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The Effects of Patient Engagement on the Reduction of Seclusion and Restraints:

A Literature Review

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A Scholarly Project submitted to the faculty at St. Catherine University in partial fulfillment of  
the Masters in Science in Nursing: Nurse Educator degree requirements.

St. Catherine University

May 2018

### Abstract

Interventions for the prevention and reduction of the use of restraints and seclusion in acute psychiatric care emergencies continues to be an ongoing dilemma for healthcare organizations. Nurses wish to form a therapeutic relationship with their patients, however, research in psychiatric care is still indicative of difficulties in the interactions within patient engagement and nursing staff. As patient engagement is an essential component to recovery, nursing services within the confinements of an acute locked psychiatric unit must also focus on providing a safe therapeutic milieu. This literature review explores models of patient engagement and their positive effects on a locked psychiatric ward in the promotion of reduction in the number of restraint and seclusion episodes. Additionally, it will describe strategies to improve patient engagement within the mental health system and communities.

Keywords: restraint, seclusion, patient engagement, psychiatric unit, mental health, psychiatric nursing, safety

### Acknowledgements

I wish to acknowledge my late husband James Nelson Hill who was suddenly taken in 2013. Without him I would not have had this opportunity to further my educational studies. I have successfully accomplished this scholarly project with the oversight and direction of Emily Nowak. I have much appreciation for Emily's clear, straightforward, and direct communication style. Although it took time, the benefits of this style were much appreciated as I progressed through the program. I wish to thank Emily for her guidance in my educational journey.

Lastly, I wish to congratulate my daughter Jordan Heinz on her recent life accomplishments. I love you and I am proud that you have flourished into the strong young woman you have become.

Finally, I wish to thank my new-found friend and love, Michael Haessly. Thank you for finding me and evoking feeling in me that I thought I had lost.

## **Introduction**

Patient engagement in every discipline of healthcare is essential to improve patient and healthcare systems outcomes. Making patients active participants in the delivery of their health care is considered a possible solution to reduce health care costs as well as promoting patient engagement into the management of his/her care, decreasing the length of hospitalizations, and reducing poor clinical outcomes (Barello, Guendalina, Graffigna, & Vegni, 2014).

Patient engagement is an essential component to recovery and nursing services within the confinements of an acute locked psychiatric unit must also focus on providing a safe therapeutic milieu. As many health care systems strive to move toward a restraint and seclusion free environment, acute psychiatric & behavioral emergencies will continue to be present in emergency departments and locked psychiatric units. Rational for utilizing restraint and seclusion is to maintain unit safety and prevent harm to both patient and staff.

The American Psychiatric Nurses Association (APNA) Institute for Safe Environments (ISE) has focused on key elements that affect safety in psychiatric treatment environments; one of these key elements is patient engagement (Polacek, Allen, Damin-Moss, Schwartz, Sharp, Shattell & Delaney, 2015). In the following literature review, an investigation of the effectiveness of how patient engagement on locked psychiatric wards contributes to the decreased rate of the incidents of restraint and seclusion will be explored.

## **Method**

A literature search was conducted through four key online databases: PUBMED, CINAHL, Google Scholar, and PsychINFO. Search terms were “Keyword” restraint, seclusion, patient engagement, psychiatric unit, mental health, psychiatric nursing, safety. Articles selected were published between 2005 and 2018. A total of 166 were retrieved for review. All abstracts

were reviewed for relevance. After full analysis 58 articles were retained. Of these 26 articles were retained. Upon review, fifteen were literature reviews, seven were experimental research at the systems level, two systematic review and one meta-synthesis analysis. Each article focus on alternative methods of reducing the rate of restraint and seclusion within an acute care setting and/or how to promote patients to engage in their health care decisions.

### **Definitions**

**Restraint and Seclusion.** The Centers for Medicare and Medicaid, (2017), services define physical restraints as any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the patient's body so that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Chemical restraints are any drug used for discipline or convenience and not required to treat medical symptoms. Seclusion is defined as the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving (Knox & Holloman, 2012).

**Patient Engagement.** Broadly defined, engagement signifies being clinically involved with a patient while the patient moves toward clinical treatment goals. The literature on psychiatric mental health nurses and engagement suggests that engagement is a clinical relationship with the patient in direct patient care and that active participation and meaningful involvement with patients in a range of activities is a critical component of the commitment to their role in the work environment (Polacek et al., 2015).

**Milieu.** A healing environment which is adaptive, responsive: one that provides a safe, caring environment for personal growth and development (Espinosa, Harris, Frank, Armstrong-Muth, Brous, Moran, & Giorgi-Cipriano, 2015).

### **Background and Significance**

Milieu management within a locked psychiatric unit is often limited. Widely used interventions by nursing staff to promote a safe and healing environment include frequent staff contact, decreased stimulation, medications and, at times, seclusion or restraints. It is also important to note that a patient's level of functioning may be grossly impaired by psychosis, altered perceptions, distorted thinking or substance use upon initial entry of a locked psychiatric unit. During this time, patient safety and unit security are of the utmost concern and as violent incidents may occur, the use of restraint or seclusion may be unavoidable.

