UNCONTROLLABLE BEHAVIOR AND RESTRAINTS POLICY ANALYSIS

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Abstract

Aim: To assess and analyze the uncontrollable behavior and restraint policy for National Center of Mental Health in Jordan according to administrative ease, cost and benefits, effectiveness, equity, legality and political acceptability.

Background: The use of restraint in psychiatric settings supports to restrict policy and program on how to deal with uncontrollable behavior as a result of the decrease in number of restraint patients.

Conclusion: There are many alternatives that are effective, safe to patient and staff, legal, easy to apply, and accepted politically, instead of use of physical restraint.

Key words: Policy, Restrain, Restraint, Patient, Psychiatric Settings, Uncontrollable Behavior

Introduction

Restraint is often used to control the behavior of people with mental conditions in a variety of settings including hospitals and psychiatric treatment facilities (Haimowitz, Urff, Huckshorn, 2006). Psychiatric settings use medical intervention as a restraint to reduce risk demonstrated by violent patients from harming themselves and others (Regan, Wilhoite, Faheem, Wright, & Hamer, 2006). Restraint is an intervention used in the treatment and management of violent behaviors in psychiatry (McCue, Urcuyo, Lilu, Tobias, & Chambers, 2004).

The objectives of this policy analysis paper are

A) To assess and analyze the uncontrollable behavior and restraint policy for National Center of Mental Health in Jordan, according to administrative ease, cost and benefit, effectiveness, equity, legality and political acceptability.

B) To suggest an alternative that can be applied in the National Center of Mental Health.

C) To discuss possible alternatives according to literature.

The MEDLINE, CINAHL and EBSCOhost database were reviewed for searching the topics; the keywords restrain , restrain policy were used.

Health policy was defined as “a set course of action undertaken by governments or health care organizations to obtain a desired outcome” (Cherry & Jacob, 2007).

Policy analysis is defined as “the systematic study of background, purpose, content, and anticipated or actual effects of standing or proposed policies and the study of relevant social, economic and political factors” (Dye as cited in Mason, Leavitt, & Chaffee, 2007).

Step One: Verify, define, and detail the problem

The term restraint includes either physical restraint or chemical restraint; physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient’s body that restricts freedom of movement (Regan, et al., 2004). Chemical restraint is a medication used to control behavior or to restrict the patient’s freedom of movement and is not a standard treatment for the patient’s medical or psychiatric condition (Regan, et al., 2006).

Restraints are useful to prevent injury and reduce agitation but the use of restraint in the treatment of mentally ill patients is a highly controversial and potentially dangerous practice (Lewis, Taylor, & Parks, 2009). In addition, it can produce physical and psychological effects on both patients and staff (McCue, et al., 2004).

The improper use of restraints can lead to patient harm and potential civil litigation. The researcher and clinicians have become focused on physical restraint because of lack of consensus within the field about the appropriate use of restraint, damage of therapeutic relationships, in addition it produces significant physical and psychological risk; including death related to asphyxia, aspiration, cardiac events brought on by exertion and medication-interaction (Haimowitz, et al., 2006). In 2005, a case where a woman was admitted to a county hospital psychiatric inpatient unit, guards and technicians restrained her, and during the restraint process, had her face down on the floor for thirteen to fifteen minutes then she died of asphyxiation. Also in 2005, an Alzheimer's patient was hospitalized and within 24 hours after she was restrained, was found dead related to an accidental asphyxiation (Regan, et al., 2006).

The use of restraint in the psychiatric setting supports putting restrictions on such policy and a program on how to deal with uncontrollable behavior and as a result decrease in the number of restrained patients.

Physicians, nurses, patients, other patients, and their families are concerned about this policy; the nurse who deals with psychiatric patients has high skill and knowledge to assess and observe patients over 24 hours, such nurses have expert power. The physician is the only person who has legitimate power to get a restraining order. Regan et al. (2006) found that other patients and their families often view patient restraints negatively and as traumatic events there for must be information about the indication of restraint for patients with uncontrollable behavior so they have referent power. Because the patient cannot refuse restraint then he/she has no power.

