Reducing Seclusion and Restraint Use in Inpatient Settings: A Phenomenological Study of State Psychiatric Hospital Leader and Staff Experiences (USA)

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Background of Research

- Currently a large number of inpatient and residential mental health settings still base their services on a "traditional" model of care that is uninformed by recovery, trauma, client-directed care, or evidence-based practices. (Wale, Belkin & Moon, 2011; NASMHPD, 2014)
- Previous research has focused on patients' experience that document the unnecessary use of force, lack of respect from staff, being ignored and having a hard time getting personal needs met. (Ray et al., 1996; Allen et al., 2003; NASMHPD, 2014)

Background of Research

- As such, it is of no surprise that conflicts occur in mental health environments that then escalate to violence and the use of seclusion and restraint (S/R).
- Seclusion and restraint are controversial and dangerous interventions that lack any evidence-base. S/R use is based on subjective observations by staff who are often untrained to manage conflict.
- And, S/R use cause injuries to clients and staff up to and including death

(NASMHPD, 2014; NAPHS & APA, 2003; Weiss et al., 1998; USGAO, 1999).

Purpose of this Study

- Much work has been done in the last 15 years in the US public mental health system to reduce the use of S/R. Up to and including an Evidence-based Best Practice.
- In order to move this work forward, the researcher decided to "explore and describe the experiences of leaders and their staff who had successfully reduced the use of S/R in their respective facilities.
- Due to a lack of empirical knowledge about inpatient cultures that support S/R use a qualitative research method was chosen.

(Huckshorn, 2013)

Research Questions

1. How do inpatient mental health leaders/staff describe the experience of reducing S/R use?

2. How did mental health hospital leaders/staff change their organizational culture from one that used S/R to one that was able to implement new practices to avoid S/R use?

3. What strategies did mental health leaders/staff use to implement successful organizational change, and how did they communicate these strategies to staff? (Huckshorn, 2013)

Methods

- Convenience Sample: Two Public State Mental Health Hospitals in a northeastern state. Chosen due to S/R reductions already published; willingness to participate; approval by state IRB; and access by researcher.
- Choice of Participants: Identified by Hospital administrators as key to success; held senior, middle or direct care staff roles during change process; agreeable to participate in time lines.
- Purposeful Sampling was used to choose participants
- End cohort was 21 staff.

(Huckshorn, 2013)

Methods

- Interview questions were refined during process. Resulting in 33 open-ended questions that were used in semi-structured protocol.
- These questions were field tested with three other state hospital directors and one MD.
- All interviews were audio taped while the researcher took personal notes.
- Staff interviewed were named in results as: Senior leaders, Middle Managers, and Direct Care Staff. Many interviewed were registered nurses or nursing staff.

(Huckshorn, 2013)

Methods

- Phenomenology requires very active researcher activities. Gathering the data, audio taping, transcription, and reviewing this data.
- Includes both “dwelling with the data” and “bracketing personal beliefs and biases” during the analysis process.
- Through this process the researcher looked for common themes in the over 110 single spaced transcription pages of the interviews.
- The researcher initially found 115 initial common themes.

(Huckshorn, 2013)

Methods

- The researcher then engaged a statistician and two external expert raters who were asked to review the same raw data against the initial 115 themes found.
- The expert raters found 98 themes, of the original 115, that they agreed on based on a kappa coefficient process used by the statistician to reach agreement on inter-rater reliability among the raters.
- Of these 98 themes, 32 themes that reached at least fair agreement (.21-.40) and up were used to determine results.

(Huckshorn, 2013)

