Category, →: Direction of change in nursing care

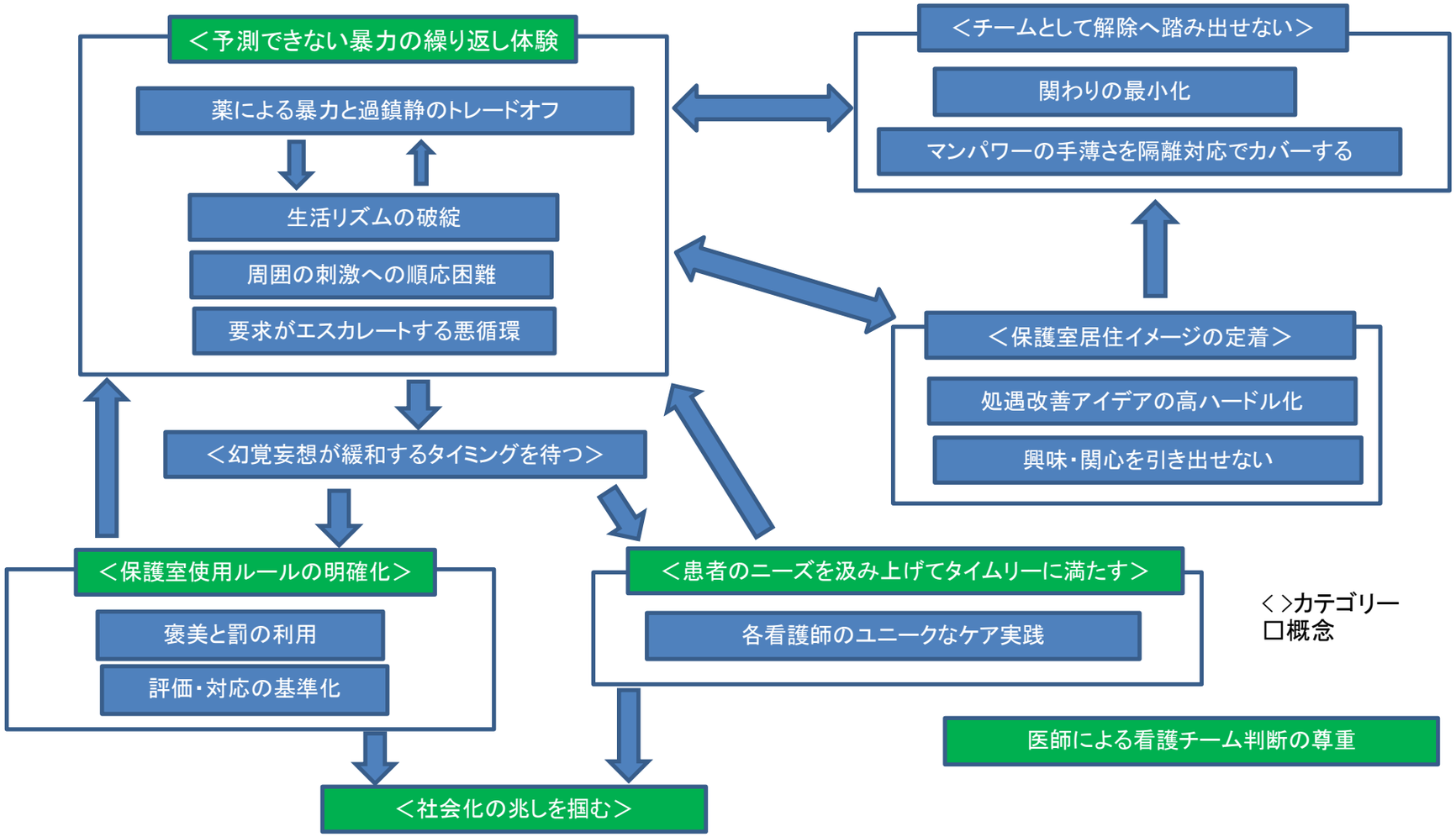
Table 1. Nurse participant characteristics (n=18)

