Nurses' experiences of restraint and seclusion use in short-stay acute old age psychiatry inpatient units: a qualitative study

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Accessible summary

- While the decision to use restraint and seclusion was not taken lightly, nurse participants felt that there were no effective alternatives to the use of these measures.
- Adverse interpersonal, physical and practice environments contributed to the onset of aggression in old age psychiatry inpatient settings.
- Policies to reduce or eliminate the use of restraint and seclusion need to take account of wide-ranging strategies to deal with aggression, including the provision of appropriate education and support and addressing ethical and workplace cultural issues associated with these practices.

Abstract

Restraint and seclusion are often ineffective and can affect patients adversely. In this study, we explored nurses' experiences of restraint and seclusion in short-stay acute old age psychiatry inpatient units and how these experiences underpin resistance to eliminating these practices. Qualitative interviews were conducted with nurses in three old age psychiatry units in Melbourne, Australia. The results provide one overarching theme, *lack of accessible alternatives to restraint and seclusion*, indicating that nurses believe there are no effective, accessible alternatives to these practices. Three related themes contribute to this perception. First, an *adverse interpersonal environment contributes to restraint and seclusion*, which relates to undesirable consequences of poor staff-to-patient relationships. Second, an *unfavourable physical environment contributes to aggression and restraint and seclusion use*. Third, the *practice environment influences the adoption of restraint and seclusion*. The findings contribute to the limited evidence about nurses' experiences of these practices in short-stay old age psychiatry, and how account needs to be taken of these experiences and contextual influences when introducing measures to address these practices. Policies addressing these measures need to be accompanied by wide-ranging initiatives to deal with aggression, including providing appropriate education and support and addressing ethical and workplace cultural issues surrounding these practices.

Introduction

Restraint (restricting patients' freedom of movement by physical, mechanical, chemical and/or emotional means;

National Mental Health Consumer Carer Forum 2009) and seclusion (confining patients alone in rooms with locked doors and windows; Parliament of Victoria 1986) may be used to address aggression (Bowers *et al.* 2004) but

can have deleterious effects on patients. Both measures are commonly used interventions for elderly patients in hospital (Sullivan-Marx 2001), nursing homes (Engberg *et al.* 2008) and psychiatric settings (O'Connor *et al.* 2004, Gerace *et al.* 2013). Usage varies widely between and within organizations (O'Connor *et al.* 2004, Gerace *et al.* 2013) and globally (ranging from 12% to 47%) (Evans *et al.* 2003). There is growing concern these measures are ineffective and have adverse effects on patients (Mohr *et al.* 2003, National Mental Health Working Group 2005), and, according to Cochrane Reviews, their use is not evidence based (Mohler *et al.* 2011, Muralidharan & Fenton 2012, Sailas & Fenton 2012). In Australia, reports recommend that restraint and seclusion should be reduced and, where possible, eliminated (National Mental Health Working Group 2005, National Mental Health Commission 2012); however, these practices persist.

Research on nurses' perceptions of containment practices in elder care has focused primarily on restraint use, where they have been found to resist elimination of this practice (Johnson *et al.* 2009, Perkins *et al.* 2012). A systematic review of studies of nurses' attitudes to physical restraint in elder care identified that while nurses have negative feelings towards its use, they perceive a need to retain this measure (Mohler & Meyer 2014). However, these studies were undertaken, predominantly, in medical-surgical, residential, and long-term geriatric and psychogeriatric settings; none were conducted in short-stay old age psychiatry inpatient units. In general, they cite patient safety and treatment compliance as the main justifications for restraint use (Chien & Lee 2007). Lack of knowledge or understanding of alternatives to restraint has been identified as a barrier to reducing or eliminating usage (Moore & Haralambous 2007, De Bellis *et al.* 2013). Other barriers include staff and resource limitations, environmental constraints, policy and management issues, beliefs and expectations of staff, inadequate review practices and communication barriers (Moore & Haralambous 2007).

It is necessary to understand nurses' experiences of, and attitudes towards, restraint and seclusion because not only can they influence adoption of these practices, they need to be taken into consideration when devising strategies to reduce or eliminate these measures (Mohler & Meyer 2014). To date, research in elder care has focused on restraint and predominantly used quantitative measures to assess nurses' attitudes. Only two recent qualitative studies (Chuang & Huang 2007, Saarnio & Isola 2010) and no Australian qualitative studies have been identified (Mohler & Meyer 2014), despite the value of such methodology for providing a deep and rich understanding of nurses' unique experiences of the use of physical restraint.