Methods

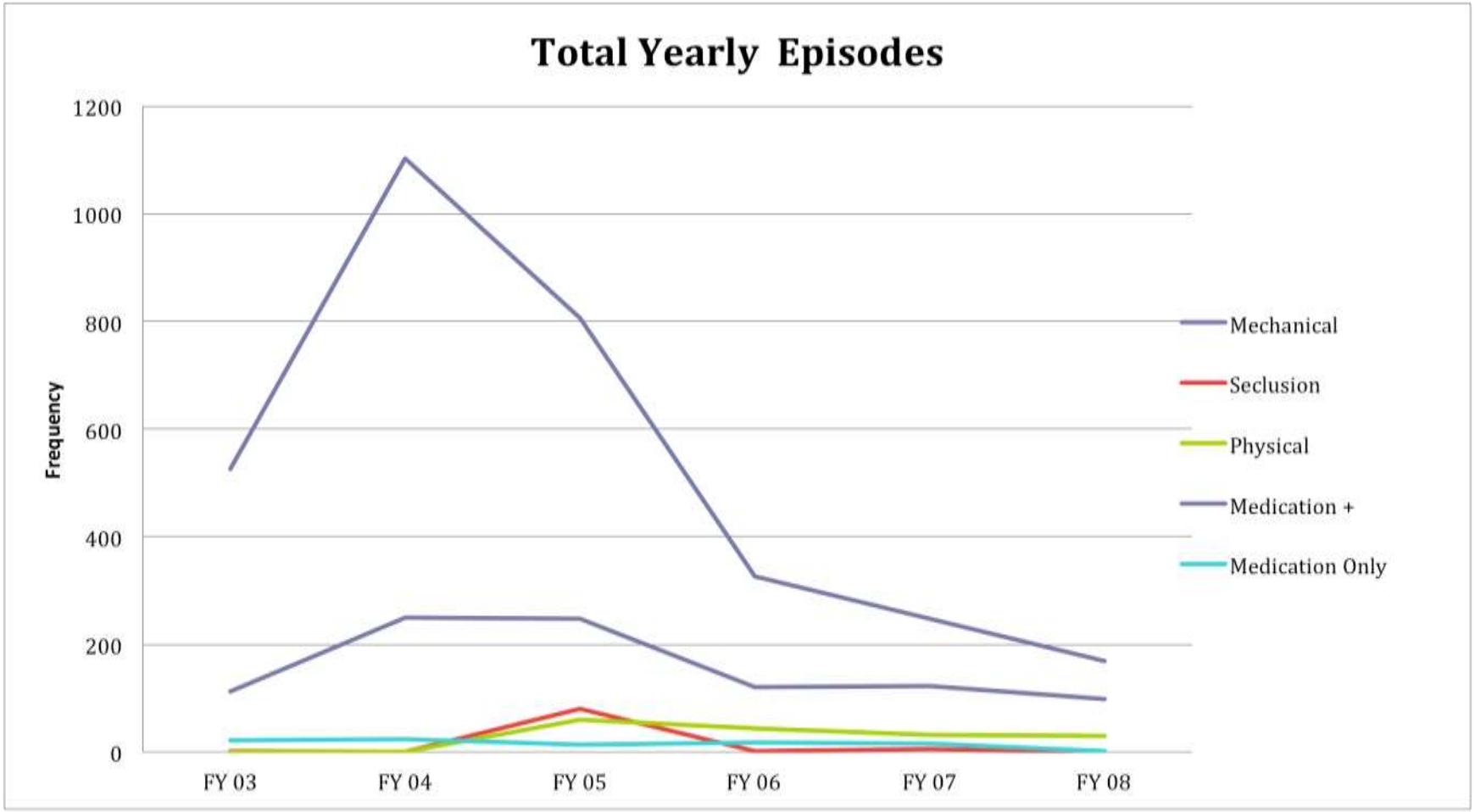
- Of the original 115 themes, reduced to 98 themes by expert raters, and then to 32 themes the researcher was able to synthesize these into:
  - Five Meaning Themes that led to:
  - A Textural Description (what the study participants experienced when reducing use of S/R)
  - A Structural Description (reflecting the setting and context in which this S/R reduction work was done)
  - A Composite Description (that synthesizes the above two descriptions) and serves to describe the essence of the research study on what it was like to participate in a successful reduction of S/R.

(Huckshorn, 2013)

