

# **The National Quality Improvement Project Concerning the Use of Restraints**

## **Change Package**



Nationalt kvalitetsprojekt  
– TVANG I PSYKIATRIEN

August 2004

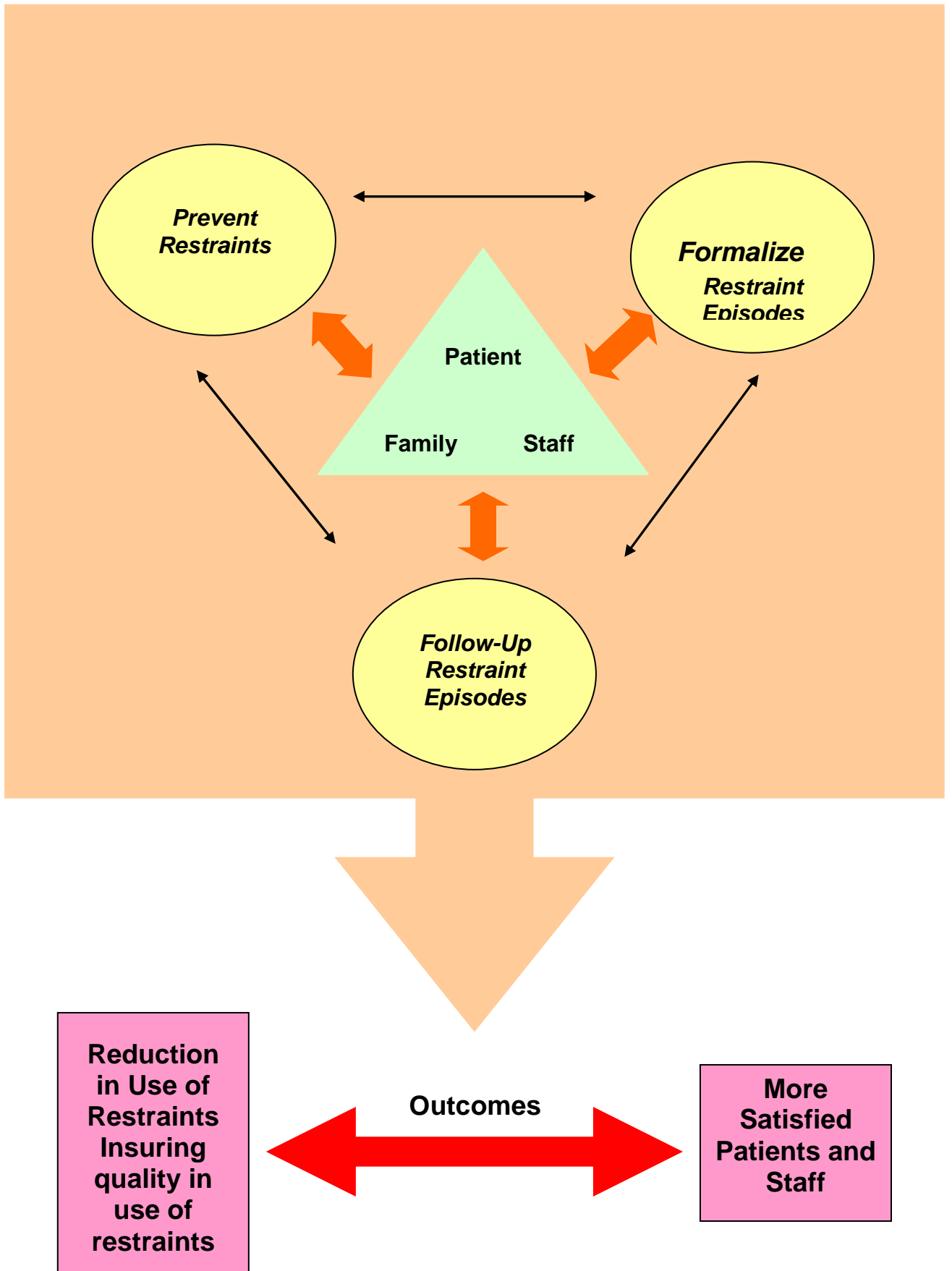
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# Change Package for the National Quality Improvement Project Concerning the Use of Restraints

## Summary:

### Theme 1: Prevention of Formalised Restraints

*By strengthening the staffs understanding and respect for the individual needs of patients and by securing the inclusion of patients in their care.*

Strategies for change:

- Improve information and communication
- Staff education
- Intervention
- Informing and involving relatives
- Secure continuity in the patient's course of development
- Flexible offers of activity
- Create intimacy, accessibility and flexibility in the department
- Sexuality
- Reduce the need for intensive care and avoid the use of restraints

### Theme 2: Formalised Restraint Episodes

*To document and make each episode of restraint as short, comfortable and secure as possible*

Strategies for change:

- Reduce patients experience of restraints when committed
- Belt fixation
- Isolate restraint episodes
- Inform and involve relatives
- Working with the staff's emotional reactions

### Theme 3: Follow-up on Formalised Restraint Episodes

*Learn from each restraint episode and make sure a stable and secure atmosphere is established in the department after an episode of restraint*

Strategies for change:

- Working on restraint episodes and creating mutual understanding
- Insuring quality in relation to the use of restraints
- Improve staff working environment

# Change Package for the National Quality Improvement Project Concerning the Use of Restraints

## *Theme 1: Prevention of Formalised Restraints*

FI= Expert Group.  
B&P= Patient-Relative Group.

### Strategies: Improve information and communication

Effort Area	Concrete Initiatives of Change	Appendix
Reception	<ul style="list-style-type: none"> <li>• Patient is informed about commitment plans</li> <li>• Patient is informed about expected timeframes</li> <li>• Verbal walk through, if written material and brochures are handed out</li> <li>• Inviting interior decoration, serving the purpose of creating an environment (with flowers, curtains, possibilities of lying down, offering of food and drink) in which the patient can feel safe. During hospitalisation (or as soon as possible) the patient will be asked about prior experiences/episodes involving the use of restraints. Clarifying, in cooperation with the patient, how such episodes can be avoided.</li> </ul>	<p>FI p. 14 FI p. 14 B&amp;P p. 2, FI pp. 4 -5, 14</p> <p>B&amp;P p.2, FI pp.14</p> <p>American Psychiatric Association (2000)</p>
Securing patient dignity	<ul style="list-style-type: none"> <li>• Staff will on an everyday basis ask themselves whether the patient is treated with dignity and according to the contract.</li> <li>• Positive elements are discussed in order to assert mutual staff agreement on whether patient dignity is maintained according to the contract.</li> <li>• A dignity package will be produced containing ideas on how situations violating the patient's dignity can be handled differently in order to diffuse the situation.</li> <li>• The Dignity Package will be use by newly employed, students and staff and will continuously be updated.</li> </ul>	<p>FI p.3</p> <p>Appendix: Fælles værdigrundlag (2004) Kirsten Hansen (2004) Thorgaard (1995)</p>
Psycho education	<ul style="list-style-type: none"> <li>• Educating patients on their condition/illness.</li> </ul>	B&P p.2
Filling out Kardex journal (nursing journal)	<ul style="list-style-type: none"> <li>• Staff and patient fill out the Kardex journal together.</li> </ul>	FI p. 5 B&P p.2

## Theme 1: Prevention of Formalised Restraints

Timeframe perspective and structure in daily routines	<ul style="list-style-type: none"> <li>• Work will systematically be focused on increasing the patient's ability to orientate him self within a timeframe and changes in the patient's condition will be clarified on a micro scale.</li> <li>• The patient is offered a weekly schedule or a daily schedule.</li> <li>• The patient is oriented on doctor's appointments and possible cancellations hereof.</li> <li>• The schedule of the day is discussed with the patient on staff initiative as a part of the daily routine.</li> </ul>	FI pp. 4 -5  Appendix: Bech-Jørgensen (2003)  Appendix:
Joint meeting	<ul style="list-style-type: none"> <li>• Setting up meetings on department level with staff and patient participation.</li> <li>• Possibly in the afternoon/evening. The purpose is a more open dialogue about activities in the department and a higher degree of patient participation.</li> </ul>	B&P p.2

### Strategies: Staff Education

Effort Area	Concrete Initiatives of Change	Appendix
Strengthening of staff communication skills	<ul style="list-style-type: none"> <li>• Courses/topic days focusing on communication – for example education in “non violent communication”</li> </ul>	FI p. 18
Psycho-Physical training	<ul style="list-style-type: none"> <li>• Psycho-Physical training of staff with regular follow up courses</li> </ul>	FI pp. 20-21 Appendix: Nordjyllands Amt

