



Psychiatric Patient Advocate Office

Bureau de l'intervention en faveur des patients des établissements psychiatriques

Review of Seclusion and Restraint Practices in Ontario Provincial Psychiatric Hospitals

Perspectives of Patients, Clinicians and Advocates

October 2001

55 St. Clair Avenue West
8th Floor, Box 28
Toronto, ON, M4V 2Y7

Telephone: (416) 327-7000
Toll Free: 1-800-578-2343
Fax: (416) 327-7008

E-mail:
ppao@moh.gov.on.ca
Website:
www.ppao.gov.on.ca

Table of Contents

<i>Acknowledgement</i>	1
<i>Preface</i>	2
<i>Executive Summary</i>	3
<i>Summary of Findings</i>	4
<i>Summary of Client-Centred “Best Practices” Identified Through This Review</i>	6
<i>Introduction</i>	9
<i>Purpose</i>	10
<i>Legislative Framework</i>	10
<i>Classification of Restraints</i>	11
<i>Definitions</i>	12
<i>Restraints Distinguished From Treatment</i>	12
<i>Restraints Distinguished From Safety Devices</i>	12
<i>Methodology</i>	13
<i>Target Population</i>	13
<i>Materials and Procedures</i>	13
<i>Results</i>	14
<i>Participants’ Profile</i>	14
<i>Findings from Patient Interviews and Observation</i>	15
<i>Types of Seclusion/ Restraints Used</i>	15
<i>Time Spent in Restraints</i>	15
<i>Reasons for Restraint Use</i>	16
<i>Known Risk of Restraint and Alternatives Offered</i>	17
<i>Patient Care During Seclusion/ Restraint</i>	18
<i>Awareness of and Process for Release from Seclusion/ Restraint</i>	21
<i>Patient Injuries while in Restraint/ Seclusion</i>	22
<i>Findings from Clinician Interviews</i>	22
<i>Findings from Clinical Record Reviews</i>	26
<i>Physicians’ Orders/ Involvement</i>	30
<i>Documentation/ Notes</i>	30
<i>Use of Seclusion/ Restraint and Treatment of Patient</i>	30
<i>Views of other Clinical Staff about Seclusion/ Restraint</i>	31
<i>Findings from Facilities’ Seclusion/ Restraint Policy Reviews</i>	33
<i>Seclusion</i>	33
<i>Restraints</i>	36
<i>Comparing Patient and Clinical Staff Responses</i>	37
<i>Discussion, Conclusions and Recommendations</i>	39
<i>Discussion</i>	39
<i>Assessment</i>	39
<i>Planning and Individual Preference</i>	40
<i>Treatment or Care Planning</i>	41
<i>When Not to Use Seclusion or Restraint</i>	42
<i>Emotional Support</i>	42
<i>Seclusion Room and Environmental Considerations</i>	43
<i>Approved Restraints</i>	44
<i>Documentation</i>	44
<i>Education and Training</i>	45
<i>Monitoring and Observation</i>	46
<i>Complaint Mechanisms</i>	46
<i>Quality Improvement</i>	47
<i>Conclusions</i>	48
<i>Limitations and Next Steps</i>	50
<i>References</i>	51

Acknowledgement

The Psychiatric Patient Advocate Office (PPAO) would like to thank the patients, health care providers and other contributors who generously gave their time to participate in this snapshot review of seclusion and restraint use in provincial psychiatric facilities. Each perspective is valuable in gaining insight into current practice and associated issues, facilitating the development of client-centred best practices, with the aim of achieving restraint free healthcare environments.

Preface

The Psychiatric Patient Advocate Office (PPAO) is an arms length program of the Ministry of Health and Long-Term Care. It was established in 1983 to protect the rights and entitlements of patients in Ontario's provincial psychiatric hospitals.

Each year, the PPAO has approximately 14,000 client contacts, which relate to about 4,500 cases of patient concerns or complaints requiring Patient Advocates' interventions, and the balance relates to rights advice situations. Patients seeking PPAO's advocacy services consistently raised issues related to their experience in seclusion and/or restraint. Given the significance of this issue for our clients, the PPAO initiated this snapshot review of seclusion/restraint practices. As a snapshot review, the findings present what Patient Advocates learned from their interview of patients and clinicians and review of clinical records and facility policies. The patients' views are anecdotal and reflect the very personal experiences and impressions of their experience of being secluded or restrained. It is in this context that this snapshot review should be regarded. However, despite its limitations, the review identified important themes and issues related to the use of seclusion/restraints. These were consistent with our review of the related literature. The insights, thoughts, impressions and experiences have allowed the PPAO to identify several best practices, which may improve the quality of life of all patients who are subjected to seclusion/restraints. The PPAO recognizes that a formal research in this area is required, given the limited scope of this snapshot review.

Advocacy issues arising during the course of this project were dealt with at the time and these issues do not form part of this report. The data collection phase of this project was undertaken in January 2000 and completed in May 2000.

The PPAO acknowledges that since this project has been underway several of the psychiatric facilities have either reviewed or are in the process of reviewing and/or revising their seclusion and restraint policies and procedures. It is hoped that after reviewing this report more client-centred approaches will be considered and that all psychiatric facilities in Ontario will move towards becoming restraint free care and treatment environments.

Executive Summary

Seclusion and restraint procedures not only represent a significant infringement of an individual's right to autonomy and self-determination but also are associated with significant morbidity and mortality. Whereas the risks of seclusion and restraint have been well established, the benefits remain uncertain.

The following report describes a snapshot review conducted by the Psychiatric Patient Advocate Office (PPAO) in 2000 of seclusion and restraint practices within Ontario Provincial Psychiatric Hospitals and the former Queen Street Mental Health Centre. The PPAO undertook this review in response to the high frequency of concerns and issues raised by patients served related to the use of seclusion and restraint. The purpose of this snapshot review was to assess the use of seclusion and restraint from the perspectives of patients, clinicians and Patient Advocates. The review involved structured interviews with patients who had been secluded or restrained and front-line clinical staff, audits of clinical records, and reviews of relevant policies and procedures. The intent of this paper is to contribute to the development of comprehensive client-centred best practices from *a client perspective* with respect to seclusion and restraint use with the aim of achieving restraint-free care and treatment environments.

The PPAO learned a great deal from the patients, clinicians and Patient Advocates who participated in this snapshot review and who provided insight into the use of seclusion and restraint. Several limitations had an impact on this project, including: few of the clinical staff, who were responsible for the seclusion and restraint decisions for the patients involved in the snapshot review, participated in the project; and a noteworthy amount of data was missing from the surveys and interviews across all methods of data collection. There is a need for a scientific study to be conducted based on the preliminary findings of this snapshot review. However, the findings of this review are no less valuable as the issues, concerns and suggested best practices highlighted will facilitate a discussion amongst all stakeholders.

A number of themes emerged as Patient Advocates spoke to our clients about the use of seclusion and restraints. Some of these included:

- Patients told us that staff were not available to talk to them about their fears or their experiences while in seclusion or restraint or provide them with emotional support,
- Patients told us that they were not made aware of what was required of them in order to be released from seclusion or restraint,
- Patients told us that they were not offered less restrictive alternatives to seclusion or restraint.

Quality improvement opportunities were identified particularly with respect to early assessment, identification and intervention, attention to contributing interpersonal and environmental factors and addressing psychotherapeutic needs during the implementation and termination of each episode of seclusion/restraint use. Optimally, these initiatives would be components of an integrated organizational and/or system wide commitment to seclusion/restraint reduction. Twenty-three best practices with respect to seclusion/restraint use are presented based on the perspectives of patients and other findings of this review.

This snapshot review suggests that the implementation of a cross-sectoral, inter-ministerial task force with a mandate to standardize seclusion and restraint practices may be a critical success factor in addressing existing and emerging concerns and issues province-wide and would facilitate achieving the goal of restraint free care and treatment environments.

Summary of Findings

- The snapshot review revealed that the most commonly used form of restraint was physical. Physical restraints included being restrained in a bed or chair by the wrists or waist, wrists together (two point), leg to waist (two-point), and both arms and both legs (four-point).
- Over 50% of the patients interviewed indicated that they had not posed a threat to themselves or another person and there had not been in a confrontation with another person prior to being secluded or restrained.
- Just over 50% of the patients reported that the staff did not encourage them to talk about their feelings while they were in seclusion or restraint and almost 50% reported that they were not encouraged to discuss their feelings after being released.
- Almost 50% of the patients reported not being aware of what was required of them to be released from their seclusion or restraint.
- With respect to monitoring of physical status, only 12% reported that their position was changed, and none of the respondents reported having their vital signs checked.
- Clinical staff interviewed reported that 41% of patients were not offered an alternative to seclusion or restraint due to staffing levels or not having access to less restrictive options.
- In just over 50% of all cases did the physician actually assess the patient in person prior to ordering the seclusion or restraint.
- Of the clinical records audited, only just over 50% indicated that the reasons for the seclusion or restraints were explained to the patients prior to use. In at least three cases, there was no documentation as to why the patient had been secluded or restrained.
- Some inconsistencies were identified between facility policy and practice, including:
 - a) no written physician's order;
 - b) physician did not assess in person and/or sign an order;
 - c) order for chemical restraint did not include the medication, dose, or route;
 - d) documentation was unclear, inconsistent and sporadic;
 - e) the documented behaviours did not indicate the rationale for seclusion; and
 - f) no indication of considering whether seclusion would be traumatic given a history of child abuse and prior trauma that involved confinement.
- In 6 of the 9 facilities, policies on seclusion reviewed did not require a physician's order prior to use. In those policies where a physician's order was not required, the policy required that a physician's order must be obtained between 15 minutes to 1 hour of the seclusion. In one case, the policy required that a physician's order must be obtained "as soon as possible".
- In 6 of the 9 facilities, the policies required reports with respect to the observed events that precipitated the need for seclusion; however, only two facilities' policies indicated that the reasons for choosing seclusion were to be reported.
- Just over half of the policies clearly specified that less restrictive measures were to be offered to patients and that the minimal force necessary should be used to place patients in seclusion or restraint.

- Once the patient had been released from seclusion, approximately half of the policies reviewed required staff to talk with the patient to help them deal with their feelings and approximately a third of the policies required staff to discuss their own feelings after being involved in a seclusion event.

Summary of Client-Centred “Best Practices” Identified Through This Review

Based on the findings of the snapshot and a review of recent literature*, the PPAO proposes the following “best practices” to assist facilities in moving towards a restraint free environment:

- That the use of seclusion and restraint be limited to managing behavioural emergencies when all less restrictive measures have failed and unanticipated severely aggressive or destructive behaviour places the patient or others in imminent danger of harm and immediately discontinued when less restrictive alternatives are feasible.
- That seclusion and physical restraint require a written order by the physician.
- That where in the absence of immediate access to a physician, a seclusion and restraint is implemented by a registered nurse, continuation requires a face-to-face examination by a physician as soon as possible following initiation of seclusion or restraint.
- That facilities develop proactive and collaborative crisis plans, which identify interpersonal and environmental triggers to behavioural emergencies, self-management activities and clinician interventions which the client finds most helpful in ameliorating distress. When supplemented with the use of assessment and screening tools, which capture patient specific needs, preferences and choices, if acted upon, would be expected to diminish the traumatic and coercive perceptions of seclusion and restraint.
- That care planning be an inclusive process with problem identification, goals/objectives and treatment plans being collaboratively developed with the patient.
- That timely and comprehensive assessments of patients are carried out to identify at-risk persons, including, complete bio-psycho-social evaluations, detailed past psychiatric history and careful physical examination. The initial assessment should determine whether seclusion or restraint is contraindicated or must be used with caution, e.g., decompensation or other psychiatric sequelae associated with this intervention(s); history of physical and/or sexual abuse; neuroleptic malignant syndrome; unstable neurological, cardiovascular or respiratory disease.
- That psychiatric facilities establish fail safe communication mechanisms to ensure that multidisciplinary team members are notified 24/7 of patient care restrictions or precautions where the physician after completing the initial assessment determines that seclusion or restraint are contraindicated or must be implemented with caution.
- That as a minimum standard, the plan of care of patients who have been secluded or restrained reflect preferences and choices; provision of counseling, reassurance and support; explanation of the purpose for the use of seclusion or restraint; explanation of specific behaviours prerequisite to discontinuation and the process for reintegration into the program milieu.
- That the basic dignity of patients who have been secluded or restrained be protected; e.g., provided with regular personal hygiene, bathroom, exercise, nutritional and fluid breaks.

* Some of the best practices are drawn from a review of recent literature. Appropriate references are made later in this report, "Discussion, Conclusions and Recommendations".

-
- That patients who have been secluded or restrained be provided with a comfortable environment, which supports and maintains human dignity, is safe, clean and attractive, has suitable lighting and ensures both auditory and visual privacy; that natural light and exterior views be used to enhance the environment and reinforce orientation; and that ventilation allow for acceptable levels of temperature, humidity and elimination of odours.
 - That safety devices, which patients cannot remove easily and that restricts freedom of movement or normal access to their body, be categorized as physical restraints and that they be subjected to evaluation by standardized restraint assessment and intervention tools, targeted for restraint reduction programs and application of demonstrated strategies for prevention of restraint use.
 - That psychiatric facilities standardize acceptable physical restraint methods/devices and which, at a minimum, are compliant with appropriate quality and product safety standards.
 - That the use of seclusion and restraint be viewed as an extraordinary event requiring regular evaluations of mental, functional and physical status and rigorous documentation with clinical record entries no less than 15-minute intervals.
 - That staff orientation/education consistent with a “hands off” philosophy and commitment to restraint reduction is mandatory and reinforced at regular intervals, including but not limited to: mental health legislation and patients’ rights; principles of client-centred care; deleterious effects of restraint and seclusion on patients; antecedents and precipitating factors, such as environmental and interpersonal variables which contribute to aggression; early intervention; conflict resolution; de-escalation techniques; alternatives to physical restraints and proper application of restraints or therapeutic holding.
 - That clinical staff receive sensitivity training with respect to the experience of seclusion and restraint, preferably facilitated by a patient who had been previously secluded or restrained and a Patient Advocate.
 - That patients who are secluded or restrained be continuously observed and cared for by regulated health professionals.
 - That psychiatric facilities establish and standardize investigation policy and procedures related to complaints arising from seclusion and restraint episodes. The complaint and investigation process must be effectively communicated to patients, family members and all hospital staff, easily accessible, require independent investigation consistent with the principles of due process, protect the complainant from reprisal, stipulate timeframes for completion of the investigation and decision-making, and include avenues of appeal.
 - That psychiatric facilities implement risk reduction strategies, including providing fall prevention education to patients and their families, and clinical staff.
 - That the core competencies of clinical staff be continuously monitored and evaluated; these competencies to include: early recognition of signs/symptoms of incipient crisis; conflict resolution; de-escalation techniques; crisis intervention and management; supportive psychotherapy; critical incident stress debriefing and psychoeducation.

