

Managing Symptoms by Reducing Restraints: Promotion of a Philosophy

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Centralized Assessment, Triage and Support
(CATS)



camh

Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Who We Are:



- The Centre for Addiction and Mental Health (CAMH) is Canada's largest Health Sciences Centre and a leading addiction and mental health teaching hospital located in inner-city Toronto.
- The Centralized Assessment, Triage and Support (CATS) Program of CAMH consists of Emergency and Crisis Services, Inpatient Services, Ambulatory Care, and Outpatient Services.
- The Inpatient Services consist of:
 - A 23 bed acute care general psychiatry unit (GPU) with an average length of stay of 21 days
 - A 6 bed intensive care unit (ACU) with an average length of stay of 7 days



Who We Serve: Our Clients

- The General Psychiatry Unit (GPU) and Acute Care Unit (ACU) serve a very diverse population of adults from the Greater Toronto Area .
- Our average length of stay is 21 days on GPU, and 7 days on ACU.
- Our clients come from a wide variety of cultures with diverse cultural, ethnic, religious, economic, and sexual backgrounds.
- We treat clients with a full range of acute mental health, addiction and concurrent issues including, but not limited to, mood disorders, psychosis, personality disorders, substance-related disorders, delirium and dementia, and somatoform disorders.

ACU/GPU Mission

- Our mission is to improve the lives of those affected by addiction and mental health problems by providing excellent, evidence-based, client-centred care to persons hospitalized for mental health, addiction, or concurrent problems and their families/supports. In addition, we strive to promote the health of the clients we serve by providing quality, holistic mental health and addiction treatment and education.

ACU/GPU Vision

- Our vision is to provide people with mental health and addiction problems with appropriate and effective treatment in a supportive, environment that is respectful of diversity, is holistic, and focused on harm reduction and recovery. We aim to maximize a positive outcome for clients and families, and to support a smooth transition back to the community with appropriate resources in place.

Our Staff

- **Multidisciplinary staff team consisting of: Psychiatry, Nursing, Medicine, Social Work, Recreation Therapy, Pharmacy, Chaplaincy, and Dietary**
- **Focus on inter-professional collaboration: we have students from a variety of disciplines including: nursing, social work, medicine, psychiatry, pharmacy, and recreation therapy**



Our Model of Care

Client – Centered
Focused on Learning
Respectful of Diversity
Receptive to Feedback and Evaluation
Based on a Holistic View of Health
Creating Partnerships



Promoting Symptom Management: Least Restraint

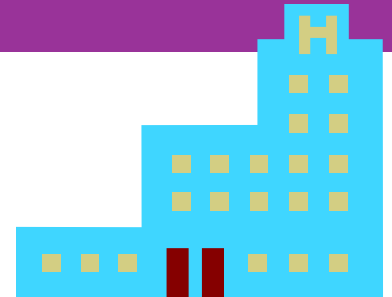
Original Objectives (2005-06)

- Evaluate the current restraint practices on ACU and GPU.
- Ensure adherence to the least restraint policy at CAMH.
- Accurately monitor the use of mechanical restraints in the ACU.
- Maintain a safe environment for patients and staff, with no increase in patient or staff injuries, or patient complaints.

Current Objectives (2009/10)

- Use all the data available to inform practice
- Assist staff to identify and help the client manage symptoms early in care process

Beginning Steps



- A data collection system was implemented across CAMH in 2005 so that all episodes of restraint (continuous monitoring, seclusion, mechanical restraints, and chemical restraints) are entered into a computerized database
- In 2006, the ACU/GPU began participating in the pilot and eventual rollout of a Restraints Events Report AND
- The APNs began reviewing every incident of restraint using a Checklist that evaluated adherence to the Least Restraint Policy; in situations where the policy was not followed, they began following up with staff to provide education.

And Next Steps . . .

- The APNs began to identify and address possible barriers to implementing the least restraint policy at that time:
 - Unit Culture
 - Past Practices,
 - The Belief that Restraints keep Staff and Clients Safe
 - Staff not Understanding of the Least Restraint Policy