### Strategies: Intervention

Effort Area	Concrete Initiatives of Change	Appendix
Intervention programme used in relation to aggression.	<ul style="list-style-type: none"> <li>• Use the de-escalation programme helping staff and patients to handle outbursts of anger and aggressive behaviour, Brøset Violence Checklist or CPI for example.</li> </ul>	FI pp. 6 -7  Brøset see webside <a href="http://home.online.no/~ralm/bvcindex.htm">http://home.online.no/~ralm/bvcindex.htm</a> Appendix: CPI, Learning from Each other

## Strategies : Informing and Involving Relatives

Effort Area	Concrete Initiatives of Change	Appendix
Working out a relative policy	<ul style="list-style-type: none"> <li>• Draw up guidelines for what information and to what extent including relatives/network will affect patients in the treatment period.</li> <li>• Work out a definition of relatives.</li> <li>• Hand out contact numbers to relatives</li> </ul>	B&P p 5, FI pp. 12-13  Appendix: ”Pårørende i Psykiatrien – Psykiatrien i Århus Amt.
Network meetings/open discussions	<ul style="list-style-type: none"> <li>• Draw up guidelines on how relatives actively can become a part of the patient's progress by creating network meetings for instance with the patient, doctor and relatives, in order to put down a mutual strategy for the appropriate measures of treatment.</li> </ul>	B&P p. 5 Appendix: Seikkula, Jaakko (2000)
Educating relatives	<ul style="list-style-type: none"> <li>• Educate relatives in diseases, symptoms and treatment</li> </ul>	B&P p. 5
Possibilities for being together	<ul style="list-style-type: none"> <li>• Decoration common rooms invitingly (including smokers)</li> <li>• Create possibilities for relatives to join the social life on the ward via lectures, study groups, activities, information on accommodation facilities at the hospital or nearby the hospital.</li> </ul>	B&P p. 5  B&P p. 5

## Strategies: Secure Continuity in the Patient's Course of Development

Effort Area	Concrete Initiatives of Change	Appendix
Contact person after discharge	<ul style="list-style-type: none"> <li>• Identifying a contact person (friend, family, colleague) whom the patient can always contact after hospital discharge.</li> <li>• A deal is made with the contact person before the patient is discharged and contact information is written down.</li> <li>• Including relatives and the close network at the discharge and the forming of discharge agreements.</li> </ul>	B&P p. 6
Discharge agreement	<ul style="list-style-type: none"> <li>• Start working out discharge agreements early on in the period of hospitalization.</li> </ul>	B&P p. 6

<b>Strategies: Flexible Offers of Activity</b>		
<b>Effort Area</b>	<b>Concrete Initiatives of Change</b>	<b>Appendix</b>
Create more activities (especially for men)	<ul style="list-style-type: none"> <li>• Computer room.</li> <li>• Fitness room.</li> <li>• Shared practical tasks like gardening.</li> </ul>	B&P p. 9
The possibility of engaging activities during the daytime and evenings	<ul style="list-style-type: none"> <li>• Open workshops</li> <li>• Common study groups, literature groups, conversation groups.</li> </ul>	B&P p.9
Adapted offers of activities	<ul style="list-style-type: none"> <li>• Be able to lend ghetto-blaster and music to patients.</li> <li>• Be able to lend different board games to patients.</li> <li>• Mobile TV can be issued with VHS/DVD recorder to some patients according to need.</li> <li>• Possibly offer a combined solution adapted to each patient's individual need via construction of a mobile carts containing TV, Hi-Fi, VHS, different games, films, CD's, crafting materials etc, which the patient can use at any time.</li> </ul>	FI pp. 10-11 Appendix: Hansen, Kirsten (2000) s.69-76  Illustration included in appendix
Anxiety dampening activities and aiding facilities	<ul style="list-style-type: none"> <li>• Patients are given the opportunity to use different aiding facilities to stimulate their senses and keep down feelings of anxiety and unrest like: ballstick, ball cover, hammock etc.</li> </ul>	FI p. 11-12 Appendix: illustration of ball cover and the ballstick method

<b>Strategies: Create Intimacy, Accessibility and Flexibility in the Department.</b>		
<b>Effort Area</b>	<b>Concrete Initiatives of Change</b>	<b>Appendix</b>
House order	<ul style="list-style-type: none"> <li>• Conduct an update of house routines so that only a few and clear rules are included.</li> <li>• Make clear who will participate in this update and if possible involve patients.</li> <li>• Supplement house orders with explanations informing patients and relatives on the reasons behind house rules.</li> <li>• Secure that patients and relatives have a thorough introduction to house orders.</li> <li>• Make the House order visible and clear by bringing it up at patient meetings, posting it and talk about it at morning meetings.</li> </ul>	FI p. 9 Erfaringer fra Randers
Administrative tasks	<ul style="list-style-type: none"> <li>• Administrative tasks are removed if possible from private offices to common areas.</li> <li>• Revision of meeting routines (form, frequency, extent, participants, e.g. place supervision and staff</li> </ul>	B&P p. 10