- That seclusion and restraint policy and procedures be given priority and ongoing consideration by quality and process improvement committees; and that actual and potential sentinel events associated with seclusion and restraint episodes trigger independent administrative reviews and clinical practice audits.
- That accountability mechanisms consistently capture clinician effectiveness in identifying antecedents to behavioral emergencies, effectiveness in de-escalation techniques, crisis intervention and management, conflict resolution, professional development and training resources available with respect to any identified areas requiring improvement, specific timeframes for achieving expected level of performance.
- That seclusion and restraint orders exceeding 24 hours qualify for automatic and independent peer review.
- That psychiatric facilities systematically capture data at the program and facility levels related to incidence of seclusion and restraint, antecedent behaviours precipitating use, duration of episodes, and outcome analysis.

Introduction

The Psychiatric Patient Advocate Office (PPAO) is an arms length program of the Ministry of Health and Long-Term Care. It was established in 1983 to protect the rights and entitlements of patients in Ontario's provincial psychiatric hospitals.

Each year, the PPAO has approximately 14,000 client contacts, which relate to about 4,500 cases of patient concerns or complaints requiring Patient Advocates' interventions, and the balance relates to rights advice situations. Patients seeking PPAO's advocacy services consistently raised issues related to their experience in seclusion and/or restraint. Given the significance of this issue for our clients, the PPAO initiated a formal review. A working group of PPAO's Patient Advocates developed the methodology for such a review, including data collection forms designed to capture patient concerns, evaluate facility policy and procedures, and the facility "culture" with respect to the use of seclusion and restraint. The data collection phase of this project was undertaken in January 2000 and completed in May 2000.

Within the provincial psychiatric hospitals and other Ontario psychiatric facilities the use of seclusion and mechanical restraint remains a common practice in the management of behavioural emergencies. The Joint Commission on Accreditation of Healthcare Organizations – U.S. (JCAHO) Sentinel Event Alert (November 18, 1998) highlighted that not only does restraint present a significant infringement upon the individual's autonomy and right to self determination but has significant morbidity and mortality attached. The JCAHO reviewed 20 cases related to the deaths of patients who were physically restrained. Root causes identified included deficiencies in patient assessments, inadequate care planning, lack of patient observation and procedures or practices, insufficient staff orientation or training, competency review or credentialing, or insufficient staffing levels and equipment-related factors.

A review of recent literature provided little empirical evidence to support the assumption that the risk-benefit ratio favours the application of restraint in certain situations, i.e., the risk of legal liability to hospitals as a result of failure to restrain a patient in appropriate situations and injury has occurred (see Submission to the Standing Committee on the Legislative Assembly Respecting Bill 135 Public Hospitals Amendment Act (Patient Restraints) OHA, February 12, 2001; Bower & McCullough, 2000). The clinical benefits of this procedure remain uncertain. For example, JCAHO Sentinel Event Alert (July 12, 2000) reviewed 22 cases of fatal falls in 24-hour care facilities. Reduced use of restraint without alternatives was only one of seven root causes identified, further risk reduction strategies cited did not include the greater use of restraints. However, the risks attached to this procedure have been well established, e.g., the Food & Drug Administration (FDA) estimate that at least 100 deaths occur annually from the improper use of restraints (Bower & McCullough, 2000).

Another key assumption underlying the application and implementation of seclusion and restraint is that persons who are an imminent and serious physical danger to themselves or others can be accurately identified. However, a review of recent literature continues to demonstrate that the clinical prediction of assaultive behaviour consistently produces significant false positive and false negative rates (Dickey, 2000; Hoptman et al., 1999; Nijman, Campo, Ravelli & Merkelbach, 1999; Soliman & Reza, 2001; Steinert, Wiebe & Gebhardt, 1999). Although actuarial, demographic, diagnostic and other clinical information provide significant predictive value with respect to engaging in future aggressive episodes, these risk factors do not have the specificity and sensitivity to accurately forecast the immediacy and severity of the risk presented.

Consistent with the Ministry's commitment to the principle that services will be based on best practices, i.e., activities and programs that are in keeping with the best possible evidence about what works (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997; Ministry of Health and Long-Term Care,

“Making It Happen”, 1999), this review highlights the gaps between observed practices and the characteristics of high service quality healthcare organizations which have successfully implemented restraint reduction and avoidance initiatives (Bower & McCullough, 2000; Hancock et al. , 2001; Swanger & Tomlin, 2000; Visalli & McNasser, 2000). For example, Swanger and Tomlin (2000) describe a comprehensive restraint reduction program that reduced the use of restraints by more than 60% in the acute care setting. Hancock et al. (2001) describe an interdisciplinary project, which demonstrated that fall rates did not increase and the use of restraints decreased by 83%. The authors also present concrete strategies for the prevention of restraint use.

Purpose and Scope

The purpose of this project was to review the use of restraints and seclusion throughout provincial psychiatric facilities, and the Queen Street site (a former provincial hospital) of the Centre for Addiction and Mental Health¹, from the perspectives of patients, health practitioners and Advocates. In addition, it examined seclusion and restraint from the patients’ point of view, to allow for further discussion among stakeholders and to identify best practices that could assist facilities in moving towards providing care and treatment in a restraint free environment. The findings are anecdotal and reflect the very personal experiences and impressions of those patients who were secluded or restrained. It is a non-scientific study that raises issues around seclusion and restraint use by a small number of patients. Their insights, thoughts, impressions and experiences have allowed the PPAO to identify several best practices, which may improve the quality of life for all patients. The PPAO realizes that additional research in this area is required, given the limited scope of this snapshot review.

Specifically, the purpose of the snapshot review, included:

- to review seclusion and restraint practices
- to identify opportunities to improve seclusion and restraint practices
- to raise awareness and understanding of the issues associated with seclusion and restraint
- to identify and develop *client-centred* best practices with respect to seclusion and restraint
- to encourage dialogue between patients, families and care providers with respect to seclusion and restraint utilization
- to identify issues related to systemic advocacy, and
- to identify areas requiring further research

A major purpose for examining the use of seclusion and restraints from the patients' perspective was to ensure that their views of service quality were consistently reflected in the development of best practices.

Legislative Framework

Under Ontario's Mental Health Act, patients in psychiatric facilities are detained in accordance with their legal status, which are designated under the Act. The law pertaining to their restraint varies depending on their legal status. Under the Act, the status of a patient may be one of the following:

Voluntary Patient. A person who has an unrestricted right to discharge him or herself from the psychiatric facility at any time. Voluntary patients consent to their own admission. Nothing in the Mental Health Act authorizes the restraint or detention of a voluntary patient [Section 14].

¹ Queen Street Mental Health Centre, a former provincial psychiatric hospital, was divested in early 1998 to the Centre for Addiction and Mental Health, and where the PPAO continues to provide its services.

Involuntary Patient. A person who is detained in a psychiatric facility under a certificate of involuntary admission or a certificate of renewal [Section 1]. An involuntary patient has lost his/her unrestricted right to leave the psychiatric facility and is detained pursuant to the civil commitment criteria under the Mental Health Act [Subsections 20(1.1) and 20(5)].

Detainee under the Criminal Code. A person who is found either unfit to stand trial or not criminally responsible for an offence may be placed in a psychiatric facility rather than a penal institution. Any person who is detained in a psychiatric facility under Part XX.I of the Criminal Code (Canada) may be restrained, observed and examined under the Mental Health Act [Section 25].

Informal Patient. A person who is a patient in a psychiatric facility, having been admitted with the consent of his or her substitute decision maker for the purposes of treatment. Nothing in the Mental Health Act authorizes the restraint or detention of an informal patient [Section 14].

A person undergoing a psychiatric assessment may be restrained under the Mental Health Act [Subsections 15(1) and (1.1)]. Similarly, an involuntary patient may also be restrained [Subsections 20(1.1) and (5)]. Detainees under the Criminal Code may be restrained as well under the authority of the Act [Section 25].

Although nothing in the Act authorizes a facility to detain or restrain an informal or voluntary patient [Section 14], such patients are at times restrained. Authority for the temporary restraint of voluntary or informal patients is derived from either the common law or other, applicable statutes. At common law, facilities may employ restraint in circumstances where necessary to protect the patient or others in the facility. The risk of harm must be imminent and the form and extent of restraint must be reasonable, given all factors. Restraint, therefore, must be applied for only as long as necessary to remove immediate risk.

In addition to the common law, other statutory regimes may permit limited use of restraints. For example, the Criminal Code permits the use of force for the purposes of repelling harm. Again, the use of force must be reasonable and proportionate in the circumstances.

While these statutory and common law sources of authority do not address the issues of patient status and involuntary committal, the Mental Health Act does. It is submitted that there is no legal basis for assuming that these sources override or negate the Act's involuntary committal criteria. Nor do they entail that patients who are not under certificates of involuntary admission can be indefinitely restrained if they (a) meet the involuntary committal criteria and (b) are not suitable for discharge.

Classification of Restraints

Psychiatric facilities use restraints, which may be classified into three main categories:

- (a) Environmental Restraints (e.g., barriers to free personal movement which confine patients to specific areas, such as seclusion rooms);
- (b) Physical Restraints (e.g., physical appliances which inhibit free physical movement and which cannot be removed by the person to whom they are applied, such as jacket or hand restraints);
- (c) Chemical Restraints (e.g., pharmaceuticals which are prescribed for the main purpose of altering or inhibiting specific behaviour, such as aggression).

Definitions

Section 1 of the Mental Health Act defines to "restrain" as meaning to "place under control when necessary to prevent serious bodily harm to the patient or to another person the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient".

Use of restraint must be clearly documented in the patient's clinical record by entering a statement that the patient was restrained, a description of the means of restraint used and a description of the behaviour of the patient that required him/her to be restrained or continue to be restrained. Where a chemical restraint is used, the entry shall include a statement of the chemical employed, the method of administration and the dosage [Section 53].

"Serious bodily harm" is not defined in the Mental Health Act. The inclusion of the word "serious" requires that the risk to the patient or other persons not be slight, negligible or frivolous. Consequently, there must be an apparent risk of real harm to the patient or others before restraint is employed.

In 1987, the wording of the Act was changed from "keep" to "place" to clarify the fact that restraint is not to be used any longer than is necessary to prevent serious bodily harm to the patient or others. When restraint has the desired effect of settling the patient's behaviour to the point where control is regained, its further imposition is illegal.

The words "when necessary" entail that the imposition of "force, mechanical means or chemicals" be used as a necessary last resort. Where a less intrusive means of therapeutic intervention could prevent serious bodily harm and the situation affords an opportunity for employing it, restraint is unwarranted. Further, the Act compels facilities to use the most "minimal" form of restraint when such action is required.

The phrase "having regard to the physical and mental condition of the patient" entails a proportionality test for the imposition of restraint: the restraint must be in proportion to the strength, force or ability of the aggressor. Thus, this phrase may also influence the type of restraint used.

Restraints Distinguished From Treatment

Restraint must be distinguished from various forms of treatment involving medication or enforced measures. As stated above, a restraint involves the temporary use of force to protect the patient or others. Once the imminent threat dissipates, restraint may no longer be used. Where a pharmacological regime or behaviour modification treatment is used outside the bounds of specific, temporally linked, safety measures, the treatment must be done with the informed consent of the individual.

Restraints Distinguished From Safety Devices

For the purposes of this project, restraints were also distinguished from "safety devices", which may be removed by the patient without assistance. One example is a wheelchair belt with a front-closing buckle. If the patient has limited physical dexterity, a "safety device" can take on the character of a restraining device. A safety device, which a patient cannot control, could also become a functional restraint if it is employed for institutional reasons other than patient care and safety.

Methodology

Target Population

All patients who had been secluded or restrained during three consecutive days in early 2000 were considered eligible to participate in this project. These patients were identified from the nine provincial psychiatric hospitals (PPH) and from the Queen Street site of the Centre for Addiction and Mental Health. Clinical staff involved in placing a participating patient in seclusion or restraint, either a team leader, physician or primary nurse, were also approached to participate in the project.

Materials and Procedures

Structured interviews and questionnaires were designed to gather information from patients, Patient Advocates, hospital clinical staff, and patient clinical records. Patient Advocates conducted structured interviews with patients to elicit their perspectives related to their recent experiences of seclusion and/or restraint. Structured interviews were also conducted with clinical staff members involved in the restraint and/or seclusion of a patient. These interviews were designed to obtain information regarding each facility's philosophy and culture related to the use of seclusion and restraint. Furthermore, these interviews also explored how staff interpret and apply facility policies and procedures regarding the use of seclusion and restraint.

A questionnaire specific to areas that should be documented in a patient's clinical record was used to collect this information. Advocates completed a questionnaire regarding their own observations and comments related to the use of seclusion and restraint in their designated facility site. Advocates also completed a questionnaire regarding the facilities' documented policies for seclusion and restraint.