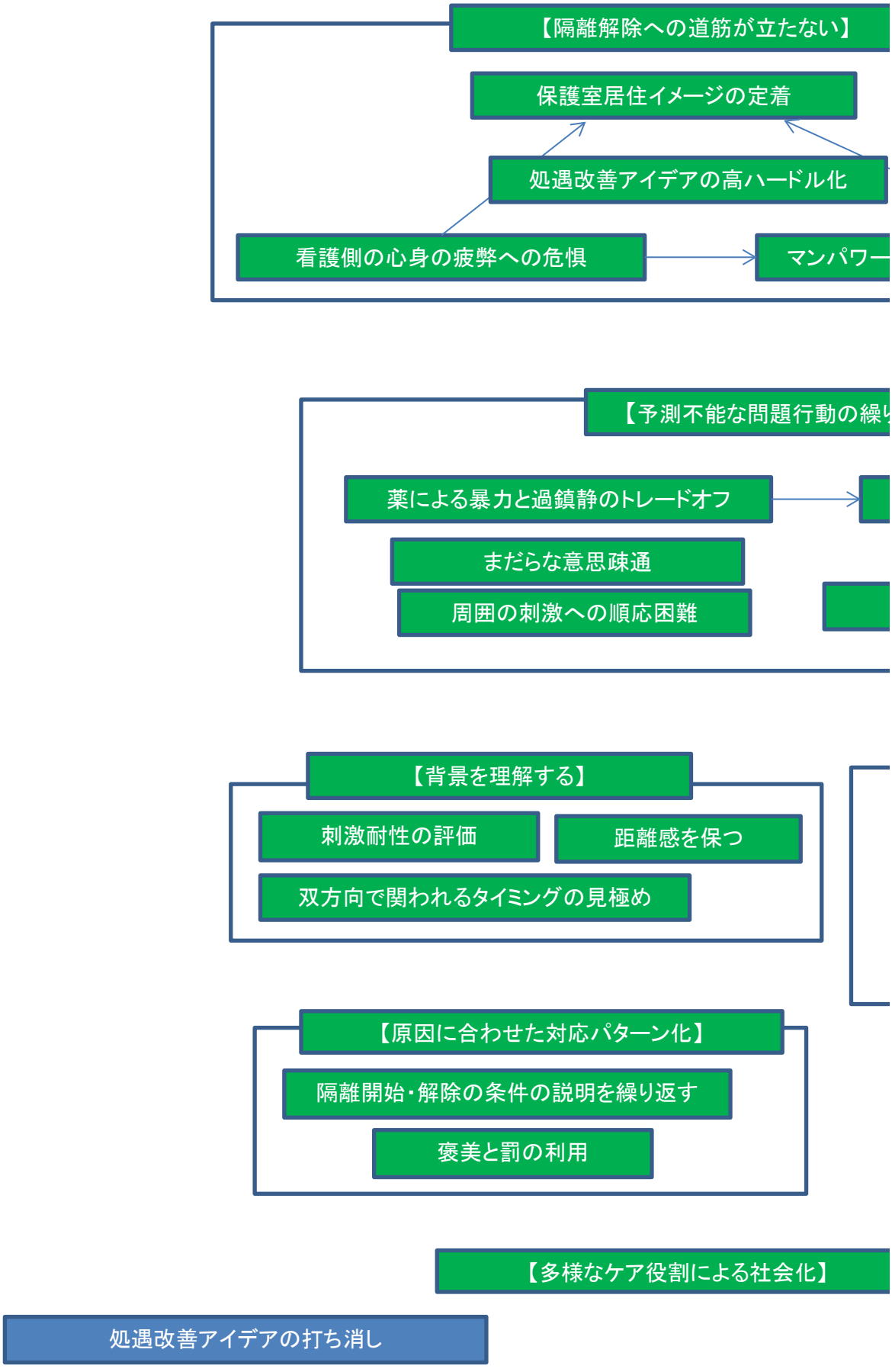
Characteristic	N (%) or mean ±standard deviation
Sex	
Male	10 (55.6)
Female	8 (44.4)
Job position	
Charge Nurse	5 (27.8)
Stuff Nurse	13 (72.2)
Survey location	
Male ward in A hospital	5 (27.8)
Male ward in B hospital	7 (38.9)
Female ward in B hospital	6 (33.3)
Years of experience	
Total in nursing	16.5 ± 9.4
In nursing for seclusion room	12 ± 6.7
Interview time (minutes)	39.5 ± 9.5