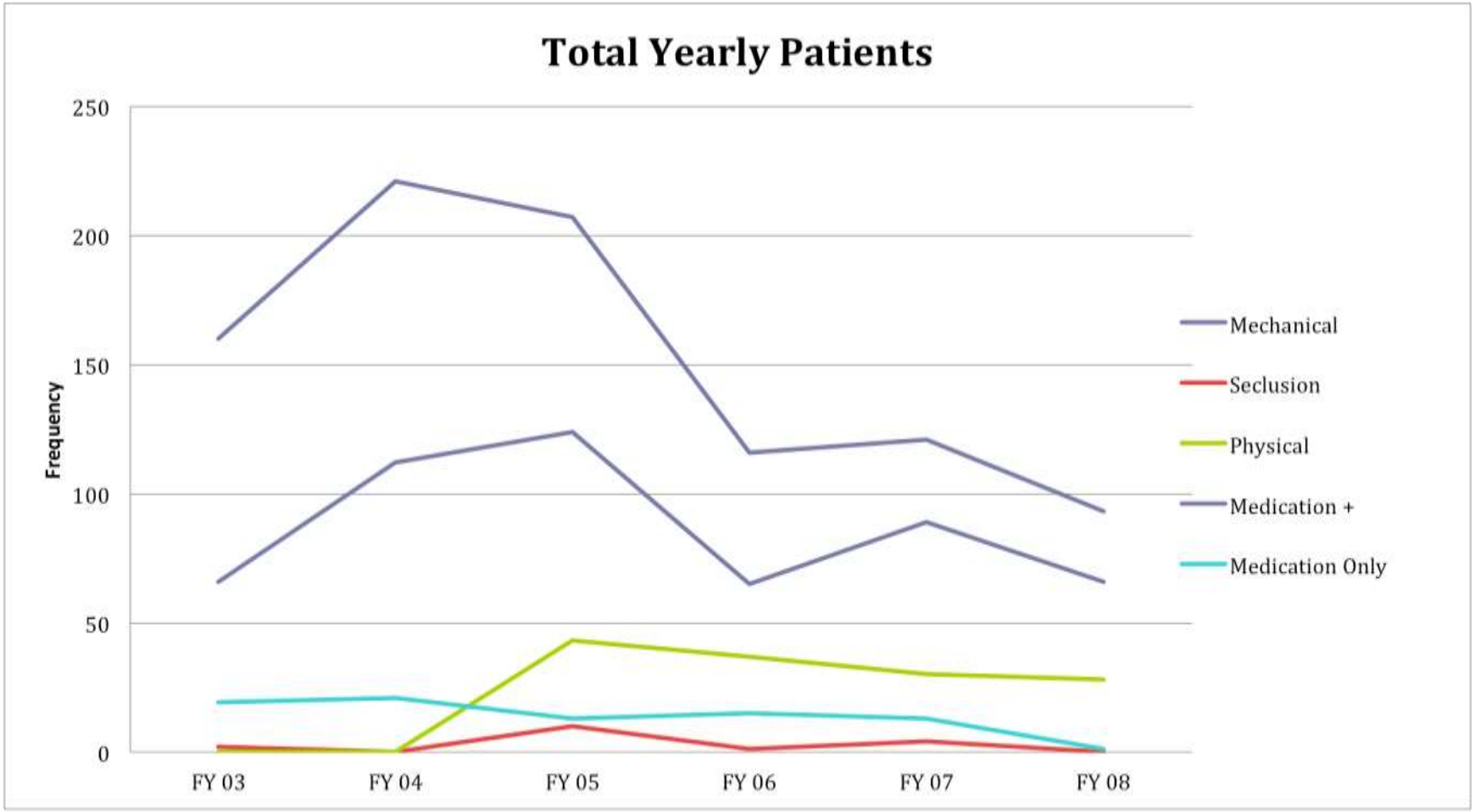
Results: Overall

- Both hospitals had reduced the use of seclusion, restraint, forced medication administration, and injury rates by 65% or over, from baseline.
- Both hospitals served people in both civil and forensic settings.
- Both hospitals had highly similar staffing patterns, types of staff, lengths of stays and similar admission and discharge activities.
- Hospital B served slightly more clients (192 beds) and adolescents. Hospital A was adults only and served clients in 169 beds. *(Data was gathered March 2009)* (Huckshorn, 2013)