Patients identified by a participating hospital as meeting the snapshot criteria were contacted by a Patient Advocate to request an interview. Prior to conducting interviews, Patient Advocates obtained informed consent from those patients interested in participating and able to comprehend the nature of the project. In cases where the patient declined to participate, they were assured that this decision would not affect their access to the services of the PPAO. When the patient agreed to participate, the Patient Advocate completed a structured interview and questionnaire with them. Interviews were then conducted with those clinicians that were responsible for the seclusion or restraint of participating patients. Further interviews were conducted with additional clinical staff to broaden the PPAO's understanding of a facility's culture and the process of restraint and seclusion use.

Information was also gathered on the use of seclusion or restraint from a review of the patients' clinical records. In addition, Patient Advocates reviewed policy and procedures within each hospital. Upon completion of the interviews and clinical record reviews, the Patient Advocates submitted a questionnaire related to their experiences and comments on the use of seclusion and restraint within each hospital site. Advocates also submitted the hospitals' seclusion and restraint policy and procedures for independent review.

The responses of clients and clinicians were compared by chi-square (χ^2) test, statistical analysis was conducted using SPSS software.

Results

Participants' Profile

A total of 44 psychiatric patients participated in structured interviews. However, clinical record reviews and clinician interviews resulted in information being gathered on 59 patients. The snapshot review sample was predominantly male (2M:1F), ranging in age from 15 to 85 ($M=49.2$). Table 1 presents the diagnoses of the patients and their program within the psychiatric facility.

Table 1: Diagnoses and placement of psychiatric patients ($N=59$)

Variable	<i>n</i>	%
Diagnoses		
Organic/Psychotic conditions	24	40.7
Schizophrenia	10	13.6
Other Functional Psychoses	6	10.2
Personality Disorder	1	1.7
Other Non-psychotic Mental Disorders	2	3.4
Mental Retardation	6	10.2
Unknown*	15	25.9
Program		
Acute care	2	3.4
Dual Diagnosis	6	10.2
Forensic	7	11.9
Admitting/Assessment	3	5.1
Geriatric**	23	39.0
Rehabilitation***	5	8.5
Continuing Care	4	6.8
Special Observation and Treatment	1	1.7
Crisis	1	1.7
Community Liaison	2	3.4
Adult	1	1.7
Adolescent	1	1.7

Note: Some patients had more than one diagnosis; therefore, totals will not equal 100%.

* unknown were patients in assessment or not reported

** includes memory disorder

*** includes Forensic Rehabilitation

Interviews with clinicians, who were involved in placing patients in seclusion or restraint, were conducted for 17 of the patients. Participating clinicians included 15 nursing staff, 1 medical staff, and 1 staff whose profession was not indicated. Clinical record reviews were conducted on 59 patients.

Findings from Patient Interviews and Observation

Types of Seclusion/Restraints Used

The survey results indicated that various forms of restraint and seclusion were administered to the patients in the facilities. Both clinical record reviews and patient interviews were conducted to determine the methods of seclusion or restraint that were used. Table 2 presents the methods of restraint and/or seclusion from both sources.

Table 2: Method of restraint/seclusion.

Method	Patient Interview (N=44)		Clinical Record Review (N=59)	
	<i>n</i>	%	<i>n</i>	%
Physical	23	52.3	24	40.7
Seclusion	16	36.3	19	32.2
Chemical	2	4.5	2	3.4
Seclusion and Chemical	1	2.3	6	10.2
Seclusion and Physical*	1	2.3	2	3.4
Physical and Chemical	0	0.0	2	3.4
Seclusion, Chemical and Physical	1	2.3	1	1.7
Unknown	0	0.0	3	5.1

*In one case, the clinical record review indicated a chemical restraint only; however, the information provided in the clinical record review clearly indicated that the patient was also physically restrained.

The most commonly used form of restraint was physical. According to patient interviews, over half of those who responded had been restrained through the use of a physical apparatus ($n=25$, 56.8%). According to information recorded in the patients' clinical records, 49% ($n=29$) of patients had been placed in a physical restraint. Physical restraints included being restrained in the bed or chair by the wrists or waist, wrists together (two point), leg to waist (two point), and both arms and both legs (four point). In some instances, more than one type of physical restraint was used with patients. For example, one patient was reportedly placed in a four-point restraint and then later in a three point restraint while another patient was reportedly occasionally restrained by the wrist to the bed or a chair and then at other times with both ankles together. The second most commonly used restraint, identified through both interviews and clinical record reviews, was the use of seclusion. Interviews with patients revealed that 43% ($n=19$) of the respondents had spent some time in seclusion and clinical record reviews indicated that 47% ($n=28$) of patients had been in seclusion.

Time Spent in Restraints

Clinical record reviews revealed that the patients' time in restraints (seclusion, physical, and/or chemical) lasted anywhere from 10 minutes to being continuous. Fourteen (23.7%) of the patients were reported to be constantly in physical restraints. These individuals were geriatric patients who were usually in a geriatric chair with either a belt or a tray restricting them through the day and a bed restraint at night (e.g., locked

posey belt, segufix, and sheet restraint). It is important to distinguish between restraints as defined in the Mental Health Act and those restraints, which are used as safety or protective devices. Aside from these geriatric patients, 27% ($n=16$) of patients were in a restraint for more than 12 hours at a time with six of these being in restraints almost constantly and 10 being in restraints between 13 hours and 7 days. Moreover, one patient was noted to have been restrained for over 9 days; however, this was reportedly not continuous. Two patients were reportedly placed in restraints at night only.

Forty-one (69.5%) clinical record reviews indicated that the patient had been placed in restraints/seclusion on other occasions over the past 12 months. Although 8.5% of patients had not previously been in restraints/seclusion, some of these patients had been in the hospital for a very short period of time. Previous seclusion or restraint information was missing or omitted for 13 (22%) patients. Information was available on 11 of those who had previously been placed in restraints/seclusion and the number of times that this had occurred ranged from between 1 and 68.

Table 3 indicates whether the patients believed that they were secluded/restrained longer than was necessary.

Table 3: Restrained/secluded longer than necessary ($N=44$)

Response	n	%
Yes	7	15.9
No	11	25.0
Unknown/unsure	3	6.8
Not applicable*	17	38.6
Missing	6	13.6

* The majority of those patients were geriatric patients who are restrained almost continuously as a means of preventing falls and possible self injury.

Of those patients who recalled the circumstances or where the question was relevant, 61% believed that they were placed in seclusion or restraint for an appropriate length of time.

Reasons for Restraint Use

Patients were asked whether they had threatened to injure or harm themselves or another person prior to being placed in seclusion or restraints. They were also asked if they had confronted another person prior to being placed in seclusion. Their responses are presented in Table 4.

Over one third of patients indicated threatening harm to either themselves or another resident or staff member and a similar number of patients actually had been involved in a confrontation with another person prior to being placed in seclusion or restraint. However, over half of the respondents indicated that they had not posed a threat to themselves or another person and had not been in a confrontation with another person prior to being restrained or secluded. However, very few of these respondents could indicate the non-aggressive behaviours they were engaging in prior to being restrained or secluded. Of those who did comment, one respondent indicated that her behaviour did not warrant seclusion noting that she was “just walking around the ward”. Other comments included, a disagreement with staff, singing too loudly, “standing up for my rights”, hearing voices, taking another’s property, wanting to stay in bed, and refusing to take oral medication as reasons for seclusion or restraint. Other comments from patients included blaming staff for their seclusion or restraint, noting that staff do not like them, push them to their

limit, are on a “control trip” and/or a “power trip”, and because staff believed that the patient “was trying to be smart”.

Table 4: Prior threats of harm and confrontation (N=44)

Response	<i>n</i>	%
Threats to self or others		
Yes	16	36.4
No	25	56.8
Unknown/unsure	2	4.5
Missing	1	2.3
Confrontation with another		
Yes	17	38.6
No	26	59.1
Missing	1	2.3

Known Risk of Restraint and Alternatives Offered

Whether or not the patient knew that they were at risk for being placed in seclusion or restraints and whether an alternative method was offered is presented in Table 5.

Table 5: Known "at risk" of seclusion or restraint and alternatives offered (N=44).

Response	<i>n</i>	%
Known risk		
Yes	11	25.0
No	9	20.5
Unknown/unsure	6	13.6
Not applicable*	17	38.6
Missing	1	2.3
Alternative offered		
Yes	8	18.2
No	13	29.5
Unknown/unsure	5	11.4
Not applicable*	17	38.6
Missing	1	2.3

* Those that were recorded as not applicable included geriatric patients where an option was not available due to personal safety.

One quarter of patients knew that they were at risk for being placed in seclusion or restraints prior to this occurring. Patients noted that they were warned prior to their restraint or seclusion in various ways, including: being told that if their behaviour did not change or stop that they would be in restraints; in another case, a patient reported that about 20 seconds before the seclusion or restraint, staff told the patient that he was about to lose his security level and be secluded. However, as can be seen in Table 5,

approximately 20% of patients were not aware they would be restrained or secluded. Comments from some of these patients included: that a staff was “intent on taking my privilege level away” and “made it look like I was being a problem”; I was “automatically locked up and nothing was said”. In some cases patients indicated that no comments were made. Less than 20% of the patients reported being offered an alternative to seclusion or restraint

Patient Care During Seclusion/Restraint

Given the length of many seclusions and restraints, personal requirements such as meals and fluids, bathroom needs, and fears or concerns may need to be addressed. Table 6 presents the responses as to whether these needs were attended to.

Table 6: Attention to personal needs in seclusion/restraint (N=44).

Needs	Needs attended to		
	Yes (%)	No (%)	Unknown, N/A, Missing (%)
Fluids	30 (68.2)	2 (4.5)	12 (27.3)
Bathroom	33 (75.0)	1 (2.3)	6 (13.6)
Meals	29 (65.9)	0 (0.0)	15 (34.1)
Break/exercise	26 (59.1)	5 (11.4)	13 (29.5)
Fears	22 (50.0)	7 (15.9)	15 (34.1)
Concerns	19 (43.2)	10 (22.7)	15 (34.1)

Note: Those in the unknown, not applicable (N/A), and missing category usually included patients who were restrained/secluded for a short period of time or overnight.

Over half of those surveyed (N=44) reported that their needs were met in most areas. However, only half of the patients felt that their fears and less than half felt that their concerns were addressed during the time that they were secluded/restrained. Furthermore, almost 35% of those who reported concerns and 24% of those with fears indicated that these issues were not addressed with them.

Table 7 presents the patients' responses to whether the staff assisted them in talking about their feelings while they were in seclusion or restraint and after they were released from the seclusion or restraint. Of those who recalled the incident or where the situation was applicable, 52.6% of patients reported that the staff did not encourage them to talk about their feelings while they were in seclusion or restraint and 46.6% reported that they were not encouraged to discuss their feelings after being released.

Table 7: Encouraged discussion of feelings during and after restraint (N=44).

Response	<i>n</i>	%
During restraint/seclusion		
Yes	9	20.4
No	10	22.7
Unknown/unsure	4	9.1
Not applicable*	17	38.6
Missing	4	9.1
Post restraint/seclusion		
Yes	8	18.2
No	7	15.9
Unknown/unsure	4	9.1
Not applicable*	20	45.4
Missing	5	11.4

* usually included patients who were restrained/secluded for a short period of time or overnight

Table 8 presents the findings of whether staff talked to the patients or had contact with them while they were in seclusion or restraint. The majority of patients reported that staff were in contact with them or talked with them during the time that they were secluded and/or restrained.

Table 8: Contact with staff during seclusion/restraint (N=44)

Response	<i>n</i>	%
Yes	31	70.5
No	7	15.9
Unknown/unsure	3	6.8
Not applicable*	1	2.3
Missing	2	4.5

* usually included patients who were restrained/secluded for a short period of time or overnight

A total of 25 patients who participated in the interview process were placed in some type of restraint. Their experiences are presented below in Table 9.

Table 9 presents patients' responses to questions related to the tension of the restraint as well as to the care they received by staff as required from being in a restraint. The majority of patients who were placed in restraints indicated that their restraints were loose enough and that the circulation in their arms and legs was checked. However, only 12% reported that their position was changed and none of the respondents indicated that their heart and pulse were checked. Those respondents who indicated that these questions were not relevant were restrained with a belt or a sheet that allowed for movement during the night and/or restrained in a chair during the day, either with a belt or a tray.

Table 9: Patients' experiences of being in a restraint (N=25)

Response	<i>n</i>	%
Restraint was loose		
Yes	17	68.0
No	0	0.0
Unknown/unsure	2	8.0
Not applicable	2	8.0
Missing	4	16.0
Circulation was checked		
Yes	17	68.0
No	0	0.0
Unknown	2	8.0
Not applicable	2	8.0
Missing	4	16.0
Arms/legs were moved on regular basis		
Yes	2	8.0
No	1	4.0
Unknown	1	4.0
Not applicable	17	68.0
Missing	4	16.0
Position changed		
Yes	3	12.0
No	1	4.0
Unknown	2	8.0
Not applicable	17	68.0
Missing	2	8.0
Pulse/heart checked		
Unknown	2	8.0
Not applicable	15	60.0
Missing	6	24.0

Thirty-nine patients (88.6%) of patients reported that they were taking medication for a psychiatric condition and twenty-five (56.8%) indicated that they were on medication for other conditions. During seclusion or restraint, thirty-one (70.4%) of respondents indicated that they were given medication; however, just over half (52.3%) of the participants recalled being told the reason for the medication and twenty-six (59%) indicated consenting to take the medication that they were offered while in seclusion or restraint. It is important to note that twenty-four (54.5%) reported that the medication they received in seclusion or restraint was the same medication that they are usually prescribed.

Of those participating in the interview, eleven (25%) indicated that they smoked. However, of those who were smokers, only 3 (12%) reported receiving cigarettes while in seclusion and restraint.