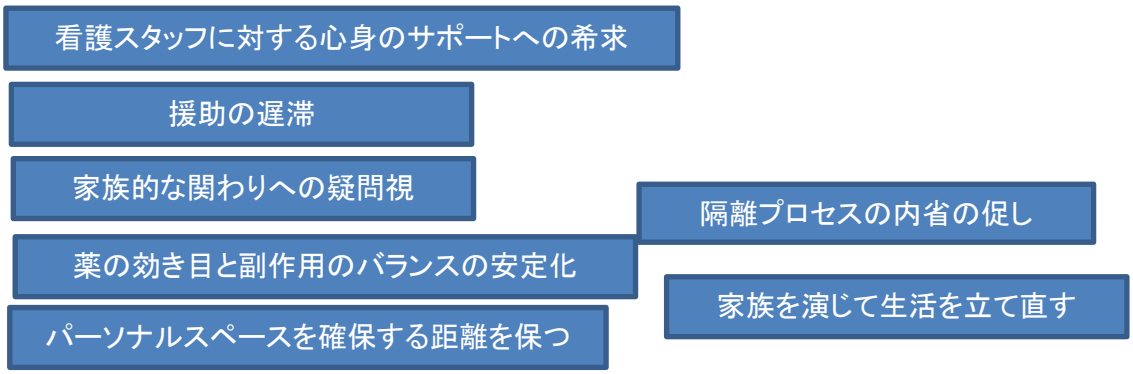
Table 2. Inpatient characteristics (n=5)

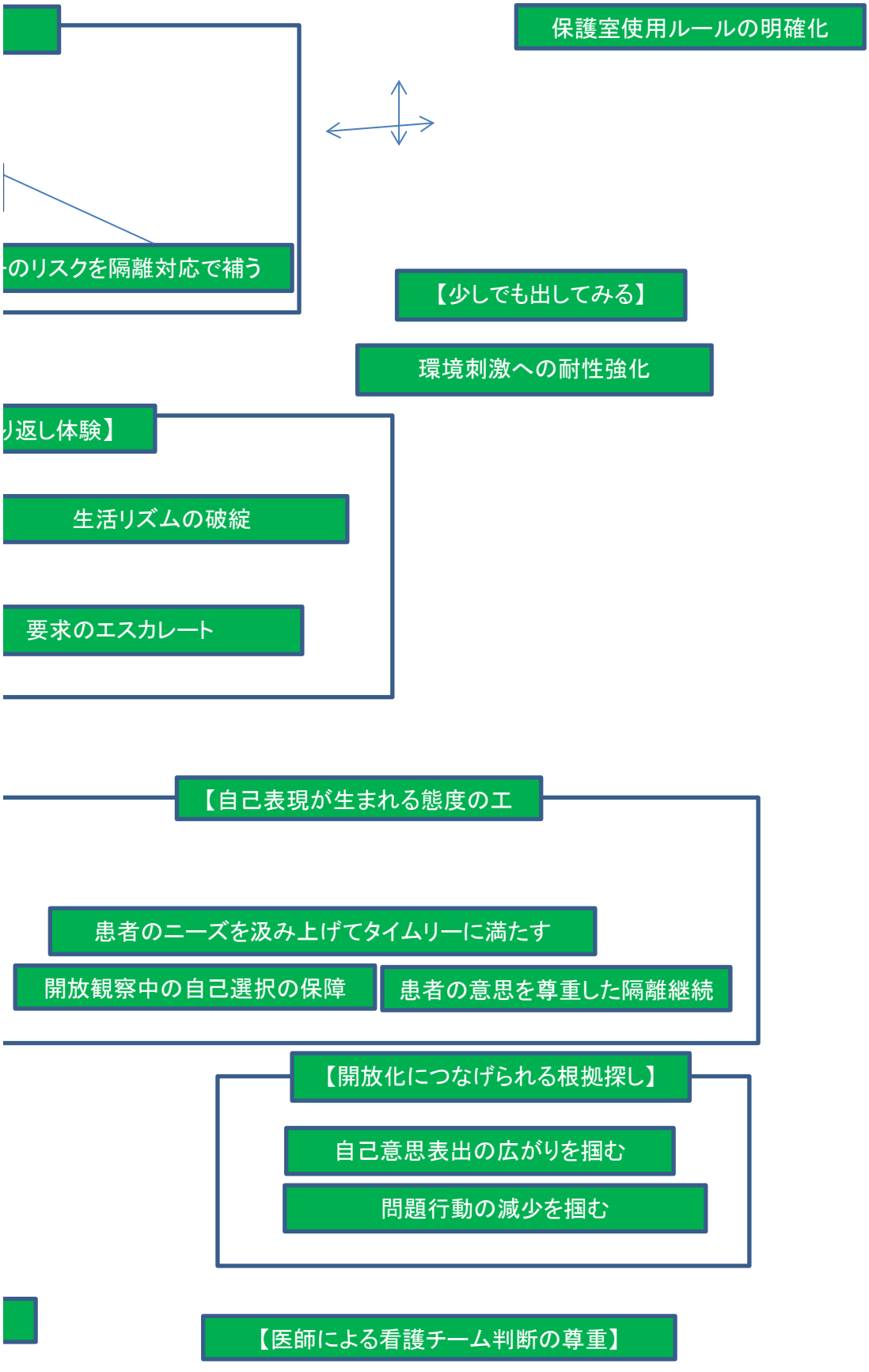
Characteristic	N (%) or mean ±standard deviation
Sex	
Male	3 (60)
Female	2(40)
Psychiatric diagnosis	
Schizophrenia	5 (100)
Duration of hospital admission (years)	6.3 ± 3.5
Total number of seclusion days	808 ± 773.2
60-150	2 (40)
800-1000	2 (40)
<2000	1 (20)
Suspending time of seclusion for a day	
9am-4pm (time on day shift)	1(20)
Time observing and staying with patients	4(80)
Reason for seclusion (multiple)	
Violent language and behavior	3 (60)
Causing trouble to other patients	2 (40)
(stealing to eat, touching personal belongings)	
Polydipsia	1 (20)