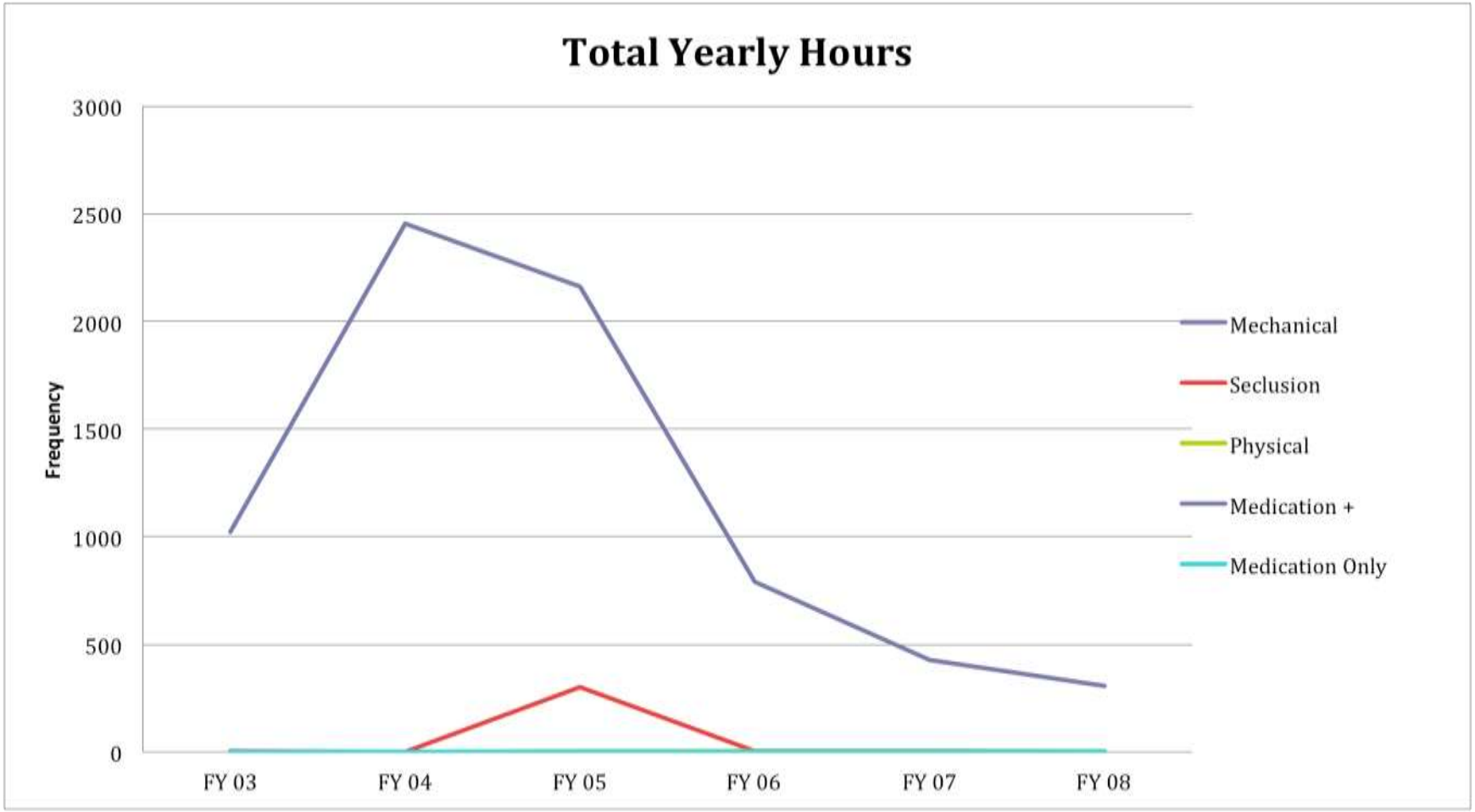
Hospital A- Total Yearly Episodes



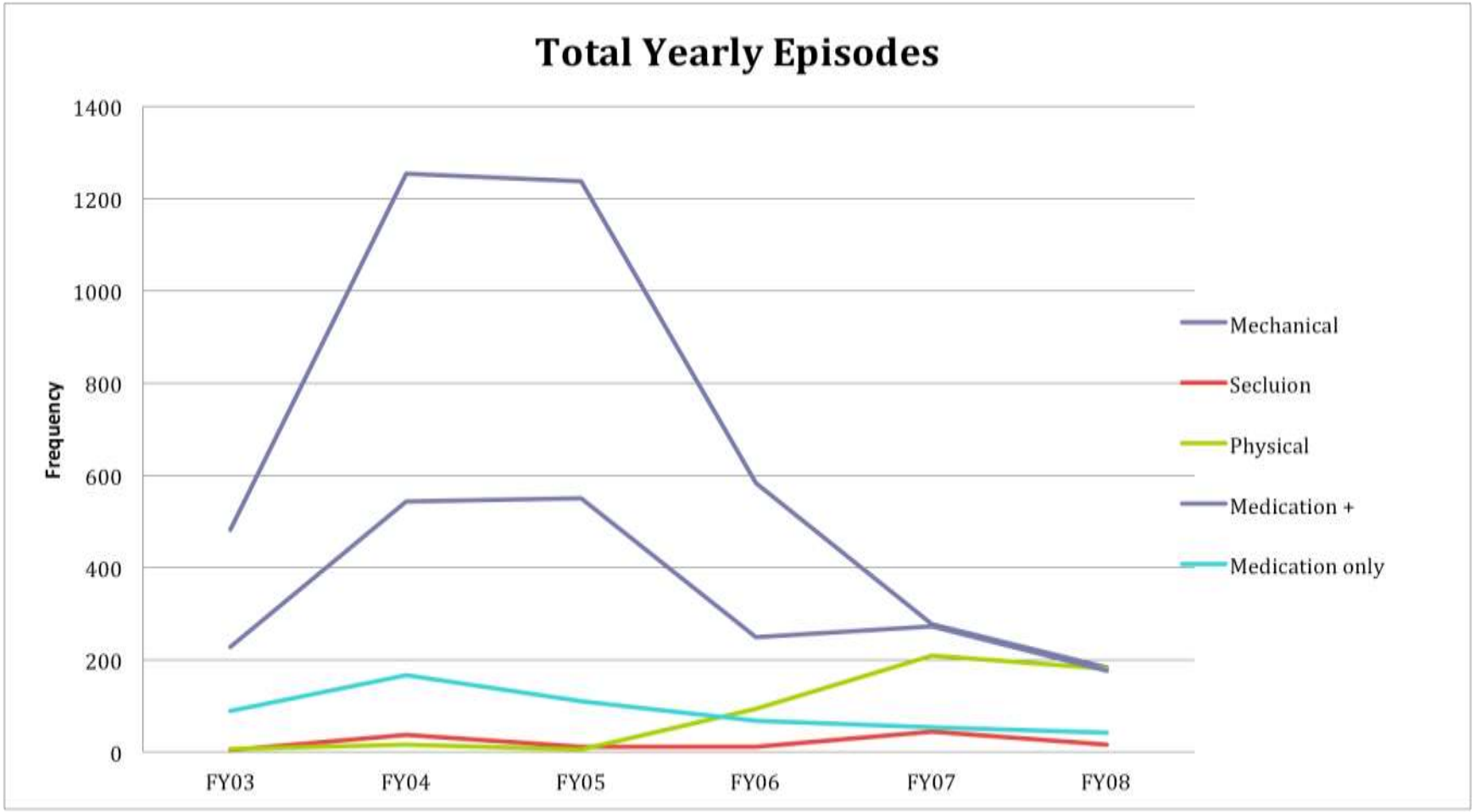
Hospital A- Total Yearly Patients



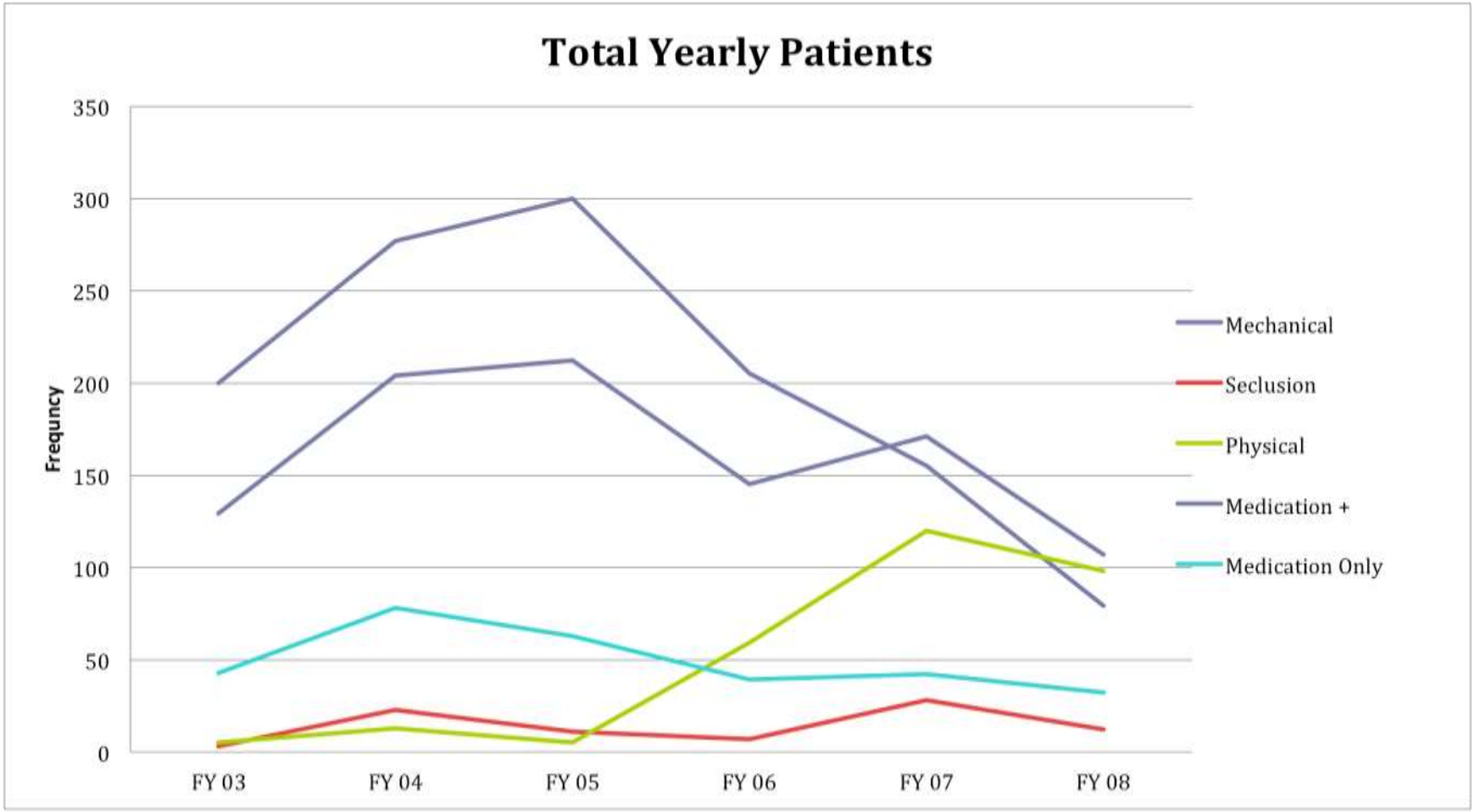
Hospital A- Total Yearly Hours



Hospital B- Total Yearly Episodes



Hospital B-Total Yearly Patients



Hospital B- Total Yearly Hours

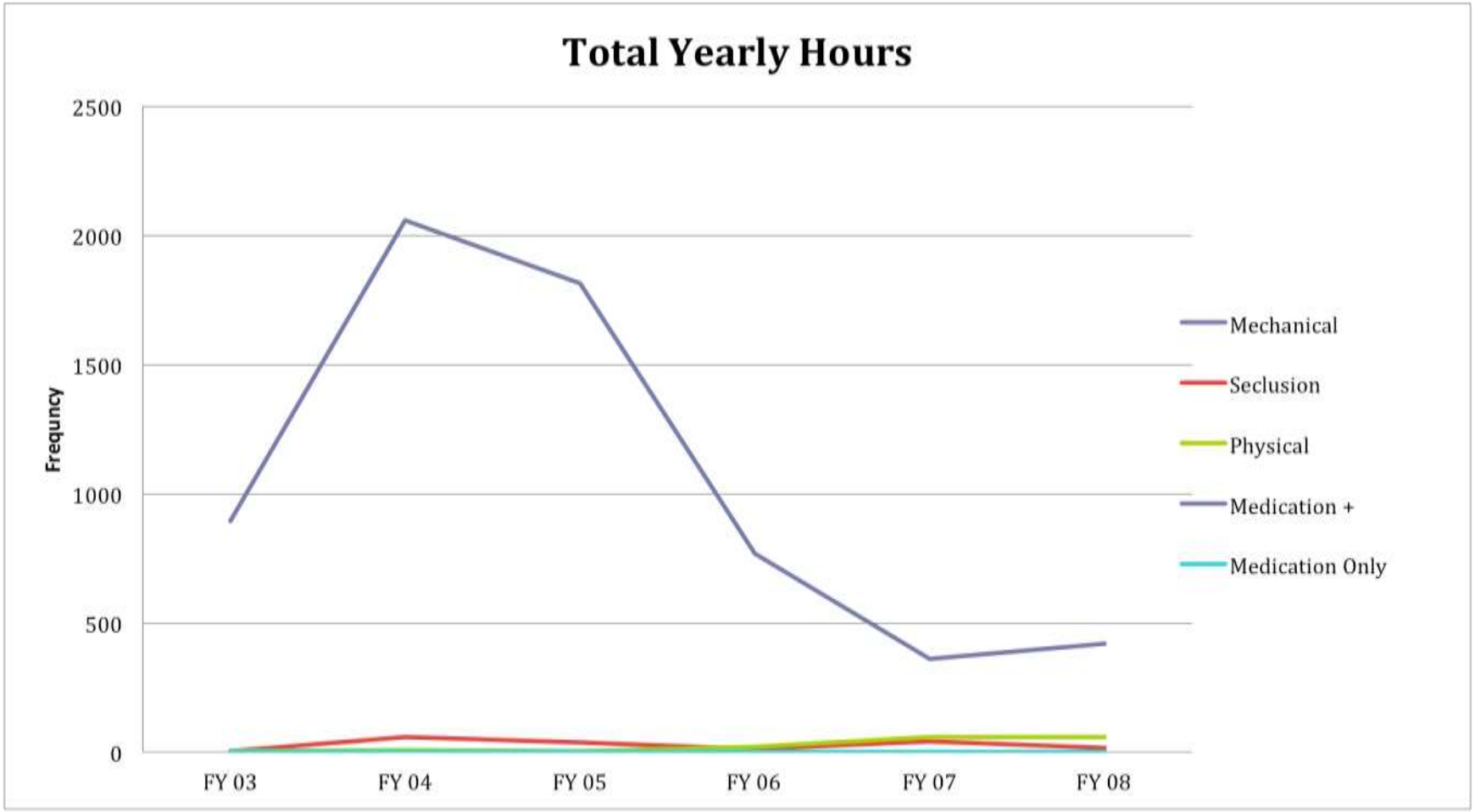


Table XX. Kappa Coefficients for 32 Themes with Fair Moderate Agreement
Five Examples

”Project was a performance/quality improvement; discretely analyzed current practices to improve future practices”	0.50**
“Including patients in change was important”	0.21*
“Would focus on staff development and training new skills and practices to staff, right away”	0.52**