The aim of this paper is 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 eliminate these practices. The paper is part of a larger mixed methods study exploring clinical staffs' attitudes towards aggression in old age psychiatry. A qualitative methodology has been adopted because of our focus on nurses' subjective experience of restraint and seclusion and the broader contextual influences on this experience. Moreover, a qualitative approach is helpful in shedding light on complex and controversial issues, particularly in under-researched areas.

Method

Design

Interpretative phenomenological analysis (IPA) informed data collection and analysis. IPA aims to explore how a person (nurse) in a given context (old age psychiatry) makes sense of a phenomenon (seclusion and restraint). The main features of IPA are hermeneutics, phenomenology and idiography (Smith *et al.* 2009). The method is based on hermeneutics, the theory of interpretation. The approach is phenomenological because of the emphasis on understanding participants' major life experiences. The approach is idiographic because of the emphasis on beginning with the participant as the unit of analysis and then progressing to develop themes. Finally, the approach is useful where the problem is new or under-researched, and issues are complex (Eatough & Smith 2006).

Setting and participants

The study was undertaken in three old age psychiatry inpatient units in Melbourne, Australia. The units, each situated in separate geographical sites within the same psychiatric service, are subject to identical organizational policies. Staff-to-patient ratios are similar (unit 1, 1.2:1; unit 2, 1.26:1; unit 3, 1.33:1), and each caters for 20, 19 and 15 patients, respectively. The units provide mainly single-room accommodation with en suite toilets. Patients are admitted directly from the community or residential care for short-term management of acute episodes of organic, functional and age-related psychiatric disorders, before being discharged back to these settings. The units are different from inpatient units for people with dementia. Care is provided by mental health professionals, primarily nurses. The units were included in the study because of a wide variation in restraint and seclusion across the units; it was unclear why this variation occurred. To illustrate, in

Table 1

Sample of interview prompts relating to nurses' experiences about the use of restraint and seclusion

1. Tell me about your involvement with the use of restraint and/or seclusion.
2. What factors increase/decrease the likelihood of restraint and/or seclusion being used in aged psychiatry units?
3. What are the barriers to reducing or eliminating restraint in aged psychiatry units?
4. What practical and safe alternatives can be used to restraint and seclusion in aged psychiatry units?

2010, the year preceding data collection, seclusion rates for units 1–3 were 33, 21 and 7, respectively.

Purposive sampling was used to recruit registered and enrolled nurses from the units and their adjacent community outreach teams. The exclusion criterion was nurses working solely at night and at weekends. Nurses were the focus of the interviews because aggression is most likely to be directed at them and other patients (Chaplin *et al.* 2008, Cornaggia *et al.* 2011), and, compared with other staff, they have the most sustained direct contact with patients.

Data collection

Individual, in-depth, audio-recorded interviews were conducted, in private, informed by an 'aide-memoire' (Burgess 1984). An aide-memoire was used because little prior qualitative information existed about the topic, and it enabled flexibility in following participants' experiences in *telling their stories* (Morse & Field 1995) while remaining within the overall aim of the study. The duration of interviews was 30–45 min. Broad questions were asked initially (Table 1), and responses were probed.

Data analysis

Smith & Osborn's (2008) approach was used to analyse data. Data were transcribed verbatim and read and re-read. Transcripts were coded, and tentative transformation of codes into conceptual themes was undertaken. Preliminary themes were clustered into groups of themes, and those insufficiently grounded in the data were omitted. A more focused analytical and theoretical ordering of themes and was then undertaken.

Ethics

Ethical approval was obtained from Melbourne Health Ethics Committee. Participants gave written consent and were free to withdraw from participation.

Results

Thirty-nine mental health nurses participated. One overarching theme – *lack of accessible alternatives to* restraint and seclusion – and three related themes – *an adverse interpersonal environment contributing to use of restraint and seclusion*, *an unfavourable physical environment contributing to aggression and restraint and seclusion use*, and the *practice environment influencing the adoption of restraint and seclusion* – were identified in the data that reflected participants' experience of restraint and seclusion in the units.

Lack of accessible alternatives to restraint and seclusion

Participants stated the decision to use restraint and seclusion was not taken lightly; they found these practices difficult to implement and often felt conflicted about their involvement. However, they expressed an overall positive view about using these measures because they believed they had no better, accessible alternatives. Comments included: 'I don't like the use [of restraint and seclusion] for the dementia patients because they are really old, but sometimes there's no other way' (interviewee 1.4); '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).