Step Two: Establishing Evaluation and Implementation Criteria

Title: Uncontrolled behavior and restraints policy

Purpose: To identify how, when, and by whom restraints are applied.

The goal of policy is to assist patients in controlling behavior and preventing physical injury to the patient, other patients, visitors, and health care team.

The major desirable outcomes of behavior and restraints policy are

A) Control patients' behavior such as anger, aggressions, agitation.

B) Prevent harm to self and harm to healthcare team.

C) Decrease incidence of restraint use.

The undesirable outcomes that may result from this policy are

A) Injury of patients and healthcare providers.

B) Psychological effects to patient, other patients, family and visitors.

C) High cost effectiveness to the organization.

After evaluating the uncontrolled behavior and restraints policy in National Center for Mental Health in Jordan in terms of administrative ease, costs and benefit, effectiveness, equity, legality, and political acceptability it was found that:

A) Administrative ease: ease of applying the procedure by healthcare provider, ease to restrain patient and ease to understanding of instruction by health care team.

B) Cost and benefit: costly; needs restraint team consisting of four to five staff during shift to apply procedure, need training program for staff, time consuming (the patient must be checked every fifteen minutes) and need separate room for patient. However, the benefits of this policy is it uses the same equipment for all patients and uses little equipment for patients.

C) Effectiveness: it is effective by preventing self harm and harm to health care team, controlling patient behavior such as anger, aggressiveness and agitation, and it is a clear policy when they are dealing with the patient. However, the patient is isolated.

D) Equity: the policy is safe for patients, nurses and caregivers.

E) Legality: it is legal to apply the policy because it certified by the Ministry of Health and no harm to patient.

F) Political acceptability: unaccepted regarding human rights and human dignity.

The table below summarizes the evaluation of uncontrolled behavior and restraints policy in National Center for Mental Health in Jordan.

Table

Administrative Ease	Cost and Benefits	Effectiveness	Equity	Legality	Political Acceptability
Ease	Cost	Effective	Yes	Legal	Unacceptable

Step Three: Suggest Alternative Policies

Managing aggressive and violent behaviors has become an important skill for all staff who work with the psychiatric patient (Regan, et al., 2006). After searching for alternatives and solutions instead of use of physical restraint, some alternatives have evidence-based practices and some have not. Regarding uncontrolled behavior and restraints policy in the national center for mental health, it is good but needs to be expanded.

The alternatives are

A) Personal safety plan.

B) Staff visibility in the unit.

C) Staff training.

D) Chemical restraint.

Step Four: Assessment of Alternative Policies

All alternative policies will be evaluated in terms of administrative ease, cost and benefit, effectiveness, equity, legality and political acceptability, which will be summarized in a table in five steps.

A) Personal safety plan is a primary prevention because the health care providers do it before the patient is involved in a distressful situation. The main goal is to gather information about the patient's response to distress and identify what interventions will be most helpful for him/her to stay in control. It is initiated on admission or when the patient can participate in the planning. If the patients do not participate in the plan, the information is taken from family, care providers, or previous record.

This alternative is effective since it is primary prevention and collects data before involvement in a distress situation, it is legal to use, safe for patient and staff, accepted politically, easy to apply and no cost for the organization.

B) Increased staff visibility in the patient's environment rather than present in the nurses' station. It helps the staff to identify the problems and intervene early.

This strategy needs more staff available in the unit, which means it is costly to the organization, effective to observe distressed patients early, safe for patient and staff, legal to use, easy to apply, and accepted politically.

C) Staff training is important to the patients and staff themselves; the patient has the right to be safe when engaging in uncontrollable behavior. This alternative is effective since it deals with patients in a scientific method, is legal to use, easy to apply, safe for patient and staff, but high cost to the organization.

D) Chemical restraint by use of medication to control patient behaviors. Most often medication used in chemical restraint is Diazepam (Valium), Lorazepam (Ativan), and Haloperidol (Haldol). This alternative is highly effective, legal to use, easy to apply through medication in different routes (IM, IV) to the patient, is of cost to the organization, safe for patient and staff, and accepted politically.

Step Five: Distinguish Among Alternative Policies

The table below summarizes the evaluation of the possible alternatives:

Personal safety plan is effective since due to comprehensive assessment on admission, it is legal, ethical, clear, safe for patient and staff, easy to understand, evidenced based practice.