Awareness of and Process for Release from Seclusion/Restraint

Table 10 presents responses from patients as to whether they were told what was expected of them in order for them to be released from their seclusion or restraint.

Table 10: Patients knew the requirements for being released (N=44)

Response	<i>n</i>	%
Yes	11	25.0
No	10	22.7
Unknown/unsure	4	9.1
Not applicable*	18	40.9
Missing	1	2.3

* usually included patients who were restrained/secluded for a short period of time or overnight.

Although 25% recalled being aware of what was required of them in order to be released from their seclusion or restraint, almost half (47.6%) of those who recalled the incident and responded to the question were not aware of what was required of them.

The process used for removing patients from seclusion or restraint are listed in Table 11.

Table 11: Process for being released from seclusion/restraint.

Methods
<ul style="list-style-type: none"> ▪ fell asleep and when woke they said they would try and bring me out of seclusion again ▪ staff let me out and then I spoke to my physician ▪ the night staff came on and they agreed to let me out without further explanation ▪ asked to come out and staff gave me a chance ▪ gradually ▪ suddenly ▪ gradually through segregation

In most cases, patients did not comment on how they were removed from seclusion or restraint. Patients also described why they believed they were released from seclusion or restraint including: the physician assessed and released patient in the morning; their behaviour was settled; the patient “offered to be good”; their affect was calmed and flat; the patient agreed to take medication; and the patient is on a program where patients are released to do some walking (geriatric patients).

Patient Injuries while in Restraint/Seclusion

The number of patients who reported injuries occurring while they were being placed in seclusion or restraint and those who indicated injuries while they were in seclusion or restraint are presented in Table 12.

Table 12: Injuries during placement and while in seclusion/restraint (N=44)

Injuries occurred	<i>n</i>	%
While placed in seclusion/restraint		
Yes	4	9.1
No	33	75.0
Unknown/unsure	3	6.8
Missing	4	9.1
During seclusion/restraint		
Yes	4	9.1
No	30	68.2
Unknown	3	6.8
Missing	7	15.9

The majority of those who responded indicated that they did not receive injuries during the process of being placed in or while in seclusion or restraints. However, four patients did report receiving injuries while being placed in and during their seclusion or restraints. Comments regarding the injuries they suffered included bruises to their wrist, scratches, bruises and scrapes to their arm, that their arthritis was aggravated due to sleeping on a cement floor, and bruises to arms, wrists, legs, ankles as a result of punching the walls. 75% of those respondents who recalled the incident or who the question was relevant to reported believing that the least amount of force necessary to place them in seclusion or restraint was used. However, this result also indicates that 25% of respondents did not feel that the least amount of force necessary was used while they were being placed in seclusion or restraint .

Findings from Clinician Interviews

A total of 17 clinicians responded to interviews based on their experience of placing one of the participating patients in seclusion or restraint. The respondents included 15 (88.2%) nursing staff, 1 (5.9%) attending physician, and 1 (5.9%) unknown profession. The following information is based on the responses of these participants regarding the seclusion or restraint of 17 patients.

Respondents indicated that 12 (70.6%) of the patients were threatening to injure either themselves or others prior to being placed in seclusion or restraint. They indicated that the patients displayed these threats through various means including: verbally; physically with other people; physically with inanimate objects; thoughts and attempts to self-harm; and through shouting, kicking, biting. In one case, although the patient had not done anything directly, the staff felt that the potential threat was apparent. The staff indicated that the purpose of the restraint was to: settle/calm patient (29%); decrease stimuli (17.6%); keep other patients and/or staff safe (47%); provide a quiet atmosphere for the patient (11.8%); and to protect from fall or injury (17.6%). Other reasons reported for one patient each (5.8%) included protecting the patient from self-harm, to decrease the patients agitation, to consequence behaviours, and as requested by the patient.

Staff were asked whether they explained to the patient that seclusion or restraint might be used prior to its implementation, whether alternatives to seclusion or restraint were attempted or considered, and whether the patient was told what was required of them in order to be released from their seclusion or restraint. The results of these questions are presented in Table 13.

Table 13: Information provided to patient prior to seclusion/restraint (N=17)

Response	<i>n</i>	%
Patient was told about the potential use of seclusion/restraint		
Yes	10	58.8
No	5	29.4
Unknown/unsure	1	5.9
Missing	1	5.9
Alternatives to seclusion/restraint were not used/considered*		
Yes	7	41.2
No	8	47.1
Not applicable	1	5.9
Missing	1	5.9
Patient was told what was expected of them to be released		
Yes	9	52.9
No	2	11.8
Not applicable	3	17.6
Missing	3	17.6

* Staff were asked if these alternatives were not considered due to resources

More than half of the staff reported that the patient was informed that the use of seclusion or restraint was a possibility prior to them being placed in such. Prior to the patients being placed in seclusion or restraint, a number of alternative interventions were reportedly considered or used. These alternatives included medications, verbal discussions with staff, close observation, encouraged segregation, teaching inappropriateness of aggression, armchair offered without restraint, time out in room, and a punching bag. On the other hand, one patient was reportedly not offered an alternative as a result of their history of becoming aggressive and not settling down.

As can be seen in Table 13, 41% of the patients were not offered an alternative due to staffing levels or access to resources. Staff would have considered alternatives, if able; however, they noted various reasons for not using alternatives including: the facility does not have a calming/dark room; there is no alternative room; there are no diversion activities; there is a lack of safety gowns and sheets; there are not enough staff available to provide constant observation at the time of an incident; and staff are not available to provide constant nursing observation. Furthermore, one respondent commented that one of the shifts in the facility tends to experience more outbursts by patients than other shifts and it was noted that this may be due to a lack of appropriate staff training.

More than half of the staff indicated that the patients were aware of what they were required to do in order for them to be released from seclusion or restraint.

The staff indicated that prior to placing the patient in seclusion or restraint, they determined that this method was the most reasonable and used the least amount of force for various reasons. The reasons listed included: a review of the patients' history; the degree of risk to themselves; a failure of lesser and alternative interventions; is the most limited and immediate intervention until medication takes effect and the patient settles; through discussions with the physician, situation warranted seclusion for safety; the risk and danger to others was considered; and other staff supported the use of the intervention.

The mental and physical conditions of the patients were considered prior to the use of seclusion or restraint in the following ways. Staff involved family members in decision making, discussed the situation with the physician, conducted a ward conference, considered that for one patient seclusion is the least restrictive method, considered the medical and psychiatric history, considered the history of self abuse and aggression, and considered the patient's wishes. In many cases, staff noted the patient's threat of and/or history of aggression, threat or history of self-harm, and personal needs (e.g., to reduce external stimuli). The details of this assessment process need to be well documented as does the various alternatives considered and the decision made to use seclusion or restraint.

While the patient was in seclusion or restraint, the staff were asked whether they stayed in active contact with them and whether they discussed, with the patient, their feelings about having been in seclusion or restraint. Table 14 presents the results of these questions.

Table 14: Contact with patient during and post restraint/seclusion (N=17)

Response	<i>n</i>	%
Active contact during seclusion/restraint		
Yes	16	94.1
No	1	5.9
Discussed patients feelings*		
Yes	9	52.9
No	2	11.8
Unknown/don't recall	2	11.8
Not applicable	1	5.9
Missing	3	17.6

* post seclusion/restraint regarding their feelings about their experience

All but one patient reportedly received active contact from the staff throughout their time in seclusion or restraint. Half of the patients were encouraged to discuss their feelings about having been secluded/restrained once they were released. However, it is important to note that close to 30% ($n=5$) of those interviewed did not respond to this question or could not recall whether the feelings of the patients were discussed post seclusion or restraint.

Two (11.8%) patients were reportedly injured during the time that they were being placed in seclusion or restraints and one (5.9%) patient was reportedly injured while in seclusion or restraint. However, the types of injury sustained by the patients were not reported. It was noted that the medical condition of one patient reportedly worsened as a result of seclusion or restraint. In all cases but one, clinical staff only were involved in secluding/restraining the patients; however, the non-clinical staff involved in the seclusion or restraint of one (5.9%) patient was not identified.

Staff were asked whether there has ever been a history taken of the patients' possible sexual or physical victimization. In cases where this information is known, staff were also asked if this was taken into account prior to seclusion or restraint. Their responses are presented in Table 15.

Table 15: Consideration of sexual and/or physical abuse history (N=17)

Response	<i>n</i>	%
History of abuse taken		
Yes	8	47.1
No	1	5.9
Unknown/unsure	7	41.2
Missing	1	5.9
History of abuse considered prior to seclusion/restraint*		
Yes	3	37.5
No	2	25.0
Not applicable	2	25.0
Missing	1	12.5

* includes only those where a history of abuse has been taken

A history of physical and/or sexual abuse was taken on less than half of the patients. Furthermore, less than half of the staff admitted to having no knowledge of whether a history of abuse had ever been determined for their patients. In one case, no history of abuse had been conducted. As can be seen in Table 15, staff considered the known history of abuse for 3 patients prior to placing them in seclusion or restraint. Moreover, in 2 (25%) cases, staff deemed that a known history of abuse was not applicable to whether they were placed in seclusion or restraint.

Where a history of abuse was considered prior to seclusion or restraint, staff indicated that one patient had seen a psychologist and attended anger management group; however, from the staff's perspective, this patient continued to use their abuse history as an excuse for physical behaviour. On the other hand, consideration of an abuse history have lead staff to modify their intervention, e.g., administration of an intramuscular injection in the leg rather than hip area, thereby responding to the patient's request of not wishing to have his pants being taken down.

Seven (41.2%) patients received medications, in addition to those regularly prescribed, while in seclusion or restraint. Of those who took additional medications while in seclusion or restraint, 85.7% (*n*=6) were informed of what the medication was for and one (14.3%) patient reportedly did not consent to taking the medication.

Staff were asked whether there is a point where seclusion or restraint for their patient is contraindicated or counter-therapeutic. They were also asked whether a combination of seclusion and restraint was ever used with the patient. Their responses are provided in Table 16.

Table 16: Duration and combined use of seclusion/restraint (N=17)

Response	<i>n</i>	%
Ever contraindicated		
Yes	7	41.2
No	3	17.6
Unknown/unsure	4	23.5
Missing	3	17.6
Ever combine seclusion and restraint		
Yes	9	52.9
No	5	29.4
Missing	3	17.6

Staff indicated that there is a time period when seclusion or restraint is no longer effective with 41.2% of patients. Staff reported that the optimal length of seclusion for their patients varies and can last anywhere from 15 minutes to 1 week. The optimal length of time for four of the patients reportedly varies depending on how long they take to settle. There were circumstances noted that would require 52% of patients to be both secluded and restrained. These circumstances were described by staff as necessary in a number of situations such as: to prevent self injury; when unable to settle in seclusion; if in seclusion the patient continues to be a danger to others; when patient is overly psychotic or delusional and aggressive; or when the patient continues to be a risk to staff while in seclusion.

Staff reported that the use of seclusion or restraints is effective with all the patients that their interviews were regarding.

Findings from Clinical Record Reviews

Clinical record reviews were conducted on a total of 59 patients who were reported to have been in seclusion or restraint. Clinical record reviews were conducted on 15 patients who did not participate in an interview and in 44 cases where the clinician was not interviewed. The PPAO Patient Advocate conducted all clinical record reviews and the results of these reviews are presented below.

Reviewers were asked to note whether there was a physician's order prior to the patient being secluded or restrained and whether the physician assessed the patient in person prior to the seclusion or restraint. The results of these questions are presented in Table 17.

The results indicated that most of the patients (78%) received a physician's order prior to being placed in seclusion or restraint. However, in only 52.5% of all cases did the physician actually assess the patient in person prior to ordering the seclusion or restraint. Moreover, in those cases (78%) of seclusion or restraint where there was a physician's order, only 15 (32.6%) of the orders specified a length of time. Therefore, more than half of the physician's orders for seclusion or restraint did not specify a duration. Patients were released from their seclusion or restraint on a trial basis in 11 (18.6%) cases. In cases where patients were released on a trial basis, but were then re-restrained or secluded, the reasons included, circumstances where the patients were aggressive, vocal, intrusive, and unpredictable. However, on a number of occasions, the reasons for patients being placed back in seclusion or restraint were not documented and, therefore, unknown. In 17 (28.8%) cases, patients were not given a trial release and in 14 (23.6%) cases the information on this issue was either missing or unclear. However, in 17 (28.8%) cases, a

trial release was not considered applicable to the patients as they were geriatric patients in restraints for safety either at night only or both during the day and night.

Table 17: Physician's order and assessment prior to restraint/seclusion (N=59)

Response	<i>n</i>	%
There was a physician's order		
Yes	46	78.0
No	6	10.2
Missing	7	11.9
The physician assessed the patient in person		
Yes	31	52.5
No	10	16.9
Unknown	9	15.3
Not applicable	1	1.7
Missing	8	13.6

Reasons for the use of seclusion or restraint with patients, as noted in the clinical records, included violent behaviours such as physical aggression, threats, and verbal abuse. Self-harm was also documented and included suicidal threats and behaviours as well as self-neglect behaviours. In at least three cases, there was no documentation as to why the patient had been secluded or restrained and this should cause both the facility and the treatment team great concern. Staff charted a number of interventions that were attempted prior to seclusion or restraint including medications, verbal diffusion or intervention, offering time away from other residents (e.g., time out), teaching, choices, and offering alternative methods of coping. However, in at least 12 (20.3%) cases there were no alternative interventions documented as being attempted by staff.

Table 18 presents the results of whether clinical records documented that the form of seclusion or restraint used the least amount of force necessary with regard to the patient's physical and mental conditions. Table 18 also indicates whether the patient was informed of the reasons they were being placed in seclusion or restraint.