保護室を長期使用している精神疾患患者に対する隔離解除へ導く看護援助プロセス

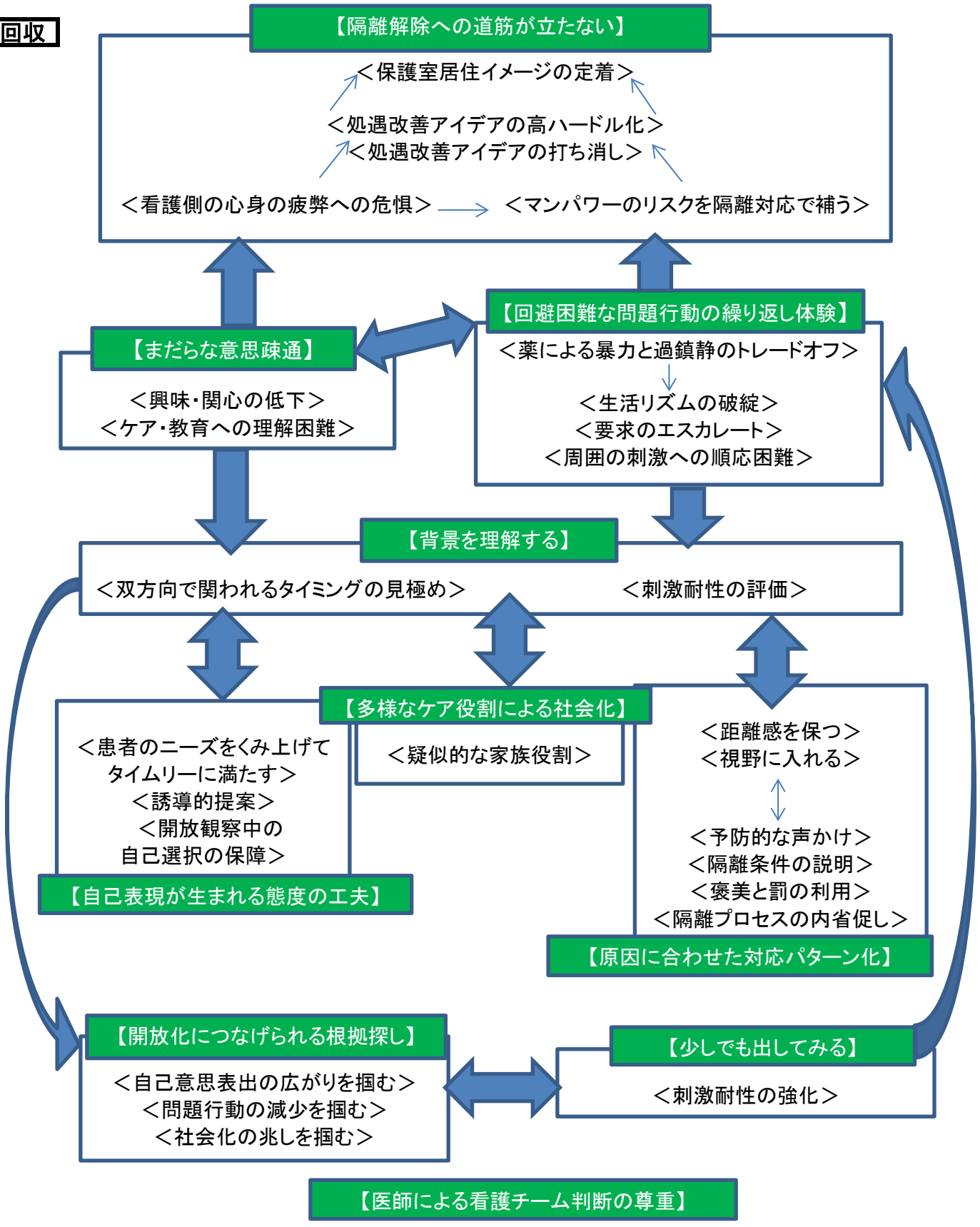



【隔離解除への道筋が立たない】
保護室居住イメージの定着
処遇改善アイデアの高ハードル化
看護側の心身の疲弊への危惧
マンパワー
【予測不能な問題行動の繰り
薬による暴力と過鎮静のトレードオフ
まだらな意思疎通
周囲の刺激への順応困難
【背景を理解する】
刺激耐性の評価
距離感を保つ
双方向で関われるタイミングの見極め
【原因に合わせた対応パターン化】
隔離開始・解除の条件の説明を繰り返す
褒美と罰の利用
【多様なケア役割による社会化】
処遇改善アイデアの打ち消し


看護スタッフに対する心身のサポートへの希求
援助の遅滞
家族的な関わりへの疑問視
隔離プロセスの内省の促し
薬の効き目と副作用のバランスの安定化
家族を演じて生活を立て直す
パーソナルスペースを確保する距離を保つ


保護室使用ルールの明確化
のリスクを隔離対応で補う
【少しでも出してみる】
環境刺激への耐性強化
り返し体験】
生活リズムの破綻
要求のエスカレート
【自己表現が生まれる態度のエ
患者のニーズを汲み上げてタイムリーに満たす
開放観察中の自己選択の保障
患者の意思を尊重した隔離継続
【開放化につなげられる根拠探し】
自己意思表出の広がりを掴む
問題行動の減少を掴む
【医師による看護チーム判断の尊重】