Staff visibility requires more staff available in the unit, which means it is costly to the organization, effective to observe distressed patients early, safe for patient and staff, legal to use, easy to apply, is accepted politically, and is evidenced based practice.

Staff training is effective since it deals with the patient in a scientific method, is legal to use, easy to apply, safe for patient and staff, high cost to organization, and evidenced based practice. Chemical restraint is highly effective, legal to use, easy to apply through medication, of cost to the organization, safe for patient and staff, accepted politically, and is evidence based practice.

Criteria / Alternative	Administrative Ease	Cost and Benefits	Effectiveness	Equity	Legality	Political Acceptability
Personal Safety Plan	Ease	Not cost	Effective	Yes	Legal	Acceptable
Staff Visibility	Ease	Cost	Effective	Yes	Legal	Acceptable
Staff Training	Ease	Cost	Effective	Yes	Legal	Acceptable
Chemical Restraint	Ease	Cost	Effective	Yes	Legal	Acceptable

Step Six: Implementation and Evaluation Plan

After evaluation of this policy and assessing all alternatives one alternative will be chosen; many studies focus on staff training since the staff play a major role in dealing with these patients.

New policy: All staff on the psychiatric setting receive a training program that can help the staff to deal with patients and use their training instead of using restraint.

Purpose: To ensure all staff have important skills and knowledge to deal with these patients.

A program such as crisis intervention, time management, stress management, and development of therapeutic relationships can help the staff to deal with these patients. Staff should receive a training program consisting of lectures, demonstrations and practice when starting a job.

This policy is safe for patients and staff, legal to use, easy to apply, effective to deal with patient, but it costs the organization.

Approval of the policy modification should be obtained from National Center for Mental Health in Jordan, to start to implement the modified policy, after a proper explanation and demonstration of the missing points in this policy, which were modified and added.

The policy evaluation will depend on the number of restraint occurences after receiving the program.

Recommendations

• The administration for organization should develop policy for assessment and management of uncontrollable behavior and restraints.

• Require training program about how to deal with uncontrollable behavior and manage it.

Summary and Conclusions

The purpose of this paper was to analyse policy used in the psychiatric setting. I chose restraint policy since it is a very important subject, is controversial, and a high-risk procedure.

The use of restraint in the psychiatric setting should be the last choice because the consequence of the procedure sometimes is fatal. There are many alternatives that are effective, safe to patient and staff, legal, easy to apply, and accepted politically instead of use of physical restraint, such as complete assessment of the patient and put into place a personal safety plan that can help the staff to deal when the distress situation occurs. Staff training should give the staff expert power when dealing with the patient, as a skillful and knowledgeable person, and there should be increased staff visibility in the patient environment to help the staff to detect and intervene in the distress situation early.

References

1- Cherry, B., & Jacob, S. R. (2007).Contemporary nursing: Issues, trends, & management (5th ed.). St. Louis: Mosby.

2- Haimoqitz, S., Urff, J., & Huckshorn, K. (2006). Restraint and seclusion- a risk management guide. Retrieved March 10, 2014, from http://www.ndrn.org/images/Documents/Issues/Restraint_and_Seclusions/NDRN_Risk_Management_Guide.pdf

3- Lewis, M., Taylor, k., & Parks, J. (2009). Crisis prevention management: a program to reduce the use of seclusion and restraint in an inpatient mental health setting. Issues in mental Health Nursing, 30, 159-164. doi: 10.1080/01612840802694171

4- Mason, D., Leavitt, J., & Chaff, M. (2007). Policy & Politics in Nursing and Health Care (5th ed.). St. Louis: Mosby.

5- McCue, R., Urcuyo, L., Lilu, Y., Tobias, T., & Chambers, M. (2004). Reducing restraint use in a public psychiatric inpatient service. Journal of Behavioral Health Services & Research, 31(2), 217-224.

6- Regan, J., Wilhoite, K., Faheem, U., Wright, A., & Hamer, G. (2006). The use of Restraints in psychiatric settings. Tennessee Medicine, 41-42.