As can be seen in Table 18, only 10.2% of clinical records indicated that the method used on patients was considered to apply the least amount of force necessary. However, this information was not documented in just under half of all cases. Moreover, 25% of the clinical records indicated that this issue was not applicable to the patients. Although most of these patients were geriatric (93.3%) and restrained for personal safety, it would be important to note that these clinical records did not indicate whether the restraint applied was considered to use the least amount of force necessary.

Table 18: Minimal force and explanation prior to restraint/seclusion (N=59)

Response	<i>n</i>	%
Restraint/seclusion used minimal force		
Yes	6	10.2
No	28	47.5
Unknown	2	3.4
Not applicable	15	25.4
Missing	8	13.6
Explanation of reason for restraint/seclusion		
Yes	32	54.2
No	5	8.5
Unknown	14	23.7
Missing	8	13.6

Just over half of the clinical records (54.2%) indicated that the reasons for the seclusion or restraints were explained to the patients prior to their use; however, 23.7% of the clinical records did not indicate this information. Reasons given to the patients for seclusion or restraint included: that they were at risk to harm themselves or others; in order for them to calm down; due to their unpredictable behaviours; because of threatening comments to staff and other patients; hostility; that their behaviour would not be tolerated; verbal abuse; and their inability to control themselves.

The clinical record documentation on the use of medication with the patients is presented in Table 19.

Table 19: Medication used and consent during restraint/seclusion (N=59)

Response	<i>n</i>	%
Medication was used during restraint/seclusion		
Yes	36	61.0
No	9	15.3
Unknown	2	3.4
Not applicable	3	5.1
Missing	9	15.3
Patient consented to medication*		
Yes	17	47.2
No	4	11.1
Unknown	3	8.3
Not applicable**	11	30.6
Missing	1	2.8

*includes only those cases where medication was charted

** in many cases patients were incapable of consenting

Clinical record reviews revealed that thirty-six (61%) patients were given medication while they were secluded or restrained. Of these 36 patients, 47.2% consented to being given this medication; however, 11.1% did not consent. In other cases, this information was either not documented in the clinical records or was not reported in the survey by the reviewer.

While in seclusion or restraint, thirty-five (59.3%) patients were allowed to remain in their own clothing; however, this information was not documented in ten (16.9%) of the clinical records. In the 15% of cases where patients were not allowed to remain in their own clothing, clinical records revealed that they were placed in hospital gowns, clothes from hospital supply, track suits, seclusion gowns, and in some cases on a blanket was provided, or the patient was nude.

The times that food and refreshments were provided to the patients varied during their seclusion or restraint; however, clinical records revealed that in 35.6% of cases, food was provided during regular meal times and an occasional snack was also offered. However, in 7 (11.9%) cases, food and liquids were not recorded and in 8 (13.5%) cases the restraint occurred overnight or the seclusion or restraint was less than 1 hour and, therefore, the question was not relevant. Access to the washroom also varied. However, clinical records indicated that 7 (11.9%) of the patients were provided with a toilet, bucket, or urinal. Eighteen clinical records documented that patients were taken to the washroom as needed and eight clinical records indicated that washroom access was not applicable as the restraint occurred either during sleep; for a short period of time only; or the patient could not access a washroom due to physical limitation.

Table 20 presents the results of whether non-clinical staff were involved in secluding/restraining patients.

Table 20: Non-clinical staff were involved in seclusion/restraint (N=59)

Response	<i>n</i>	%
Yes	5	8.5
No	39	66.1
Unknown	11	18.6
Missing	4	6.8

In the majority of clinical records, information indicated that non-clinical staff were not involved in placing the patient in seclusion or restraint. However, this information was unknown in 18.6% of clinical records. Those times where a non-clinical staff was involved in the seclusion or restraint of a patient, the non-clinical staff included security in four cases and an attendant in one case.

The final question investigated in the clinical record review regarded whether facility policy was adhered to during the commission of the seclusion or restraint. The results of this information are presented in Table 21.

Table 21: Facility policy followed during seclusion/restraint (N=59)

Response	<i>n</i>	%
Yes	39	66.1
No	12	20.3
Unknown	4	6.8
Missing	4	6.8

As can be seen in Table 21, 66.1% of clinical records reviewed indicated that facility policy was followed during the seclusion or restraint of the patients. However, in 20% of cases, the reviewer indicated that facility policy was not followed. The reasons that were provided are outlined below.

Related to Physicians' Orders/Involvement

- no written physician's order
- physician's assessment was not done in specified time frame
- physician's order cannot be located
- physician did not assess in person and/or sign an order
- order for chemical restraint did not include the medication, dose, or route

Related to Documentation/Notes

- clinical record review was not properly done and procedures are not documented
- documentation is unclear, inconsistent, and sporadic
- no notes of daily assessment
- no indication of who administered the restraint or how
- no reason for placement in seclusion
- the documented behaviours do not indicate the need/reason for seclusion

Related to Use of Seclusion/Restraint and Treatment of Patient

- restraint is being used as a treatment plan
- patient was placed in seclusion for more than allowable time frame without a physician's order
- treatment does not follow physician's order (e.g., ordered restraint but also received seclusion)
- no interaction with the patient
- no indication of who and how many placed the patient in seclusion
- no indication of the patient being taken to bathroom
- required counselling is not being used for the purposes that it is intended
- was not provided with the "special care" that they should have received given a history of abuse or trauma
- not considered for being taken to bathroom (urinal provided from the beginning)
- restraint was not removed at least every 2 hours as stated in policy
- no indication of considering whether seclusion would be traumatic given a history of child abuse and prior trauma that involved confinement

- staff's fear of the patient seems to have resulted in seclusion instead of any specific behaviours displayed by the patient

Furthermore, some of the reviewers noted a number of other concerns or issues regarding information uncovered in the clinical record reviews. Their comments are listed below.

- does not appear that the patient was given any information or an explanation as to what was happening (re: seclusion or restraint)
- lack of medical assessments when placing patients in seclusion
- concern about treatment of those patients on this ward
- patients have a lack of independence and interaction with others
- new policies are inadequate (1999) and are open to interpretation
- occasionally the physicians' orders seem questionable

Views of other Clinical Staff about Seclusion/Restraint

Clinical staff who were not specifically responsible for the restraints/seclusion of the patients who participated in this project, and who were willing to respond to the questions were interviewed regarding their views. A total of 38 clinical staff from 5 facilities completed this part of the project. Of these participants, 32 (84.2%) were nursing staff, 1 (2.6%) was a medical staff, and 5 (13.1%) of the respondents' professions were unknown. Staff were asked to respond to and comment on a variety of questions regarding the use of seclusion or restraint. The results of their responses are presented below.

Staff were asked to indicate whether they supported providing cigarettes or nicotine replacement to a patient while in seclusion. The respondents were equally split in their responses with 19 (50%) believing that this was not a good idea and 19 (50%) supporting the use of nicotine in seclusion or restraint. One staff who supported the allowance of nicotine in seclusion or restraint commented that they would use nicotine replacement if it would help to calm and relax the patient. Another respondent reported that nicotine replacement should be offered, but not cigarettes. On the other hand, there were more comments as to why the patient should *not* be offered cigarettes or nicotine replacement. These responses included: the possibility of self-harm; a health and safety issue (e.g. smoking in a closed environment); and that with seclusion or restraint comes a loss of privileges and cigarette smoking is considered a privilege. One staff commented that regardless of the patient being allowed a cigarette or nicotine, the length of stay in seclusion is not shortened; however, not allowing cigarettes can act as incentive for the patient to calm down and get out of seclusion.

Of those interviewed, 31 (81.6%) believed that taking an abuse history of all patients which includes knowledge of physical and sexual abuse/assault was important. Comments on this issue included suggestions that knowing the history would influence the decision of how to put the person in seclusion or restraints, that treatment could be individualized, that the gender of those who place the patient in seclusion or restraint as well as the type of seclusion or restraint to be used could be considered. However, those who did not support taking an abuse history did not comment as to why they would not support this.

The respondents were questioned as to whether the safety of staff and patients could be ensured without the use of seclusion or restraint. Staff were also asked whether alternative methods would be considered given their availability in their facility. The responses are presented in Table 22.

Table 22: Alternatives to the use of seclusion/restraint (N=38)

Response	<i>n</i>	%
Alternative measures could be used		
Yes	10	26.3
No	10	26.3
Unknown/unsure	12	31.6
Missing	6	15.8
Would consider alternatives if available		
Yes	12	31.6
No	9	23.7
Unknown	14	36.8
Missing	3	7.9

As can be seen from Table 22, an equal number of respondents did and did not believe that there are alternatives to seclusion or restraint that would keep staff and patients safe. It is important to note that approximately one third of the respondents were not aware of any alternative measures that they could use. Suggestions for the use of alternatives included increasing the patient to staff ratio and providing constant observation over time. However, those opposed or unaware of alternatives reported that some measure of discipline should be applied to deter aggressive behaviours and that they are unaware of any hospital not using seclusion or restraint. Table 22 also presents the number of staff who did and did not believe that less restrictive measures could be used, if they were available. One third of respondents would use another method if the opportunity was available in the facility. These respondents indicated few alternatives, but did report that therapeutic touch and discharge were alternative options. Respondents noted that examples of less restrictive measures usually considered in their facility included verbal diffusion, time outs (voluntary), rewards for changing behaviours, redirection, medication, geriatric chairs, and outnumbering patients with staff.

All of those who responded ($n=36$, 94.7%), indicated believing that educating patients as to why and how seclusion or restraint are used is valuable. These respondents noted that patients need to understand the reasons, needs, and purpose for seclusion or restraint. One staff also noted that it can be a frightening experience to see another person secluded or restrained and, therefore, prior education may reduce the fear in patients. Other comments included: that it is important for patients to understand that seclusion or restraint is a form of treatment and not punishment; and that once patients are aware of the use of the seclusion rooms, they try to avoid being placed there.

The final questions asked of the respondents regarded whether they believed that it was valuable to include patients in their own treatment plans. Specifically, clinical staff were asked whether they believed it was a good idea to ask patients their thoughts on ways or mechanisms that could be used to de-escalate themselves. Their responses are included in Table 23.

Table 23: Patient input regarding their own de-escalation (N=38)

Response	<i>n</i>	%
Methods should be discussed with patients		
Yes	23	60.5
No	11	28.9
Unknown/unsure	1	2.6
Missing	3	7.9
Routine patient interviews should be conducted		
Yes	29	76.3
No	3	7.9
Unknown	1	2.6
Missing	5	13.2

As can be seen in Table 23, most of the participants reported supporting the inclusion of patients in the decision-making as well as supported the use of routine interviews with patients to assist with treatment plans. Respondents noted various reasons for supporting input from patients including: that patients need to be aware of things that could be done differently to avoid the use of seclusion or restraint; if the patient can describe a method of calming that would be successful for them, it would benefit everyone if these methods were utilized; if it is going to add to their treatment it makes sense; and this would help to make the patients' involved and accountable for their behaviours. Furthermore, although one respondent pointed out that this process would depend on the type of patients on the unit, another noted that patients should have input into trying to find ways of de-escalation.

Clinical staff were asked for any final comments on the issue of restraint and seclusion. The few that were noted included the belief that the use of seclusion or restraints is necessary to help control and to keep staff and patients safe, that one of the biggest problems is that people look at seclusion or restraint as a form of punishment and not as a form of treatment, and that the use of seclusion or restraint is a necessary evil.

Findings from Facilities' Seclusion/Restraint Policy Reviews

Seclusion

The Patient Advocates reviewed the seclusion/restraint policies of nine facilities. Of these reviews, all nine facilities reportedly had a policy regarding circumstances under which a patient could be secluded. Eight (88.9%) of the Advocates indicated that the policies outlined circumstances under which a person could be placed in seclusion. They included, but are not limited to, acts of aggression, self-harm, behaviours which may result in harm from others (e.g., engaging in sexually provocative behaviours), to reduce over-activity which could result in exhaustion, and in circumstances where alternative interventions have been judged to be inadequate.

The Advocates reviewed the policy requirements regarding seclusion and restraint whether the seclusion of a patient required a physician's order and whether a second opinion was required to keep a patient in seclusion for an extended period of time. The findings are presented in Table 24.

Table 24: Policy requirements for seclusion (N=9)

Response	<i>n</i>	%
Requires a physician's order		
Yes	3	33.3
No	6	66.6
Second opinion for an extended period of seclusion		
Yes	5	55.6
No	3	33.3
Unknown	1	11.1

Six of the policies on seclusion do not require a physician's order for this to be carried out. In cases where an order is not required, Advocates noted that a physician's order must be obtained between 15 minutes to 1 hour of the seclusion; however, in one case, the Advocates noted that a physician's order must be obtained "as soon as possible". Five of the policies reviewed indicated that a second opinion should be obtained in order to keep a patient in seclusion for an extended period of time. However, in four cases, this process was not required or was not clear within the policy. Those that did indicate requiring a second opinion were noted to require this when seclusion was to last between 72 hours over a seven-day period or for seven days.

The Advocates also reviewed if the policy referred to changing a patient's legal status and whether a length of time for this decision was outlined. The findings are presented in Table 25.

Table 25: Policy requirement for patients' legal status (N=9)

Response	<i>n</i>	%
Refers to changing legal status		
Yes	7	77.8
No	2	22.2
Refers to length of time for changing legal status*		
Yes	6	85.7
No	1	14.3

* includes only those where the policy refers to changing legal status

As presented in Table 25, most of the policies reviewed did make reference to changing the patient's legal status. Of those 7 that did, 6 six specified a time period in which a decision, with respect to the patient's legal status, must be made.