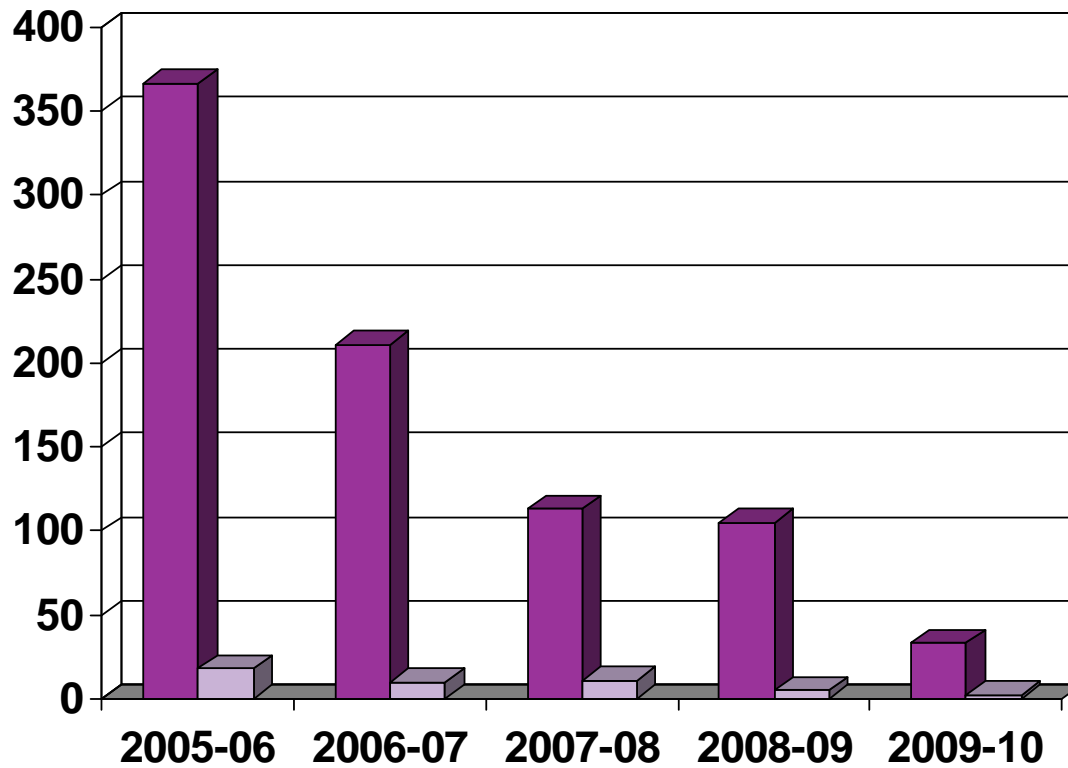
And Next Steps . . .

- The APNs and Leadership Team began to look more closely at the Restraint Data
- CATS began to tailor our annual training in the Prevention and Management of Aggressive Behaviour to meet program specific needs
- In April 2008, the CATS leadership team attended a two-day intensive training workshop which reinforced the active role of the ACU/GPU Leadership Team
- CAMH initiated a center-wide restraint reduction initiative in 2008

Additional steps taken on ACU/GPU:

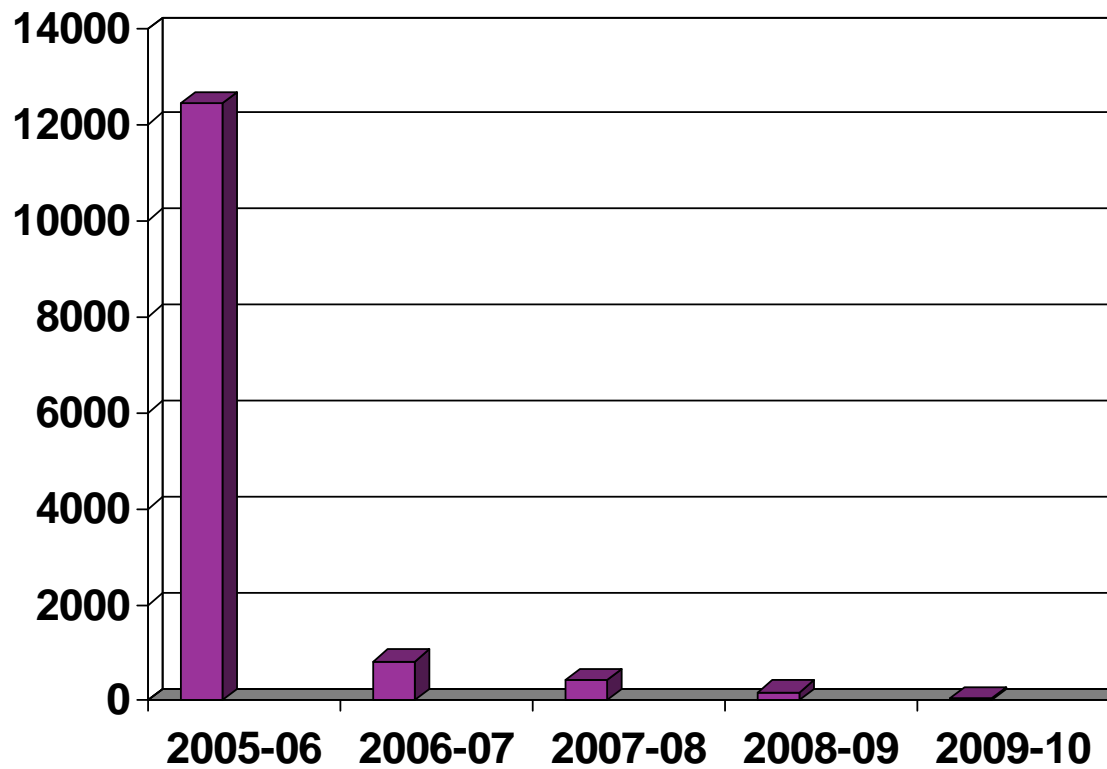
- The medical director assumed responsibility for the care of clients on the ACU for one year
- Consistent involvement of the APNs in unit rounds, case consultations, and code white incidents
- The development of an ACU/GPU Steering Committee
 - Enhanced group programming and activities
 - Unit rules are reviewed frequently
 - Interdisciplinary case conferences for complex client
 - The provision of a regular clinical supervision group
- APNs began to further analyze the data

Restraint Use by Number of Episodes

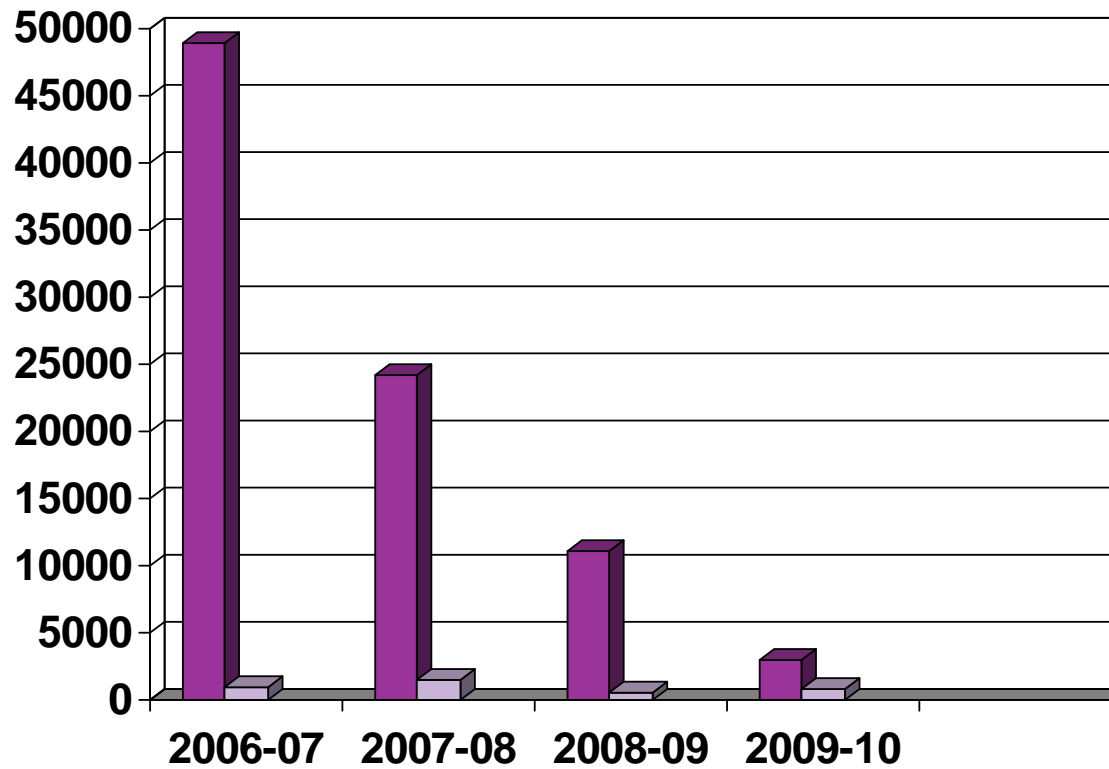


Restraint Use

by
Number of Hours



Restraint Use in Minutes



2008/09 Data Analysis: What we knew then



- Males are restrained twice as much as females
 - Q1 M=12 (29 episodes) F=6 (15 episodes)
 - Q2 M=12 (18 episodes) F=5 (8 episodes)
- 47% of the client who are restrained, are only restrained once (16/34); only 20% are restrained 3 + times
- Restraint events are more common from 0730-1530 and 1530-2330 hours than 00-0730 (13/11/7 and 8/10/6)
- More restraints happen on Tuesdays versus any other day of the week

2008/09 Data Analysis: What we knew then

- Bipolar Affective Disorder (mania) is the most common diagnosis of patients restrained:
 - Schizophrenia/psychosis: 8 clients
 - BAD: 17
 - Substance use only: 3
 - Concurrent diagnosis: 2
 - Dementia: 1
 - Personality disorder: 1
 - Dual diagnosis: 1
 - Other: 2 (1=Korsakoff's; 1=unclear diag)

Identified strategies to address these statistics:

- Continued monitoring of every event and analysis of stats
- Continue to work with staff to change attitudes regarding restraints (restraint does not improve safety)
- Monthly meetings with staff to discuss restraint data
- Try to intervene early, particularly with clients who are in a manic phase

Identified strategies to address these statistics:

- Encouraged use of continuous monitoring for clients who are restless
- Continue to address power struggles by looking at rules
- Use of the 1st floor patio for fresh air
- Entire team involved in the minimization of restraint initiative

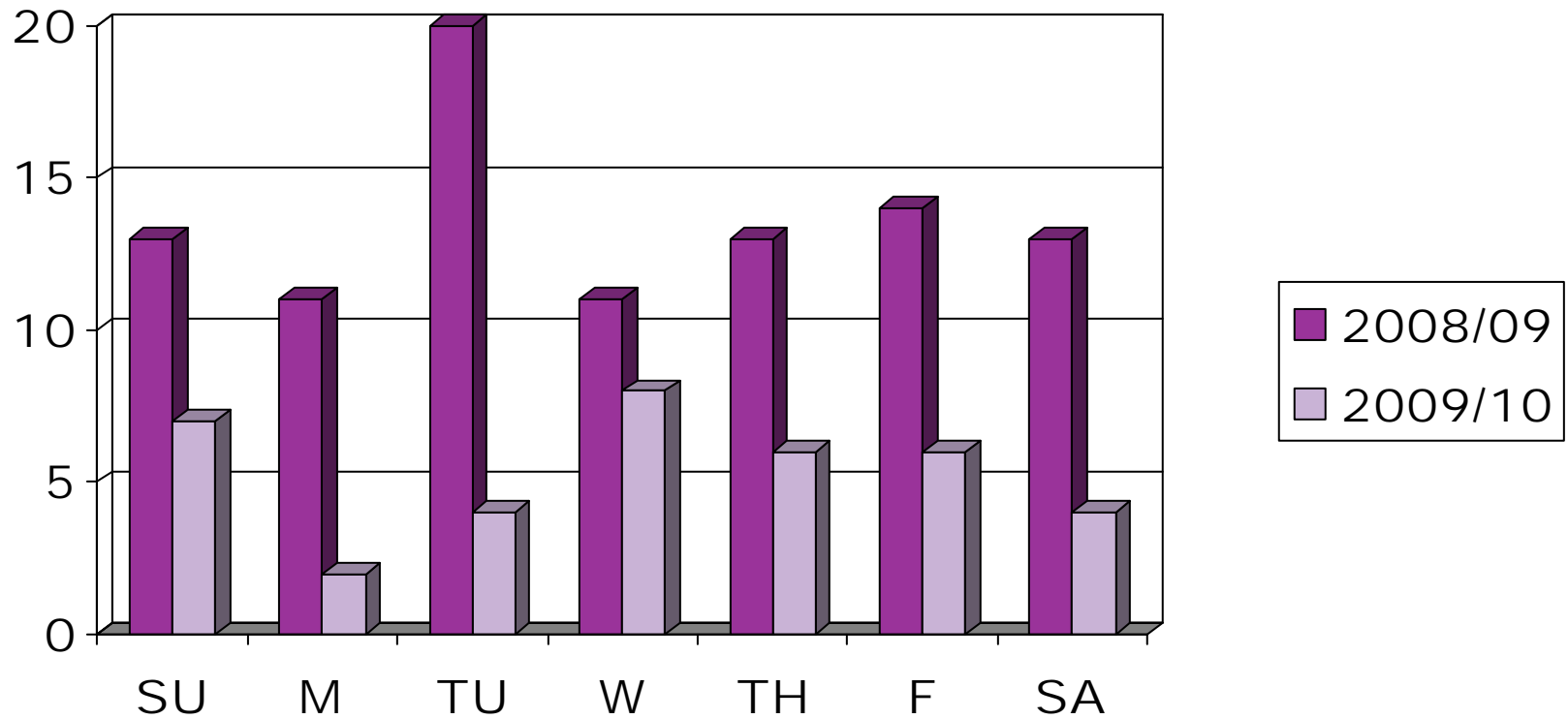


Current Data Analysis:



- Gender difference is fading
 - Q1 M=7 (13 episodes) F=10 (17 episodes)
 - Q2 M=5 (5 episodes) F=3 (3 episodes)
- 68% of the clients who are restrained, are only restrained once (17/25); only 12% are restrained 3 + times (3/25)
- Restraint events are most common from 1530-2330 hrs.
- Days of the week have changed thus far this year
- Diagnosis has also changed

Comparison of Days of the Week: 2008/09 versus current

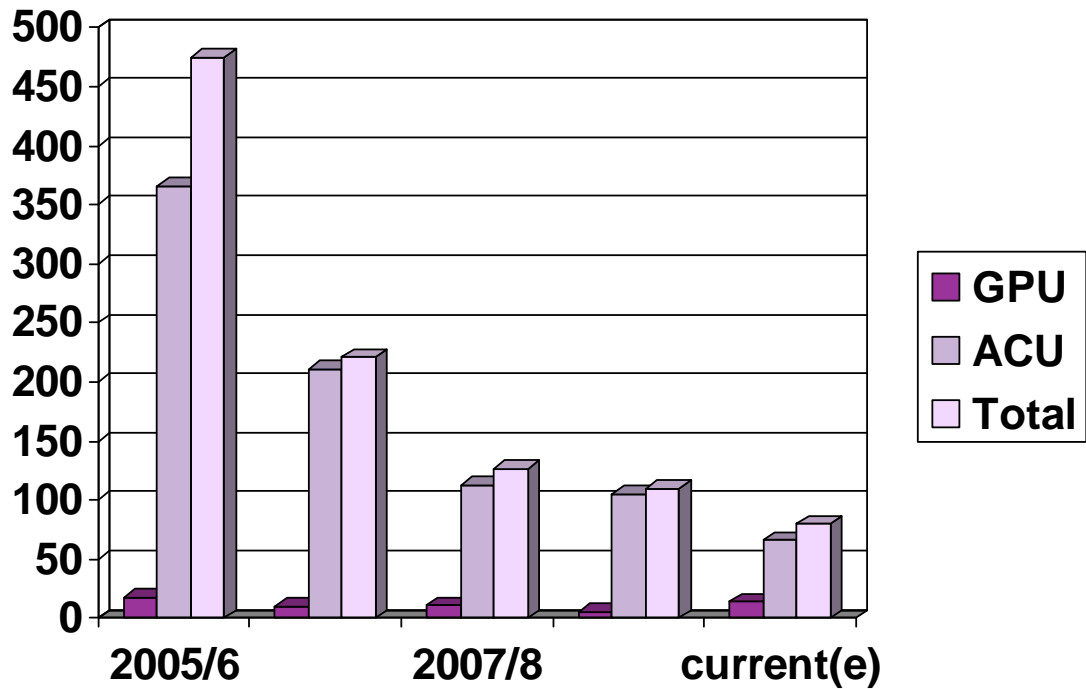


Current statistics:

- The most common diagnostic group of patients to be restrained are those with mania or psychosis:
 - Schizophrenia/psychosis: 18 clients
 - BAD: 6 clients
 - Substance use only: 0
 - Concurrent diagnosis: 5
 - Dementia: 0
 - Personality disorder: 1
 - Dual diagnosis: 0



Restraint Use by Number of Episodes



Most recent initiatives:



- CAMH updated and revised the “Least Restraint Policy” into the new “Emergency Use of Chemical Restraint, Mechanical Restraint and Seclusion”
- An APN position was created to oversee the restraint reduction initiative
 - Work groups were created to focus on data quality, restraint documentation tools, workforce development, and debriefing
- Revised policy rolled out June 1st, 2009

Further steps:

- Provided staff education on the new “Emergency Restraint Policy” and the new documentation tools
- Work with ACU staff so that a staff member is always on unit in ACU, not just in nursing station
- Limit any continuous monitoring to 2 hours/ staff at one time
- Debriefing tool to be initiated (pilot completed)
- Developing an ACU risk assessment tool and an ACU transfer checklist

Lessons Learned:

- All members of the leadership team must be on the same page
- Any practice change takes time
 - Unlearning the previous practice/s
 - Questioning and challenging the new practice
 - Testing the changes in practice
 - Incorporating the changes in practice
- Change is a never-ending process



THANK YOU

*Special thanks to the staff of the
ACU/GPU*



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