“Would manage line staff concerns better and faster”	0.40*
“Involve consumers/clients immediately in this project”	0.67***

Textural Description

The participants in this study described their experiences in successfully reducing the use of seclusion and restraint in an inpatient mental health setting, **first**,

-as a project that needed to be led by state- and hospital-level executive leaders who were able to change the way that seclusion and restraint were viewed by staff, **from**

-being an "unquestioned, culturally based, practice norm" **to** being an "event to be avoided" by reducing opportunities for staff-to-client conflicts resulting from hospital rules and old beliefs. (Huckshorn, 2013, pp. 193-194)

Textural Description

The initial announcement of the goal to reduce seclusion and restraint was met with mixed reactions from staff that ranged from very negative, to skeptical, to being welcomed.

Over time, most hospital staff learned new skills to avoid use and demonstrated new beliefs as evidenced by the data that showed that seclusion and restraint were now rarely used in these two organizations and only for very dangerous behaviors.

Key challenges were identified that are common barriers in implementing organizational changes such as 1) a lack of resources, 2) communication issues, 3) staff uncertainty in practicing new ways of working and that 4) people generally react to change from a negative place. (Huckshorn, 2013, pp. 193-194)

Structural Description

At the beginning of the seclusion- and restraint-reduction project, participants characterized the two hospitals' organizational cultures as 1) believing that the use of seclusion and restraint was a normative practice, 2) part of usual staff practices, 3) a way to efficiently control the clients, 4) a way to keep the units safe, and 5) the only option available for staff to use.

The introduction of a new way of thinking about seclusion and restraint occurred, initially, through specific and credible training, and this training was seen as a key change agent. (Huckshorn, 2013, pp. 194-195)

Structural Description

As the project progressed, it became experienced as a performance-improvement process where leaders and staff could carefully analyze events and learn how to improve.