## Theme 1: Prevention of Formalised Restraints

	education from 7 to 9 AM)	
Staff	<ul style="list-style-type: none"> <li>• Only experienced staff on evening and night shifts.</li> </ul>	B&P p. 7 Appendix: Norge, Learning From Each Other

### Strategies: Sexuality

Effort Area	Concrete Initiatives of Change	Appendix
Patients' sexuality during commitment	<ul style="list-style-type: none"> <li>• Make the department conscious about attitudes and practice towards patients' sexuality</li> <li>• Produce a policy on patients' sexuality during commitment.</li> <li>• Involve sexual counsellors</li> <li>• -Arrange contact to the local County's Utility Central concerning sexual applications.</li> </ul>	B&P p. 9  Appendix: Torpdahl (1999)

### Strategies: To reduce the need for intensive care and avoid the use of restraints

Effort Area	Concrete Initiatives of Change	Appendix
Intensive psychiatric care (treatment) via shielding	<ul style="list-style-type: none"> <li>• Standard for shielding methods must be worked out with focus on the relation between the patient and caretaker.</li> <li>• Intensive shielding will be supported by other methods with stabilising effects on the patient like environmental therapeutic activities.</li> </ul>	FI s. 8  Amtsrådsforeningen (2002):  Udd. Afd. Århus
Conversations	<ul style="list-style-type: none"> <li>• Time, space and attention to psychotic experiences and hearing of voices.</li> <li>• Focus on the importance of the conversation</li> <li>• Use of life stories (narrative therapy)</li> <li>• Process oriented rather than result oriented psychiatry.</li> <li>• Pay attention to what patients' see as problematic issues.</li> <li>• Openness towards staff involvement as the patient's equal but with special skills in relation to the patient.</li> </ul>	Romme, Marius og Eschere: "Giv stemmerne mening". System Academic  B&P p. 6

## ***Theme 2: Formalised Restraint Episodes***

<b>Strategies: Reduce patient's experience of restraints when committed</b>		
<b>Effort Area</b>	<b>Concrete Initiatives of Change</b>	<b>Appendix</b>
Information and special procedures at force commitments	<ul style="list-style-type: none"> <li>• Staff must converse with the committed patient and provide information about the course of treatment intended.</li> <li>• An environment in which the patient can feel safe must be produced, having a reception room for instance specially arranged for this purpose.</li> <li>• Patient medical history and experiences with psychiatric wards is reproduced.</li> <li>• All relevant information is distributed to the staff.</li> </ul>	FI pp.14 -15

<b>Strategies: Belt fixation</b>		
<b>Effort Area</b>	<b>Concrete Initiatives of Change</b>	<b>Appendix</b>
Reduce time spent in belt fixations	<ul style="list-style-type: none"> <li>• Maintaining belt fixation must be assessed every two hours by a doctor, and reasons for continuing belt fixation are noted.</li> <li>• Observation of patients physical and psychological reactions to belt fixation every hour by a nurse, and observations are noted.</li> </ul>	Appendix. (Norway) B&P p. 7
Regular shifts	<ul style="list-style-type: none"> <li>• Only tenured staff is sitting guard during fixation episodes</li> </ul>	FI p. 15 Appendix (Norway), Learning from Each Other
Walks	<ul style="list-style-type: none"> <li>• It is assessed whether a walk or physical activity is beneficial for the patient and belt fixation therefore temporarily loosened.</li> </ul>	B&P p. 7

<b>Strategies: Isolate restraint episodes</b>		
<b>Effort Area</b>	<b>Concrete Initiatives of Change</b>	<b>Appendix</b>
"Catastrophe Plan"	<ul style="list-style-type: none"> <li>• Coming up with a plan for the distribution of responsibility in a conflict situation:</li> <li>• For every shift 1 person is elected " First Catastrophe Person"</li> </ul>	B&P p. 5

## Theme 2: Formalised Restraint Episodes

	<ul style="list-style-type: none"> <li>• Every shift must have one person responsible for all other patients in a conflict situation.</li> <li>• Every shift must have one person responsible for calling the doctor.</li> </ul>	
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### Strategies: Inform and involve relatives