Nurses commented that restraint and seclusion in their unit did not need to be improved: 'because we are doing a good job of it' (interviewee 3.7). Alternatively, they felt no improvement was possible as there were no accessible alternatives: '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' (interview 1.3). Consequently, while favouring minimizing their use, participants did not believe that these practices should be eliminated. In fact, they were greatly concerned about the possible outcomes should these measures be eliminated: 'without restraint and seclusion, there will be chaos' (interviewee 1.14) and that 'people would get hurt; nurses would leave the profession' (interviewee 1.4).

Below, we explore participants' views about factors contributing to a lack of accessible alternatives to restraint and seclusion in the units.

Adverse interpersonal environment contributing to use of restraint and seclusion

Participants referred to the adverse interpersonal environment – behaviours of, and relationships between, patients and staff – as an important consideration with restraint and seclusion. They identified patient aggression as the main cause of 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 were regarded as

being at risk from aggression and, therefore, needed protection from harm through restraint and/or seclusion use: 'It prevents patients from hurting other people and staff' (interviewee 3.5).

Restraint and seclusion were described as legitimate and effective measures to manage aggression by containing it: 'the good thing is, I suppose, being able to isolate those who are escalating to a point where they are a danger to themselves and to others' (interviewee 2.6).

Participants acknowledged that poor staff-to-patient interpersonal relationships contributed to patient aggression; for example, failing to listen to or meet patients' needs may lead to patients resorting to this type of challenging behaviour 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 may also respond inappropriately or insensitively to a patient, leading to an 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 between staff and patients may also lead to a 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

Participants stated that the physical environment influenced the initiation or exacerbation of aggression and the decision to adopt restraint and seclusion to contain these behaviours. In particular, the units were described as noisy, crowded environments with patients being unable to avoid the noise and stimulation: 'It could be noise level, especially that we have a small unit, that there's no garden to escape' (interviewee 1.6). In fact, some patients requested seclusion in order 'to be left alone from the others' (interviewee 2.1). One participant described the noisy unit environment as upsetting to her and to patients: '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).

Having a space where patients could go, either of their own volition, such as a garden or activity room, or being placed there for a short time by staff, such as in a low-stimulation area or high-dependency unit, were identified as effective alternatives to restraint and seclusion. Such places were generally regarded as being much quieter than the public areas in units. Absence of these alternatives adversely affected nurses' use of these practices by reducing

their 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

Participants indicated the practice environment influenced their decision to use restraint and seclusion. This included policies about the use of these measures, low staff-to-patient ratios, level of care need and gender mix, as well as the emphasis on providing a safe environment for patients and staff. They described restraint and seclusion as being 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, the nurses generally believed they were using these measures appropriately and that no changes to their practice were needed (as highlighted earlier).

The ability to manage patients within a framework of using restraint and seclusion as a last resort was dependent on staff numbers, education and clinical experience. Having sufficient numbers of well-educated and experienced staff was described as important in reducing restraint and seclusion use: '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). However, having inadequate numbers, insufficiently educated and experienced staff could increase restraint and seclusion use: '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).

In addition to staff, patients' level of care needs affected restraint and seclusion use. Higher level need patients were seen as inappropriately admitted to the units, or too many were admitted, when the units were deemed unsuitable for caring for these patients within the constraints of the 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). Other aspects of the level of care need that influenced restraint and seclusion were patients' age and diagnosis. Staff expressed reluctance 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 a safe environment was central to participants' understanding of their practice, and restraint and seclusion were described as vital tools to meet this goal:

'Safe environment is the top priority' (interviewee 1.4). Conversely, participants were aware of the potential for restraint and seclusion to have an adverse impact on patient and staff safety. They commented that using these measures could increase the potential for physical injury to frail, elderly patients and to staff: 'Sometimes there could be injuries to clients and staff' (interviewee 1.11). They also discussed the adverse physical, emotional and psychological impact of restraint and seclusion on the patient, staff and other patients: 'It causes physical and emotional trauma for the individual and staff' (interviewee 1.11). A further consideration was the adverse impact of these measures on therapeutic relationships: 'It ruins the relationship between patients and staff' (interviewee 2.4).

Discussion

The findings of our study provide an overarching theme and three related themes depicting their experiences of, and views about, usage of these practices. The overarching theme, *lack of accessible alternatives to restraint and seclusion*, encapsulates that these measures, although regarded as a last resort, were perceived as the only effective, accessible means participants had to manage aggression when it did not respond to less intensive interventions. Reluctance to eliminate these practices has also been reported elsewhere in Australia (Johnson *et al.* 2009) and the UK (Perkins *et al.* 2012). The principal reasons for reluctance in the present study were perceptions about lack of effectiveness of alternative measures and concern about safety, and these concerns have been reported elsewhere (Chien & Lee 2007). What these findings suggest, though, is a lack of understanding of, and education about, effective alternatives to restraint and seclusion (Smith *et al.* 2005, Moore & Haralambous 2007), and a lack of consideration of ethical issues surrounding these practices. They also highlight a dichotomy between recommendations of national reports in Australia to reduce and, where possible, eliminate these practices (National Mental Health Working Group 2005, National Mental Health Commission 2012) and actual clinical practice. Moreover, while these national reports emphasize that people should be cared for in the least restrictive environment, the findings of this study highlight a further dichotomy with the reality of clinical practice.

The first related theme, an *adverse interpersonal environment contributing to use of restraint and seclusion*, emphasizes the importance of good staff-to-patient behaviours and communication in addressing aggression. The value of good staff-to-patient interaction has also been highlighted in a UK study of staff attitudes towards aggression in residential care settings for elderly people with dementia (Pulsford *et al.* 2011, Duxbury *et al.* 2013). High levels of engagement of nursing home residents who have dementia with nursing staff, family members and volunteers has also been identified in a US study to be associated with less agitation and aggression (Cohen-Mansfield *et al.* 2012). In contrast, poor staff-to-patient communication may culminate in aggression, and this, in turn, may contribute to restraint and seclusion use (Whittington & Wykes 1996).

The second related theme, *an unfavourable physical environment contributing to aggression and use of restraint and seclusion*, highlights the influence of poor unit design on the prevalence of aggression and restraint and seclusion use. Participant comments ranged from concern about noise to lack of activities and privacy for patients. In addition, they felt there were limited options to address aggression; in particular, there was a need to provide low-stimulus environments for susceptible patients to be placed for a short time. By inference, if physical environments were improved, patients would be less susceptible to aggression. These findings resonate with other studies highlighting the contribution of aspects of physical environments to aggression, including boredom and insufficient patient activities (National Institute for Health and Care Excellence 2011, Cohen-Mansfield *et al.* 2012), lack of privacy and noise (Nijman 2002, Papadopoulos *et al.* 2012), and overstimulation (Fleming & Purandare 2010). Similarly, the prevalence of aggression decreases in uncrowded environments and those making provision for quiet spaces for patients (American Psychiatric Association 2003, Champagne & Stromberg 2004).

The third related theme, the *practice environment influencing the adoption of restraint and seclusion*, focuses on broader contextual factors, such as government and organizational policy about restraint and seclusion, education, clinical experience, staff-to-patient ratios and patient acuity levels. This theme resonates well with literature highlighting the need for wide-ranging initiatives to be implemented in order to minimize or eliminate these practices (Saarnio & Isola 2010). To illustrate, in Pennsylvania wide-ranging measures contributed to a major reduction in the use of these practices; for example, government policy, better patient-to-staff ratios, staff training about aggression and treatment improvements (Smith *et al.* 2005).

This study has two limitations. Generalizability is not obtained from sample representativeness, but from themes that are applicable in similar situations (Polit & Beck 2010, McCann & Lubman 2012). This is an important consideration as there are distinctions between these and other old age psychiatry units. Funding limitations restricted recruitment to staff working during weekdays; however,

most staff were accessible during these time periods because they were rotated between day and night and between weekday and weekend work.

Conclusion

Our study provides new insights into the contentious issues of restraint and seclusion by affording an in-depth exploration of the contextual influences underpinning resistance to reducing or eliminating these practices in the under-researched area of short-stay old age psychiatry inpatient settings. Such influences need to be addressed if there is to be meaningful and sustainable reduction in, or elimination of, such practices in these environments. The findings also highlight that policies advocating minimal use or elimination of these measures cannot take place in a vacuum; instead, they need to be accompanied by appropriate education and support, including consideration of ethical and workplace cultural issues concerning these practices and introduction of comprehensive initiatives to address aggression. Finally, more research is needed to investigate alternatives to restraint and seclusion.

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