要回収



【】カテゴリー
＜＞概念
→　援助の変化の方向

図1　保護室を長期使用している精神疾患患者に対する隔離解除へ導く看護援助プロセス

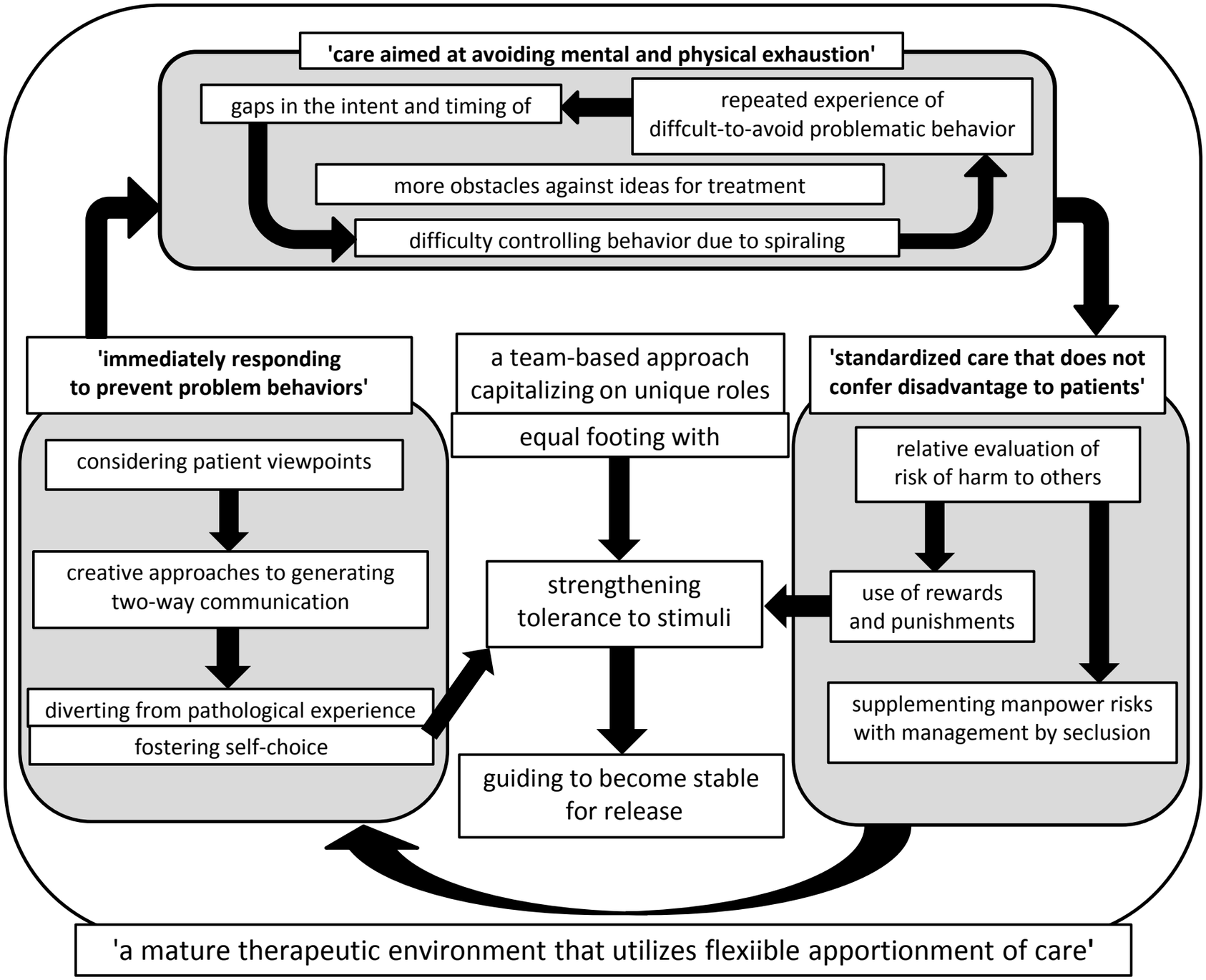

'care aimed at avoiding mental and physical exhaustion'
gaps in the intent and timing of
repeated experience of diffcult-to-avoid problematic behavior
more obstacles against ideas for treatment
difficulty controlling behavior due to spiraling
'immediately responding to prevent problem behaviors'
considering patient viewpoints
creative approaches to generating two-way communication
diverting from pathological experience
fostering self-choice
a team-based approach capitalizing on unique roles
equal footing with
strengthening tolerance to stimuli
guiding to become stable for release
'standardized care that does not confer disadvantage to patients'
relative evaluation of risk of harm to others
use of rewards and punishments
supplementing manpower risks with management by seclusion
'a mature therapeutic environment that utilizes flexiible apportionment of care'

Figure 1.