Effort Area	Concrete Initiatives of Change	Appendix
	<ul style="list-style-type: none"> <li>• When a patient is committed relatives must be informed about the practice of restraints and patient rights in order for them to understand the meaning of administered restraints.</li> <li>• Relatives must be informed if the patient is exposed to the use of restraints during his stay in the ward.</li> </ul>	B&P p. 5 Appendix: Holck, Karin & Gregersen, Ø. Jane (2003): Århus Amt (1997):

### Strategies: Working with the staff's emotional reactions

Effort Area	Concrete Initiatives of Change	Appendix
Supervision	<ul style="list-style-type: none"> <li>• During episodes involving the use of restraints staff reaction is assessed.</li> <li>• This may be in the form of a debriefing, which can and should be a part of focused supervision/learning, which can contribute to increased expertise in the handling of difficult situations.</li> </ul>	FI p. 19

## ***Theme 3: Follow-Up on Formalised Restraint Episodes***

<b>Strategies: Working on restraint episodes and creating mutual understanding</b>		
<b>Effort Area</b>	<b>Concrete Initiatives of Change</b>	<b>Appendix</b>
Patient post restraint talk	<ul style="list-style-type: none"> <li>• After each episode involving physical restraint a systematic interview must be conducted with the patient, typically one day after the restraint episode with a repetition after fourteen days and again after patient discharge.</li> <li>• The post restraint talk should be conducted by familiar and trained members of the staff.</li> <li>• Who will be the patient's contact person is appointed in full agreement.</li> <li>• A check list/structured schema on various subjects that needs to be touched upon must be produced for instance: What happened before, during and after fixation?</li> </ul>	
Conflict negotiation	<ul style="list-style-type: none"> <li>• Two caretakers will examine the possibility for one or two negotiation talks between staff and the patient. It is important that both parties are willing to engage in negotiation talks.</li> <li>• The negotiation talks include the patient (perhaps 1-2 relatives) and staff (maximum of 2) besides the negotiator.</li> <li>• After two weeks after negotiation talks a follow-up meeting is conducted where the patient and staff is asked to talk about their experience of the negotiation talk.</li> </ul>	FI p. 17

<b>Strategies: Insuring quality in relation to the use of restraints</b>		
<b>Effort Area</b>	<b>Concrete Initiatives of Change</b>	<b>Appendix</b>
Audit system for the use of restraints	<ul style="list-style-type: none"> <li>• Audit is conducted some time after the incidence after one week for instance or as monthly meetings.</li> <li>• The audit group must be of interdisciplinary composition including participants from all involved sections in the department (internal audit).</li> <li>• Audit Must consist of 5-7 participants one of which is foreman and responsible for preparing the meeting.</li> <li>• In these meetings all or an adequate number of</li> </ul>	FI p. 23-24

### Theme 3: Follow-Up on Formalised Restraint Episodes

	<p>relevant incidents must be discussed in an agenda set beforehand which might contain pre warned incidents where restraints have been used. Files, journals, called staff and Kardex etc. on the patient could be presented.</p> <ul style="list-style-type: none"> <li>• A report available for members of staff must be produced.</li> <li>• There must be focus on routines, daily business, instructions, injuries, sick days and so on. No emotional processing, supervision or similar will take place in this regard.</li> </ul>	
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## Strategies: Improve staff working environment

<b>Effort Area</b>	<b>Concrete Initiatives of Change</b>	<b>Appendix</b>
Staff debriefing	<ul style="list-style-type: none"> <li>• After each violent and restraint episode involved staff is debriefed as part of routine procedures.</li> <li>• Conducted right after the episode in groups.</li> <li>• A systematic exposition of the episode is produced including for instance a checklist with subjects to be discussed.</li> </ul>	FI pp. 21 -22 B&P p. 7 Appendix:
Follow-up on violence and threats of violence	<ul style="list-style-type: none"> <li>• Collegial support must be given right after the incident.</li> <li>• Securing that the victim is capable of transport on his own right after the incident and if not a taxi will be provided.</li> <li>• Securing that the victim is not alone after arriving at his home.</li> <li>• Department management will put down a committee responsible for following up on the episode the next day at the latest and in conference with the victim decide whether to press charges.</li> <li>• A threat and violence scheme is to be produced which must be filled out by all how are exposed to threats of physical and psychological nature.</li> </ul>	FI pp. 22 - 23  Appendix: