Least Restrictive Practice: A Healthcare Staff Perspective

Summary Report

May 2022

Improvement Hub

Enabling health and social care improvement

Introduction

In autumn of 2021, the Scottish Patient Safety Programme for Mental Health (SPSPMH) engaged with healthcare staff to understand the use of restrictive practices, particularly restraint, and potential areas for improvement. Key themes which emerged include the need to ensure: safe staffing; adequate training for staff; 1:1 time between staff and patients, and the opportunity for patient to participate in activities.

A package of evidence based guidance and support has been developed in partnership with the SPSPMH Co-Design Group which focuses on the essentials identified as being central to supporting the safe delivery of care.

What this report will do

This report sets out the key findings of a survey of healthcare professionals working in an adult inpatient mental health setting across Scotland.

What we aimed to do

We aimed to understand the use of restrictive practices, particularly restraint, and potential areas for improvement for the perspective of staff.

How we did it

This was undertaken at a service level across adult inpatient mental health settings using an online questionnaire (n=137).

Learning

The survey identified 4 main opportunities for improvement. These have been included in the SPSPMH change package for 22/23.

Overview of themes

Overview

We aimed to understand the use of restrictive practices, particularly restraint, and potential areas for improvement through a questionnaire.

A thematic analysis of the feedback was completed, which identified the following opportunities for improvement:

- Adequate staffing ratio of staff to patients
- Staff being formally trained in the use of restraint including de-escalation techniques
- Valuing a focus on 1:1 time for staff and patients
- Patients have opportunities to participate in appropriate activities and feel important.

Staffing

Training

1:1 Time

Activities

Summary

137 questionnaire responses were received from staff working in 10 boards in total. Nearly a third of responses came from one territorial board. Most (over 70%) of those responding to the questionnaire were nursing staff, with 11% medical staff and smaller respondent numbers of AHP and healthcare support workers. Most (over 70%) respondents had 5 or more years length of service with their organisation, with 60% having 10+ years.

The Evidence and Evaluation Team (EEvIT) analysed the data resulting from the survey exercise. The responses have been grouped where appropriate in to the Q1- Q7 format set out in table 1.

The following pages details the highest responses received for each question.

Table 1. Questions	
1	What reasons would result in you using restraint?
2	What de-escalation techniques do you use to prevent incidents of restraint?
3	How do you feel following an incident of restraint?
4	Who would you able talk to about an incident of restraint after it happens?
5	How do staffing levels impact on the likelihood of the use of restraint happening on a ward?
6	What do you feel would reduce distress and make it safer for patients experiencing restraint?
7	What do you see as the biggest opportunity for improvement when supporting people to reduce stress and distress?

What reasons would result in you using restraint?

When there were instances of aggressive behaviours (52 comments about)

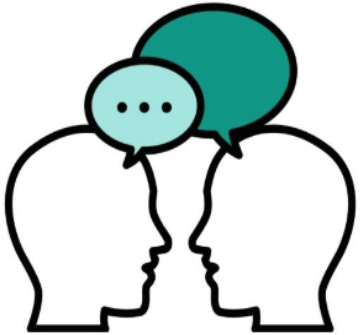
Preventing harm (either to the patient themselves, other patients or staff) (93 comments about)

To administer required medication/medical procedure when the patient had refused (26 comments about)

What de-escalation techniques do you use to prevent incidents of restraint?

Active listening, empathising and spending time talking and building professional relationship with patients (56 comments about)

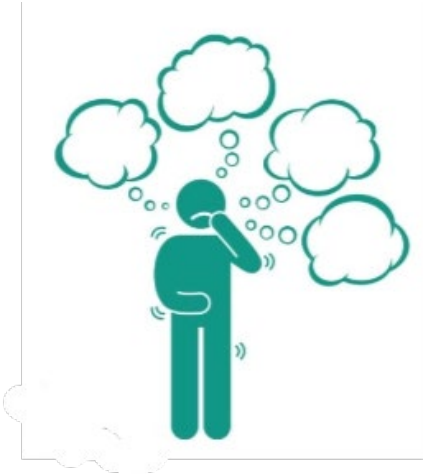
Using verbal de-escalation techniques (38 comments about)



Visibility of staff (29 comments about)

How do you feel following an incident of restraint?

Feeling anxious, upset, sad or worried it may happen again (44 comments about)



Feeling physically or emotionally drained (31 comments about)

Physical sensation (heart rate/adrenaline/shaking/pain) (27 comments about)

Who would you be able to talk to about an incident of restraint after it happens?

Line manager (67 comments about)

Ward colleagues (97 comments about)

there was a desire for an immediate debrief
(with potential variation how achievable this was in practice)
(30 comments about)

How do staffing levels impact on the likelihood of the use of restraint happening on a ward?

Fewer staff leading to less support and therapeutic time available which may lead to distress and frustration (36 comments about)

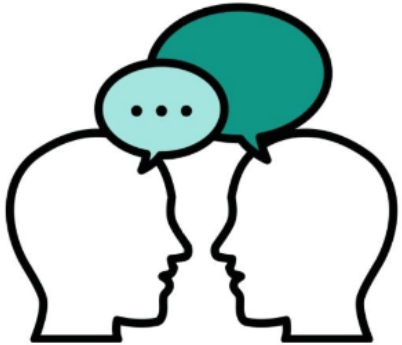
Fewer staff leading to delay to restraint or restraint not taking place due to a need for adequate staff to carry out restraint (35 comments about)

What do you feel would reduce distress and make it safer for patients experiencing restraint?

Appropriate ward environment including physical space and verbal calm and removing people who do not need to be in the area (41 comments about)

Appropriate staffing levels of multi-disciplinary team such as occupational therapist, nursing, medical, psychology, support staff (27 comments about)

Appropriate respectful and compassionate communication throughout to keep the patient informed and check understanding of the event (25 comments about)



Response

Response

SPSPMH has taken the findings of this report along with an recent evidence scan and interviews with people with lived experience and developed new improvement resources to support mental health inpatient teams across Scotland.

The new SPSPMH change package reflects a significant amount of the feedback identified by staff.

Key opportunities for improvement and the SPSPMH response are highlighted in the table opposite.

Opportunity for improvement	SPSPMH response
A desire for an immediate debrief (following an incident of restraint)	Safe communication driver of 'The Essentials of Safe Care' and 'Communication process' driver of SPSPMH change package
Fewer staff leading to less support and therapeutic time available which may lead to distress and frustration	Safe staffing driver of 'The Essentials of Safe Care' and the introduction of the 'Safe Staffing Real-time Resource' to plan for safe care.
Staff being formally trained in the use of restraint including de-escalation techniques	Our change package contains the change idea 'De-escalation techniques: Staff are trained and use'
Patients have opportunity to participate in appropriate activities and feel important	Our change package contains the change idea 'Introduce staff led group activities'
Staff were familiar to the patient, having spent more 1:1 time with that staff member	Our change package contains the secondary driver 'Continuous interventions are delivered by core, familiar and skilled staff'

Acknowledgements

We would like to extend our thanks to our co-design group and the healthcare staff who responded to the questionnaire.

MENTAL HEALTH NETWORK

SCLD

CARERS TRUST SCOTLAND

NHS SCOTLAND

support in mind scotland
action for people affected by mental illness

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Published May 2022

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