Challenges were identified during the project that included a 1) lack of resources, 2) difficulty in communicating in a timely way with all staff, 3) delays in responding to staff concerns, 4) staff uncertainty in trying new approaches with clients, 5) attempts to include “patients” in the change process, and 6) doing anything that staff perceived as blaming or criticizing them. (Huckshorn, 2013, pp. 194-195)

Structural Description

- Success in both hospitals occurred as a result of the involvement of key leaders at the state and hospital executive level and some direct-care staff who led by example;
- a shift that occurred in staff beliefs and values about when seclusion and restraint should be used;
- the use of data sent to staff consistently about events on their units;
- staff learning new skills to replace seclusion and restraint,
- and a core group of staff who were willing to risk and change their behaviors and help other staff change theirs.
- Lessons learned included the need to involve clients sooner and manage staff concerns better and faster.

(Huckshorn, 2013, p.)

Composite Description

The successful reduction of the use of seclusion and restraint in mental health settings requires an organizational culture change that starts with key executive organizational leadership staff acting as change agents; the ability of leaders and staff to change their beliefs and behaviors as new information is gained on what works; and the ability of leaders and staff to practice and model success, resolve challenges, and incorporate lessons learned along the way. (Huckshorn, 2013, pp. 195)

Results: Five Meaning Themes(extracted from original 98, then 32 themes)

1. State and hospital leaders took on critical roles to reduce S/R in these hospitals
2. Hospital leaders and their key staff had to change beliefs about the use of S/R throughout the project.
3. Hospital leaders and key staff had to identify and operationalize new practices to prevent use of S/R.
4. Hospital leaders and their key staff need to identify and resolve some key challenges on the way to successfully reducing the use of S/R.
5. Hospital leaders and their key staff were able to report on important lessons learned as a result of this process and what they would do differently "next time". (Huckshorn, 2013, pp. 192-193)

Significant Findings

1. Senior state office, senior hospital leaders and middle managers assumed critical roles in leading and modeling an organizational effort to change staff beliefs about S/R. Other studies support this finding (Wale et al., 2011; Lewis et al., 2009; Ashcroft et al., 2012; Azeem et al., 2011)

2. At the beginning Hospital staff believed that S/R use was normal; kept the units safe; that S/R use was efficient; and that staff could control the use of S/R.]

(Wale et al., 2011; Ashcraft et al., 2012; Barton et al., 2009)

Significant Findings

3. Hospital staff member's beliefs about seclusion and restraint significantly changed over time and came to be viewed as "practices that could be avoided by reducing opportunities for staff-to-client conflicts by minimizing hospital rules, learning new skills, adopting a prevention approach to conflict, including clients in the project and finding champions amoung the direct care staff to help." These findings were supported in other studies

(Lewis et al., 2009; Sullivan et al., 2005; Ashcraft et al., 2012; and Azeem et al., 2011)

Significant Findings

4. The work to reduce the use of seclusion and restraint resulted in a number of challenges hospital leaders and staff reported as they implemented change. These challenges included a reported "lack of resources, communication issues, resistance from some staff, and leadership behavior that was interpreted as 'blaming staff' for the use of seclusion or restraint that were important to manage in this study." (Wale, Belkin & Moon, 2011; Azeem et al., 2011; Witte, 2008).

5. Approaching the seclusion- and restraint-reduction project through a performance-improvement lens was helpful as it avoided blame and focused on what worked. The use of data to direct practice changes was a key component of performance-improvement work (Wale, Belkin, & Moon, 2011; NASMHPD, 2014; Lewis, Taylor & Parks, 2009; Azeem et al., 2011).

Significant Findings

6. Hospital leaders and staff "lessons learned" included that if they were to repeat this project again, they would focus on staff development and training right away, would manage staff concerns better and faster, involve clients immediately in the project, show the data to direct-care staff right away, and avoid anything that could be interpreted as blaming direct-care staff

(Barton, Johnson & Price, 2009; Wale, Belkin, & Moon 2011; Azeem et al., 2011; Lewis, Taylor, & Parks, 2009; Sullivan et al., 2005, p. 64; Witte, 2008).

Conclusions

- It appears, from this study, that hospital leaders and staff, particularly nursing staff, have a powerful role in implementing best practices to prevent coercion, violence and events that lead to the use of S/R and forced medications in inpatient settings. Hospital staff need support in doing this work. More research needs to be published on this subject, especially regarding identification of required staff competencies and effective training that translates to practice changes.

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