Reviewers were asked to determine whether the policies included information regarding the documentation required following the seclusion of a patient. Documentation noted to be required by nursing staff included information on the need for seclusion, safety, nutrition, hydration, elimination, time in seclusion, description of behaviours prior to seclusion, alternative attempts, mental status, and

improvement or deterioration information. It is important to note that these were general requirements to be documented; therefore, all of those listed were not required by all of the policies reviewed. Similarly, required documentation by physicians included written orders for continuation of seclusion, seclusion order, daily reassessment, level of observation, and order for discontinuation of seclusion. Again, these documentation requirements reflect the overall responses and are not, therefore, necessarily included in all of those policies reviewed. In four of the policies, the use of seclusion requires an incident report to be completed; however, in three cases this is not required and two of the policies did not indicate this information. Six of the policies required reports regarding the observed events that precipitated the need for seclusion; however, only two of the policies indicated that the reasons for choosing seclusion were to be reported.

The reviewers were asked to note whether the policies directed that the less restrictive options be offered to the patients and whether minimal force was to be used to seclude/restrain patients. Their responses are presented in Table 26.

Table 26: Policies outline restriction and force requirements (N=9)

Response	<i>n</i>	%
Directs least restrictive options to be offered		
Yes	5	55.6
No	2	22.2
Unknown/unclear	1	11.1
Missing	1	11.1
Directs minimal force to be used		
Yes	5	55.6
No	1	11.1
Unknown/unclear	1	11.1
Missing	2	22.2

Just over half of the policies clearly outlined that less restrictive measures are to be offered to patients and that the minimal force necessary should be used to place patients in seclusion or restraint.

While in seclusion, 66.7% ($n=6$) of the policies direct staff to provide the patient with access to a toilet, 77.8% ($n=7$) direct staff to provide nourishment to the patient, and only 1 (11.1%) policy directs that patients be allowed to wear their own clothing during seclusion. Examples of clothing for patients included tracksuits without drawstrings, safe gowns, blankets, hospital gowns, and pajamas.

Less than half of the policies reviewed clearly stated when the use of seclusion could be discontinued. 7 of the 9 policies (77.8%) reviewed stated who has the authority to release a patient from seclusion. Over half of the policies reviewed did not allow for a graduated release of the patients from seclusion only 1 (11.1%) of the policies did allow for this procedure.

Once the patient has been released from seclusion, 55.6% ($n=5$) of the policies require staff to talk to the patient to help them deal with their feelings and only 33.3% ($n=3$) of the policies require staff to discuss their own feelings after being involved in a seclusion event.

Regarding the process of carrying out the seclusion of a patient, none of the policies were indicated to outline the type or amount of training that staff must receive prior to their involvement. The seclusion policies also do not refer to or allow the use of security staff to forcibly seclude a patient. In 3 (33.3%) of the policies, there is reference to the minimum standards pertaining to the number of staff required to forcibly seclude a patient if necessary; however, in more than half of the policies, this information is not relevant.

Responses to issues regarding the release of a patient from seclusion are presented in Table 27.

Table 27: Policy requirements for release from seclusion (N=9)

Response	<i>n</i>	%
States when seclusion can be discontinued		
Yes	4	44.4
No	2	22.2
Unknown/unclear	1	11.1
Missing	2	22.2
States who has authority to release patient		
Yes	7	77.8
No	1	11.1
Missing	1	11.1
Allows for graduated release		
Yes	1	11.1
No	5	55.6
Unknown/unclear	1	11.1
Not applicable	1	11.1
Missing	1	11.1

Restraints

Patient Advocates reviewed whether the facilities had a policy for mechanical and chemical restraints. Their findings are presented in Table 28.

Table 28: Policies for mechanical and chemical restraints (N=9)

Response	<i>n</i>	%
Mechanical restraint policy		
Yes	6	66.7
No	1	11.1
Not applicable	1	11.1
Missing	1	11.1
Chemical restraint policy		
Yes	6	66.7
No	1	11.1
Not applicable	1	11.1
Missing	1	11.1

Six (66.7%) of the Advocates who reviewed the policies indicated that a policy for the use of mechanical and chemical restraints existed.

The final questions regarding the policy review required the Patient Advocate to provide any further comments pertaining to the policies of the facility. Their comments are as follows:

- all recommendations were implemented in the current drafts of the policy
- there are too many policies covering seclusion or restraint: a total of 13 were noted
- precautions for seclusion include excited delirium, victims of torture, trauma and abuse, cross reference with nicotine withdrawal; hypothermia
- metal handcuffs are not to be used within this facility, but are allowed for transport only
- a single policy governs seclusion and mechanical and chemical restraint
- specific reference is made to training in “holding” procedure, but no detail regarding this is provided

Comparing Patient and Clinical Staff Responses

Comparisons between staff and patient responses were conducted on similar questions. Between the two surveys, a total of 10 questions were matched. Responses from patients who were able to consent and those where information was gathered by the Patient Advocate through questions and observation were combined and compared to the responses from the clinicians involved in the seclusion or restraint. As a total of 17 clinicians responded to the survey, the matched patient interviews were used for the comparisons. Therefore, comparisons were based on both the patient and clinician involved in each seclusion or restraint. Table 29 provides the common questions and the number of patients and clinicians who agreed and disagreed with each question. When the question was responded to as “unknown/unsure”, the information was not included in the table but was reflected in percentages that do not total 100. Responses that were missing or indicated to be “not applicable” were not calculated into the total number or percentages. Therefore, the table represents only those responses that were relevant to each question.

Table 29: Comparison of patient and staff responses

Question	Clinical Staff Responses (N=17 ^a)			Patient Responses (N=17 ^a)		
	Yes % (n)	No % (n)	Total %**	Yes % (n)	No % (n)	Total %**
Threatening to injure self or someone else prior to seclusion/restraint.	75 (12)	25 (4)	100	53 (9)	41 (7)	94
Knew that there was a risk of seclusion/restraint.	63 (10)	31 (5)	94	47 (8)	24 (4)	71
Staff talked or kept in contact with patient in seclusion/restraint.	94 (16)	6 (1)	100	67 (10)	27 (4)	94
Patient was told what was needed or expected in order for removal from the restraint/seclusion.	64 (9)	14 (2)	78	50 (8)	19 (3)	69
Patient was aware of the name of the medication they were given while in restraint/seclusion.*	63 (5)	13 (1)	76	64 (7)	18 (2)	82
Patient consented to taking medication while in seclusion/restraint.	75 (6)	00 (00)	75	82 (9)	9 (1)	91
Staff helped patient talk about their feelings while in seclusion/restraint.	69 (11)	25 (4)	94	38 (6)	31 (5)	69
Staff helped patient talk about their feelings after removal from seclusion/restraint.	64 (9)	14 (2)	78	31 (5)	31 (5)	62
Patient was injured while being placed in restraint/seclusion.	13 (2)	87 (14)	100	13 (2)	87 (14)	100
Patient was injured while in seclusion/restraint.	6 (1)	94 (15)	100	29 (4)	71 (10)	100

Note: All chi-square (χ^2) analyses resulted in *nonsignificant* results. ^a missing information and “not applicable” responses were not included in the total scores or percentages.

* Responses included only those where patients who indicated being given medication while in seclusion/restraint. ** When percentages do not equal 100, those missing responded to the question as “unsure/unknown”

Although chi-square (χ^2) analyses were performed on the data, nonsignificant results were found. This likely reflects the small number of participants. As Table 29 shows, clinicians indicated that in 75% of cases the patient was threatening to harm him/herself or others; however, just over half of the patients acknowledged that was the true. Most of the staff (94%) indicated being in contact with the patient during the seclusion or restraint; however, 27% of the patients indicated that they did not receive regular contact from staff. Of those patients given medication while in seclusion or restraint, both the staff and patients agreed that more than 60% of patients were aware of the name of the medication and that more than 82% of patients consented to taking this. Although 69% of staff indicated that the patients' feelings were discussed during and post-seclusion, less than 40% of patients reported this to be the case. Although there was agreement between clinicians and patients that two patients were injured while being placed in seclusion or restraint, there was significant discrepancy with the reported incidence of injury while in seclusion or restraint between patients and clinical staff (30% and 6% respectively).

Discussion, Conclusions and Recommendations

Discussion

Prior to discussing best practices with respect to the use of seclusion and restraint, it is necessary to articulate the PPAO's position with respect to their use. The PPAO encourages psychiatric facilities to move towards providing care and treatment in a restraint free environment. However, the PPAO acknowledges that there is much work to be done before this can become a reality as facility policies and procedures must be updated, staff educated on providing care and treatment in such an environment and the culture of the facility must be challenged so that staff are receptive and supportive of adopting a restraint free environment. Facilities need to develop policies and procedures that discourage the use of seclusion and restraint and encourage the use of other less intrusive measures. In moving towards a restraint free environment, the PPAO has identified several key areas, which must be addressed and provides client-centred best practices with the aim of remedying these issues and concerns.

Assessment

It is essential that clinical staff complete a full assessment of patients on admission to determine a history of abuse, domestic violence or any other episodes of victimization to ensure that during hospitalization the patient is not re-traumatized if placed in seclusion or restraint. The patient may be traumatized simply because of the gender of the person secluding or restraining them, the type of restraint used, the physical environment where the individual is placed and the level of physical force used to restrain them. The PPAO recommends that psychiatric facilities review their policies and procedures, staff orientation, training and education and the location and physical environment of their seclusion rooms in order to be responsive to these concerns.

Given the significance and intrusiveness of seclusion and restraint, the PPAO recommends that all assessments for seclusion or restraint be conducted in-person by a physician, that a physician's order be required for both secluding or restraining a patient and that an order be required to discontinue it. The order must also state the duration of the seclusion or restraint and that the patient can be released for trial periods at the discretion of the staff. The assessment must also include a review of the patient's legal status, their medical history, special needs of the patient, other less intrusive alternatives available and the use of de-escalation techniques prior to deciding that seclusion or restraint is the most appropriate intervention. Rigorous documentation of the assessment must be the minimum standard, given the significance of this event and the potential negative consequences on the therapeutic relationship between the patient and their treatment team.

As a best practice, facilities should develop a screening and self-harm assessment tool to assist in the evaluation or assessment of the patient being placed in seclusion. Regardless of the assessment method chosen, documentation of all findings from the assessment should be thorough, recorded in a timely fashion and appropriate information shared with the other members of the treatment team.

Due to health concerns or other factors, seclusion and restraint may be contraindicated. Other alternatives such as one-to-one staff, constant observation or short time outs might be more appropriate. This is especially true for patients who have a history of self-harm, have a dual diagnosis or experience severe anxiety/fear when confined. The screening tool used should evaluate all of these individual factors and take them into consideration prior to seclusion being used. Regardless of the intervention chosen, documentation should accurately reflect how this decision was made, ethical considerations, who was involved, factors considered, special circumstances of the individual, their special needs and any previously expressed preferences or choices with respect to the type of seclusion or restraint chosen.

Any patient who is placed in seclusion or restraint should be assessed frequently, which should be discontinued immediately when settled so that the period of seclusion or restraint does not become excessive. Lengthy periods of seclusion or restraint must be subject to closer scrutiny, periodic reviews, a second assessment by a physician independent from the treatment team. In addition to this level of safeguards, any time that seclusion or restraint is used repeatedly, the treatment team should be encouraged to develop a specialized care plan in conjunction with the patient. This specialized plan would result in the development of an individualized approach that would meet the needs of the patient, clearly state the alternatives to be used with the patient prior to seclusion or restraint, the patient's preferences and choices with respect to the type of seclusion or restraint to be used, and termination of seclusion and reintegration into the program milieu. Built into this plan would also be features such as emotional support, closer monitoring of the mental and physical health of the patient, having specialized staff assigned to assist the patient while in seclusion. The aim of such a process would be to provide more care and less control.

Best Practices

- **That the use of seclusion and restraint be limited to managing behavioural emergencies when all less restrictive measures have failed and unanticipated severely aggressive or destructive behaviour places the patient or others in imminent danger of harm and immediately discontinued when less restrictive alternatives are feasible.**
- **That seclusion and physical restraint require a written order by the physician.**
- **That where in the absence of immediate access to a physician, a seclusion and restraint is implemented by a registered nurse, continuation requires a face-to-face examination by a physician.**

Planning and Individual Preference

Currently, most psychiatric facilities do not take into account a patient's preference for the type and method of restraint that is to be used. It appears that most health practitioners do not have explicit discussions with their patients about the preferred method of restraint and that there is no opportunity for a patient to express their "choice". In a client-centred environment such a discussion should take place and the preferences and choices of the patient recorded and incorporated into the individualized plan of care. It appears that patients are not provided with this opportunity and the decisions are left solely to the discretion of the staff member on duty at the time of the seclusion or restraint.

In this snapshot review of seclusion and restraint, it became apparent that clinical staff need to spend more time talking to their patients about less intrusive alternatives, providing the least restrictive environment and

educating their patients on de-escalating techniques and diversionary activities. Most facilities do not have a "quiet room" where patients can go to unwind, relax and get away from others when the need arises. Such a room could be considered an alternative to the patient being placed in seclusion. It would allow the patient to learn how to manage their behaviour and take responsibility for proactive steps to perhaps avoid the more intrusive measure being taken.

In this snapshot, patients stated that during the seclusion and restraint often there was nobody to talk to, to address their fears or to provide debriefing after the seclusion and restraint. Readily available supportive counseling and reassurance during the seclusion and restraint process should be viewed as a best practice, reducing subjective distress and minimizing the negative impact upon the therapeutic alliance.

Best Practices

- **That facilities develop proactive and collaborative crisis plans, which identify interpersonal and environmental triggers to behavioural emergencies, self-management activities and clinician interventions which the client finds most helpful in ameliorating distress. When supplemented with the use of assessment and screening tools, which capture patient specific needs, preferences and choices, if acted upon, would be expected to diminish the traumatic and coercive perceptions of seclusion and restraint.**

Treatment or Care Planning

In preparing a treatment or care plan the team must consider ways to maximize the input of the patient, to support them in the process and to ensure that they are an equal partner in the treatment process. Too often teams hold treatment planning conferences behind closed doors, make decisions "on behalf of" or in the "best interest of" the patient without having them present. This paternalistic approach to treatment planning should cease and patients must be involved in all decisions that affect their care, quality of life and treatment.

Treatment teams need to talk openly with patients about the use of seclusion and restraint and to hear what their personal preferences or choices are with respect to their usage. In the event that seclusion or restraint would be necessary they would know the prior wishes of the individual and be able to respond in a manner that would best meet their needs. Often treatment teams are not proactive or open enough with patients to have this explicit conversation with them, prior to the use of seclusion or restraint. The team could address with the patient specific situations when seclusion or restraint would or would not be used. This would serve to educate the patient about both appropriate and inappropriate use.

Talking about seclusion or restraint prior to it being used would be expected to lessen the fear and misunderstandings associated with seclusion or restraint. Such discussions should include working with the patient to identify other least restrictive alternatives (e.g., 1-1 staffing; use of a quiet room; constant observation; etc.) that might be used instead of seclusion or restraint. This discussion would allow the patient to articulate their personal preferences and choices. Treatment teams must begin to look at patients as equal partners in the treatment process and this may be intimidating or challenging for some teams to incorporate into their daily practice with patients.

Best Practices

- **That care planning be an inclusive process with problem identification, goals/objectives and treatment plans being collaboratively developed with the patient.**

When Not to Use Seclusion or Restraint

Facilities must develop protocols and provide direction to staff on when not to use seclusion or restraint due to the potential for exacerbating risk of self-harm or because of medical conditions such as unstable neurological, cardiovascular or respiratory disease or other psychiatric disorders that may result in further decompensation. The treatment team needs to explicitly state in the clinical record that seclusion/restraint is not to be used with a particular patient for the specified reasons and to clearly articulate what other interventions are to be used instead. It is important that this information be conveyed to all members of the treatment team so that the patient is not put at risk by being placed in seclusion or restraint. In cases where the patient is incapable, this discussion should be held with the substitute decision maker.

Best Practices

- **That timely and comprehensive assessments of patients are carried out to identify at-risk persons, including, complete biopsychosocial evaluations, detailed past psychiatric history and careful physical examination. The initial assessment should determine whether seclusion or restraint is contraindicated or must be used with caution, e.g., decompensation or other psychiatric sequelae associated with this intervention(s); history of physical and/or sexual abuse; neuroleptic malignant syndrome; unstable neurological, cardiovascular or respiratory disease.**
- **That psychiatric facilities establish fail safe communication mechanisms to ensure that multidisciplinary team members are notified 24/7 of patient care restrictions or precautions where the physician after completing the initial assessment determines that seclusion or restraint are contraindicated or must be implemented with caution.**

Emotional Support

Emotional support for patients placed in seclusion or restraint must be readily available and accessible to the patient, should they wish to access such supports. Many patients who are placed in seclusion or restraint find the experience to be frightening, humiliating, degrading, isolating and for some produces severe anxiety. At times while in seclusion/restraint they need someone to talk to and to help them address these fears and anxieties. Far too often this support is not offered as a consistent practice by the treatment team and often there is minimal communication with the patient during the seclusion or restraint. Treatment teams need to re-evaluate this practice to incorporate the development of a supportive environment for patients that is free of fear and anxiety and that best meets the needs of the patient. Individualized plans need to be developed when a patient is placed in seclusion or restraint and which address issues such as: support required, individual preferences and choices, a plan for release from seclusion and providing appropriate in-person assessment by a physician, supervision and observation throughout the process. Without such a plan, the PPAO is concerned that the needs of patients will not be met and that they will not receive the individualized care that best meets their needs.

Some treatment team members believe that "patients don't mind being placed in seclusion". Such beliefs which perpetuate a traditional paternalistic hospital milieu, fosters dependency rather than promoting autonomy and self-management must be actively challenged. A significant number of patients have either been secluded or restrained or have witnessed incidents involving other patients. As a result of this exposure to seclusion and restraint, many patients and staff accept this as the "norm" and do not view it as the intrusive intervention that it is. These beliefs and attitudes must change if seclusion and restraint is no longer viewed as an acceptable status quo and a higher standard of care and treatment, optimally a restraint free environment, is to be achieved.

Best Practices

- **That as a minimum standard, the plan of care of patients who have been secluded or restrained reflect preferences and choices; provision of counseling; reassurance and support; explanation of the purpose for the use of seclusion or restraint; explanation of specific behaviours prerequisite to discontinuation and the process for reintegration into the program milieu.**

Seclusion Room and Environmental Considerations

When a patient is to be secluded it is important that great care and attention be paid to the physical environment. All too often, the room is checked for "sharps" and other objects that could be used for self-harm. However, very little attention is paid to things such as artificial or natural lighting, cooling, heating, ventilation, toileting facilities, access to a bed and a way for staff to see and to communicate with the patient while they are in the seclusion room. It is essential that patients know how to communicate with staff should a medical emergency arise while they are in seclusion and require assistance and that staff respond to these requests immediately. Many patients find seclusion rooms to be unpleasant, and therefore, there is the potential that this will amplify or perpetuate the behaviour which precipitated seclusion as well as exacerbating the patient's fear and anxiety.

In some facilities, the seclusion rooms are located beside or near the nursing station but this also can be in a noisy, high volume traffic area and the patient may find the noise to be disturbing, distracting or more stimulating than they can handle. Consideration should be given to locating seclusion rooms in an area that is quiet, private and where the privacy of the patient can be protected at all times while allowing clinical staff to provide the appropriate level of observation and care.

There is a need for the room to be kept clean, free of spills, to have meal trays removed promptly. Regular inspections and cleaning of the room should be conducted. This will contribute to reducing the health and safety risks associated with an unkempt room. It will also minimize risk should the staff need to enter the room to deal with a high risk situation.

Best Practices

- **That the basic dignity of patients who have been secluded or restrained be protected; e.g., provided with regular personal hygiene, bathroom, exercise, nutritional and fluid breaks.**
- **That patients who have been secluded or restrained be provided with a comfortable environment, which supports and maintains human dignity, is safe, clean and attractive, has suitable lighting and ensures both auditory and visual privacy; that natural light and exterior views be used to enhance the environment and reinforce orientation; and that ventilation allow for acceptable levels of temperature, humidity and elimination of odours.**

Approved Restraints

As a best practice, each psychiatric facility must compile a list of "approved restraints" that are to be used in their facility. Outdated restraints should be reviewed and removed from the list. If a restraint is used that is not an "approved" restraint then the facility must investigate this breach of policy and take corrective measure to protect other patients in the future. The appropriate use, definition and education on the use of approved restraints must be a priority for staff education and training. The PPAO recommends that a list of "approved restraints" be established by all facilities and reviewed by clinical staff, by patient and family councils, Patient Advocates and other key stakeholders to ensure that any concerns about the use of a particular type of restraint can be reviewed prior to its usage.

Best Practices

- **That safety devices, which patients cannot remove easily and that restricts freedom of movement or normal access to their body, be categorized as physical restraints and that they be subjected to evaluation by standardized restraint assessment and intervention tools, targeted for restraint reduction programs and application of demonstrated strategies for prevention of restraint use (Bower and McCullough, 2000; Hancock et al., 2001).**
- **That psychiatric facilities standardize acceptable physical restraint methods/devices and which, at a minimum, are compliant with appropriate quality and product safety standards.**

Documentation

The PPAO recommends that when seclusion or restraint is used that it be considered a highly intrusive intervention and that documentation and review standards be rigorous. The PPAO recommends that in all situations where seclusion or restraint is used that there be no documentation "by exception" but rather the notes in the clinical record be detailed and that all events that occur in the course of the seclusion or restraint be recorded. As well, the PPAO recommends that flow chart recording not be used but rather a narrative and descriptive account of all occurrences be documented in the clinical record.

Alternatives to seclusion or restraint offered to the patient must be documented as should any de-escalating or diversionary techniques used. Patients who have been in seclusion or restraint on numerous occasions should still be entitled to an in-person assessment by a physician and offered less intrusive alternatives prior to seclusion or restraint being used. It would be unfortunate if these safeguards were not offered to them simply because they have a "history" of being secluded or that staff pre-judge that "nothing else would be effective." Each time, staff should provide a full range of options and alternatives to each patient, regardless of how often they have been secluded or restrained.

Hospitals should exceed the minimum documentation standards outlined in the Mental Health Act providing detailed recording the events that have transpired. Random periodic clinical record audits must be conducted of seclusion and restraint episodes to ensure that these minimum standards have been met and that the documentation is accurate, complete and reflects the assessment, planning, implementation and evaluation with each episode.

Best Practices

- **That the use of seclusion and restraint be viewed as an extraordinary event requiring regular evaluations of mental, functional and physical status and rigorous documentation with clinical record entries no less than 15-minute intervals.**

Education and Training

Education and training of clinical staff is a critical success factor in minimizing the incidence of seclusion and restraint and the method of last resort in managing disruptive or violent behaviour. Staff must also be educated on recognizing and preventing situations that lead to violent patient behaviours and intervene before they escalate to a crisis. Facilities must be encouraged to move towards providing a restraint free environment and policies and procedures need to articulate this vision if it is to be operationalized. Given the potential for injury to both patient and staff it is essential that on-going training be available to staff. The training should include: prevention; non-violent crisis intervention training; de-escalating techniques; conflict resolution; providing patients with less intrusive interventions and providing support to patients in high risk situations.

Education and training must be on-going and facilities must ensure that staff skills remain current and that refresher and in-service programs are available to support this level of practice and knowledge. Staff should be required to update their skills annually at a minimum. Training courses must incorporate the patients' perspective and client-centred care principles. The PPAO recommends that consumer-survivors and Patient Advocates be involved in providing the education to staff and that the curriculum be developed in conjunction with consumer-survivors, families, Advocates and other stakeholders. This will incorporate various perspectives by making the training more reflective of the needs of all parties and facilitate the implementation of best practices with respect to providing client-centred care. All training sessions must include information on patients' rights under the law and a focus on providing care and treatment in the context of mental health legislation.

Education and training must also focus on ethical considerations, dispel outdated beliefs about the use of seclusion and restraint, and the general attitude that the use of seclusion and restraint is useful as a "behavioural control and as a consequence for disruptive or inappropriate behaviour." Staff must be educated on the law and the standards set in legislation for restraint use. Such training will begin to challenge the attitudes and culture of the facility and begin the discussion about the provision of care and treatment in a restraint free environment.

In this review a significant number of the behaviours cited by patients which precipitated seclusion or restraint did not meet the legal threshold. There may have been better ways to manage the disruptive or inappropriate behaviour than through the use of seclusion and restraint. It is important that clinical staff continue to be educated on the legal use of seclusion and restraint and that they are aware of the legal context against which this intrusive intervention is utilized.

Many myths exist about the use of seclusion and restraint, including: that a patient who is secluded or restrained requires less supervision; that a patient in restraints is less likely to sustain physical injuries; that if a patient is in restraints, there are fewer risk management issues; and that a patient in seclusion or restraints is perhaps safer. Such myths must be dispelled given the demonstrated significant morbidity and mortality associated with these interventions. This is especially true of elderly patients or persons having coexisting medical disorders.

Best Practices

- **That staff orientation/education consistent with a “hands off” philosophy and commitment to restraint reduction is mandatory and reinforced at regular intervals, including but not limited to: mental health legislation and patients’ rights; principles of client-centred care; deleterious effects of restraint and seclusion on patients; antecedents and precipitating factors, such as environmental and interpersonal variables which contribute to aggression; early intervention; conflict resolution; de-escalation techniques; alternatives to physical restraints and proper application of restraints or therapeutic holding.**
- **That clinical staff receive sensitivity training with respect to the experience of seclusion and restraint, preferably facilitated by a patient who had been previously secluded or restrained and/or a Patient Advocate.**

Monitoring and Observation

When a patient is in seclusion or restraint there needs to be a staff assigned to provide supervision, observation and to attend to the needs of the individual. The monitoring and observation should include regular checks of vital signs, the monitoring of health or medical problems, and food and fluid intake. It is also important to release physical restraints periodically, to allow for the patient to change positions, massage the extremity, check for bruises and circulation and afford the patient an opportunity to exercise or fresh air.

This is especially true if the patient is elderly, has a history of medical problems or is at risk of self-harm. During this period the patient may be acutely vulnerable, have high needs and require more attention than usual. It is also a time when the patient may be feeling angry, desperate or extremely frustrated and may become aggressive or injure themselves. As such, it is not prudent to leave a patient in seclusion or restraints without proper observation, supervision or monitoring. Clinical staff need to have a heightened vigilance during this period and should provide such observation and monitoring. Patients must not be left in seclusion or restraint any longer than is necessary and constant supervision and monitoring will provide a feedback mechanism to determine when the patient should be reassessed and when the seclusion or restraint order could be discontinued.

Best Practices

- **That patients who are secluded or restrained be continuously observed and cared for by regulated health professionals.**

Complaint Mechanisms

Complaint processes must be transparent, accessible to the patient and easy to utilize if they are to be effective. Patients must be educated about the existence of such a process, that they have a right of complaint and that all complaints will be taken seriously. Complaint and investigation protocols must be clear, concise and transparent and if they are to be effective and patients must be educated on how to make a complaint and be aware of their rights. It is suggested that facilities post complaint processes and contact information so that the information is readily available to patients, families and any other person who may want to make a complaint.

If a patient is injured while being placed in or while in seclusion or restraint, this must be treated as a serious adverse event and the patient assessed by a physician. Any injury to a patient must be investigated with an aim of preventing similar injuries from occurring and to ensure the health and safety of all patients. Patients need to be advised that they are entitled to have a medical examination and appropriate tests so that their injury can be assessed. Further, if there is an allegation that excessive force was used by staff this complaint must be taken seriously, and an investigation conducted. If the patient feels uncomfortable remaining on that unit during the investigation then the treatment team should consider moving the patient to another unit where they will feel safe and not fear reprisals from the staff member(s) involved. In order for the patient to have confidence in the findings of the investigation, it must be conducted by an investigator who is independent from that treatment team and who is not employed on that unit. Documentation of all steps taken in the course of the investigation must be complete, detailed and reflect all actions taken. At the conclusion of the investigation a report should be written that details the measures taken during the investigation, provides a written decision and informs the patient of the next step in the process, if they disagree with the outcome of the investigation. Patients must be entitled to identify a representative or person who can assist them through the process and who will be there to support them.

Best Practices

- **That psychiatric facilities establish and standardize investigation policy and procedures related to complaints arising from seclusion and restraint episodes. The complaint and investigation process must be effectively communicated to patients, family members and all hospital staff, easily accessible, require independent investigation consistent with the principles of due process, protect the complainant from reprisal, stipulate timeframes for completion of the investigation and decision-making, and include avenues of appeal.**

Quality Improvement

Facilities should establish a committee that reviews all seclusions and restraints and the events surrounding their usage or incorporate this function in the terms of reference of hospital risk, quality or performance improvement committees. Such critical examination by the committee may lead to a reduction in the use of seclusion or restraint simply because staff will know that the event will be reviewed by an inter-disciplinary team that will provide them with feedback on their practice, the use of seclusion and restraint and that they will make recommendations regarding that particular incident. Where practice issues are evident, then the committee needs to be empowered to make recommendations and to have the authority to follow up to ensure that the recommendations have been implemented.

All proceedings before the committee should be documented as this will assist the facility in identifying trends, systemic issues and best practices. Additionally, committees must find a way to facilitate, support and encourage patient participation in the committee, as an active party with a bonafide complaint. Patients must be able to provide submissions, have representation and be involved in the resulting decision and recommendations that come from the committee. All parties must have equal standing before the committee if the intent of this review and recommendation process is to be successfully implemented.

Facilities must develop a process for conducting best practice reviews, disseminating information (both within their own facilities and with other facilities) learned from these reviews and providing appropriate training to staff that will allow them to provide more client-centred care. All policies, procedures and operating processes must be reviewed continuously with the aim of incorporating best practices, examining new and better ways of providing service and incorporating feedback from consumer-survivors, families and other key stakeholders. Mechanisms must be designed for soliciting this input from consumer-survivors, families and Advocates on an on-going basis.

All aspects of service delivery from admission to discharge processes should be examined to determine if there are institutional barriers or bias built into these processes and if by providing service in a different way the service would become more client-centred. Audits and best practice reviews should be conducted on how medication is dispensed, documentation in clinical records, the use of seclusion and restraint, how the facility communicates with patients and families and how accessible physicians are to their patients. These are all areas which need to be examined and which require the development of best practices, if facilities are to deliver client-centred care.

Best Practices

- **That psychiatric facilities implement risk reduction strategies, including providing fall prevention education to patients and their families, and clinical staff (Sentinel Event Alert July 12, 2000).**
- **That the core competencies of clinical staff be continuously monitored and evaluated; these competencies to include: early recognition of signs/symptoms of incipient crisis; conflict resolution; de-escalation techniques; crisis intervention and management; supportive psychotherapy; critical incident stress debriefing and psychoeducation.**
- **That seclusion and restraint policy and procedures be given priority and ongoing consideration by quality and process improvement committees; and that actual and potential sentinel events associated with seclusion and restraint episodes trigger independent administrative reviews and clinical practice audits.**
- **That accountability mechanisms consistently capture clinician effectiveness in identifying antecedents to behavioral emergencies, effectiveness in de-escalation techniques, crisis intervention and management, conflict resolution, professional development and training resources available with respect to any identified areas requiring improvement, specific timeframes for achieving expected level of performance.**
- **That seclusion and restraint orders exceeding 24 hours qualify for automatic and independent peer review.**
- **That psychiatric facilities systematically capture data at the program and facility levels related to incidence of seclusion and restraint, antecedent behaviours precipitating use, duration of episodes, and outcome analysis.**

Conclusions

As outlined in the purpose of this snapshot review, issues relevant to the use of restraint and seclusion were identified. This initiative examined the level of care and observation offered to patients who were in seclusion or restraints, collected information related to seclusion and restraint practices, investigated the issue of minimal force during the application of restraint and seclusion, and explored whether the patients' physical and mental health and well-being was appropriately considered during the restraint and/or seclusion process.

Although this snapshot review has significant limitations with respect to sample size and representativeness, important themes and issues were identified which were consistent with our review of recent literature. Patients participating were predominantly diagnosed with organic and psychotic disorders which is typical of the distributions of diagnostic groups found within psychiatric facilities.

According to both clinical record reviews and patient interviews, the most commonly used method of restraint was physical, with more than half of the patients indicating that they had been restrained in this manner. Most of the patients reported that their needs were met while in seclusion or restraint; however, addressing the patients' fears and concerns as well as receiving breaks/exercise seemed to be issues for a number of patients. Patients were not always aware of the requirements for release from seclusion or restraint. However, clinicians

disagreed and believed that most patients were aware of how to be released. Most staff believed that they were in active contact with their patients while in seclusion or restraint; however, fewer patients reported this to be the case. Most patients reported that a discussion of their feelings was not applicable to their seclusion or restraint experience. However, when the patients of the participating staff were considered separately, with those where the question was not applicable removed, less than half of the patients reported that the staff assisted them with their feelings. Conversely, these staff tended to believe that they did emotionally support their patients.

Staff indicated that less than half of their patients had ever been assessed for an abuse history. Furthermore, in cases where an abuse history was taken, this knowledge was considered prior to the use of seclusion or restraint in less than 40% of cases. Although some staff members indicated that knowledge of an abuse history was relevant and considered prior to the use of seclusion/restraint, others indicated that this type of information was irrelevant.

Information from staff indicated that the use of seclusion and restraint had been combined and administered to more than half of the participating patients. All staff reported supporting the use of seclusion and restraint in their facilities and noted that these were effective methods with the patients that they were interviewed regarding.

Clinical record reviews revealed that, although most patients were restrained/secluded as a result of a physician's order, in only half of the cases did the physician actually assess the patient. Furthermore, more than half of the physicians' orders did not specify the duration of the seclusion or restraint.

Staff indicated considering alternative interventions to restraint and seclusion. However, in approximately 20% of cases, alternatives were not considered. Moreover, close to half of the clinical records reviewed did *not* document that minimal force was used during the implementation of the seclusion or restraint. It is unclear whether this information was not documented due to the fact that minimal force was not used or as a result of incomplete information recording. Also significant, information pertinent to the patients' seclusion or restraint experience was often not documented in the clinical record. For example, whether medication was used with the patient or whether the patient consented to medication was occasionally unknown. Furthermore, in close to 20% of cases, it was unknown whether non-clinical staff were involved in the seclusion or restraint of a patient.

Further information was gathered from staff in the facilities regarding their beliefs with respect to alternatives to restraint and seclusion. Staff did not seem to be aware of alternatives to these methods and seemed to be unaware of whether they would use an alternative if one were available. Some of the respondents noted that staffing levels and resources precluded the use of alternative measures. Staff did tend to believe that patients should be involved in their treatment plans.

According to the Patient Advocates, most of the policies provided by the facilities outlined circumstances where a patient could be secluded. Almost 67% of the policies do not require a physician's order to place a patient in seclusion. Almost 56% of the policies direct that the least restrictive method be offered to patients and that minimal force should be used. However, 25% of patients indicated that the least amount of force necessary was not used and, furthermore, close to half of the clinical record reviews did not indicate that the least amount of force necessary was applied. A similar number of policies do not allow for a graduated release from seclusion.

Patient Advocates outlined their concerns with policies and clinical record reviews. With respect to the latter, their issues tended to include trepidation related to poor documentation, a lack of information, and ethical issues regarding patient treatment. Furthermore, Patient Advocates reported that facility policy was not adhered to in 20% of cases and in approximately 14% of cases the information of whether facility policy was followed was unknown.

Limitations and Next Steps

As a snapshot review, the findings present what Patient Advocates learned from their interview of patients and clinicians and review of clinical records and facility policies. The patients' views are anecdotal and reflect the very personal experiences and impressions of their experience of being secluded or restrained. It is in this context that this snapshot review should be regarded. However, despite its limitations, the review identified important themes and issues related to the use of seclusion/restraints. These were consistent with our review of the related literature. The insights, thoughts impressions and experiences have allowed the PPAO to identify several best practices, which may improve the quality of life of all patients who are subjected to seclusion/restraints. The PPAO recognizes that a formal research in this area is required, given the limited scope of this snapshot review.

Few of the clinical staff responsible for the seclusion and restraint of patients participated in the project, which resulted in difficulties comparing the responses of patients and staff. There was a noteworthy amount of data missing from the surveys/interviews across all methods of data collection. Missing information does not allow for a clear understanding of those issues being dealt with. It is unclear whether the missing data was a result of the information not being available, or whether it was considered not to be pertinent and, therefore, excluded. Those completing the interview forms should be advised to indicate on all questions whether the information is unknown or not applicable. Simply leaving the information missing results in gaps in knowledge. There were few similarities in the questions posed to each of the different participants. For example, as noted above, only 10 questions were considered common enough for comparison between the patient and staff interviews. This resulted in a limited number of comparisons and conclusions.

Although this project provided an overview of the issues relevant to the use of seclusion and restraint from the patient, staff, and Advocate perspectives, further data collection would be beneficial. Continuation of this project would result in a larger sample, thus allowing for more relevant analyses of the information and more meaningful.

This snapshot review suggests that the implementation of a cross-sectoral, inter-ministerial task force with the mandate of standardizing and optimizing seclusion and restraint practices may be a critical success factor in addressing existing and emerging concerns and issues province-wide.

References

- Awad, A.G. (2000). Where have all the child psychiatrists gone? *CPA Bulletin*, *32*(6), 155-156.
- Bassett, A.S. (2001). Psychiatric genetics in the 21st century. *Canadian Journal of Psychiatry*, *46*(2), 121-122.
- Bower, F.L., & McCullough, C.S. (2000). Restraint use in acute care settings. *JONA*, *30*(12), 592-598.
- Dickey, R. (2000). Assessing inmates for risk of future violence. *CPA Bulletin*, *32*(6), 168-170.
- Ford, R.C., & Fottler, M. D. (2000). Creating customer-focused health care organizations. *Health Care Management Review*, *25*(4), 18-23.
- Guebaly, N., & Atkinson, M.J. (2001). Access to psychiatrists' care. *CPA Bulletin*, *33*(1), 9-12.
- Hancock, C.K., Buster, P.A., Oliver, M.S., Fox, S.W., Morrison, El, & Burger, S.L. (2001). Restraint reduction in acute care. *JONA*, *31*(2), 74-77.
- Hoptman, M.J., Yates, K.F., Patalinjug, M.B., Wack, R.C., & Convit, A. (1999). Clinical prediction of assaultive behavior among male psychiatric patients at a maximum-security forensic facility. *Psychiatric Services*, *50*(11), 1461-1466.
- JCAHO (July 12, 2000). Fatal falls: lessons for the future. *Sentinel Event Alert*, *14* JCAHO.
- JCAHO (November 8, 1998). Preventing restraint deaths. *Sentinel Event Alert*, *8* JCAHO.
- Kates, N., Adsett, A., Bellissimo, T., Levin, L., & Humphrey, B. (1993). The Hamilton psychiatric network: the evolution of an integrated network of psychiatric services. *Canadian Journal of Psychiatry*, *38*(5), 315-318.
- Lieff, S.J. & Clarke, D. (2000). What factors contribute to senior psychiatry residents in geriatric psychiatry? A Delphi study. *Canadian Journal of Psychiatry*, *45*(10), 912-916.
- MOHLTC (1999). Making it Happen: Implementation Plan for Mental Health Reform. (15M/3/99 Cat. #2231504 ISBN 0-7778-8567-0) Toronto: Queen's Printer for Ontario.
- Nijman, H.L.I., Campo, J.M.L.G., Ravelli, D.P., & Merckelbach, H.L.G.J. (1999). A tentative model of aggression on inpatient psychiatric wards. *Psychiatric Services*, *50*(6), 832-834.
- Nijman, H.L.I., & Rector, G. (1999) Crowding and aggression on inpatient psychiatric wards. *Psychiatric Services*, *50*(6), 830-832.
- OHA (February 12, 2001). Submission to the Standing Committee on the Legislative Assembly Respecting Bill 135 Public Hospitals Amendment Act (Patient Restraints). OHA.
- Soliman, A.E., & Reza, H. (2001). Risk factors and correlates of violence among acutely ill adult psychiatric inpatients. *Psychiatric Services*, *52*(1), 75-80.
- Steinert, T., Wieve, C., & Gebhardt, R.P. (1999) Aggressive behavior against self and others among first admission patients with schizophrenia. *Psychiatric Services*, *50*(1), 85-90.
- Stuart, H., & Arboleda-Florez, J. (2001). Community attitudes toward people with schizophrenia. *Canadian Journal of Psychiatry*, *46*(3), 245-252.
- Swanger, K.C., & Tomlin, C.C. (2000). Moving toward restraint-free patient care. *JONA*, *30*(6), 325-329.
- Tushman, M.L., & O'Reilly, C.A. (1997). Winning through innovation: a practical guide to leading organizational change and renewal. Boston: Harvard Business School Press.

Visalli, H., McNasser, G., Lohnstone, L., & Lazzaro, C.A. (2000). Reducing high-risk interventions for managing aggression in psychiatric settings. J Nurs Care Qual, 11(3), 54-61.

Visalli, H., & McNasser, G. (2000). Reducing seclusion and restraint: meeting the organizational challenge. J Nurse Care Qual, 14(4), 35-44.

Visalli, H., & McNasser, G. (August 1997). Striving toward a best practice model for a restraint-free environment. Performance Improvement, Ideas & Innovations, 1-4.