Safety issues in psychiatric settings necessitate the use of special methods when implementing patient engagement approaches (Livingston, Nijdam-Jones, Brink, Calderwood, & Brink, 2012). Patients may be given choices about their care but may not entirely be in control due to the condition of their mental illness. Limitations on food, clothing, phone calls, visiting, and restricted access items such as pens, hair pins, nail clippers or personal items such as makeup or jewelry may be considered dangerous for the unit. Lack of access to personal necessities becomes frustrating for the psychiatric patient. Patient engagement may be especially challenging with patients who have chronic mental illness and lack adequate insight or the cognitive capacity to make informed decisions pertaining to their personal health and safety.

The ability to balance control and patient engagement on a psychiatric unit is an essential element to nursing practice. Effective interventions to support patient engagement embraced an attitude of respect for the patient and a conformation of their autonomy (Delaney & Johnson, 2006). Further, there are "difficult to engage" populations in the mental and psychiatric settings. Individuals experiencing first episode psychosis, homeless individuals, and patients with co-occurring serious mental illness and substance abuse disorders. Various recovery-oriented strategies have been used to enhance engagement within this special population (Dixon,

Holoshitz, & Nossel, 2016). The following review explores the best practice for nurses practicing within these parameters.

### **Review**

On review of the literature, many patient engagement references were found that identified strategic alternatives to the use restraint and seclusion. Key themes emerged that correlated a positive experience in the reduction of the use of restraint and seclusion on a locked psychiatric ward. Each theme focused on a care model that had a strong component of patient engagement. Models of patient engagement include; Engagement Model, Trauma Informed Care, Cognitive Milieu Therapy and Tidal Model. The models of patient engagement in this review are analyzed and summarized next.

**Engagement Model.** The Engagement Model is an approach in mental health care that matches best the idea of strengthening resilience to reduce rates of seclusion and restraint. The Engagement Model teaches nurses how to engage with patients in such a way that patients experience warmth, trust and hospitality. This furthers an active involvement between patients, family and caregivers (Sitvast, 2016).

The Engagement Model focuses connecting with patients to build a therapeutic alliance. This is done by nurses responding to the feelings and experiences of the patient in a proactive way. This is a critical skill in psychiatric nursing practice as most patients are involuntary admitted in crisis situations. Crisis admissions predispose patients view of the psychiatric unit as negative that may trigger a strong defensive response. To prevent an acute crisis, psychiatric nurses must give the patient time to process their current environment and ensure that they will be treated respectfully. Instead of activating existing learned ways of coping, ways that are often



reenactments of responses to earlier traumatic experiences, an engaged approach stimulates patients to try new, more helpful ways of adaptation (Sitvast, 2016).

Patient participation in treatment planning within the Engagement Model has an added benefit of decreased power struggles, particularly for patients who have borderline, antisocial, or narcissistic personality disorders (Blair & Moulton-Adelman, 2015). Offering choices to patient is critical on a locked unit and if the request is reasonable, unit or staff inflexibility should make reasonable accommodations for the request if it does not jeopardize unit safety. Other examples of offering choices include: flexibility in visiting hours, allowing candy or snacks, extra time in the milieu during sleep hours or offering therapeutic coping mechanisms such as weighted blankets, stress balls or the use of a sound machine or music headphones. Salem Hospital in Oregon found success after its implementation of the engagement model. The hospital reported an 87% reduction in the incidents of restraint and seclusion over a one year period (Recupero, Price, Garvey, Daly & Xavier 2011). Despite management changes at medical director and nurse manager levels, changes in staff hours, and no change to admission criteria for the population served, the Engagement Model remains largely intact and is still embraced and protected by staff at many healthcare organizations (Blair & Moulton-Adelman, 2015).

**Trauma Informed Care Model.** Trauma informed care complements the approach of person-centered care providing an explanation for unhealthy coping skills and how they can manifest in situation that be frightening or stressful for patient who have experienced trauma (Becket, Homes, Phipps, Patton & Molloy, 2017). This approach promotes collaboration and empowering relationships and increases that patient's awareness regarding the use of successful coping skills during stressful events. A main tenet emphasizes in Trauma Informed Care is the need to promote a therapeutic patient/provider relationship. If this core component of

therapeutic engagement is established, patient participation in their behavioral health program, development, planning, and evaluation will have greater positive outcomes.

One component of the Engagement Model is to limit the patient's response to previous traumatic events by means of comfort measures. Themes from Trauma Informed Care are highlighted within the Engagement Model. A warm comforting milieu fosters recovery and is a critical component within a healing environment. Psychiatric units must be welcoming using warm tones and the physical environment should promote stress reduction and non-violent behaviors. Stress reduction measures pertaining to the physical environment may include the use of a comfort or sensory room, utilizing the pool, or simply taking a hot shower. A three and a half year experimental research study utilizing the concept of a healing environment was implemented to investigate initiatives to reduce restraint and seclusion at a large state funded hospital in the southeastern United States. Significant findings suggest that changes to the physical characteristics of the therapeutic environment promoted a substantial reduction of 82.3% in the use of restraint and seclusion within the above said time (Benson, Borckardt, Cooney, Frueh, Grubaugh, Hanson, Hardesty, Herbert, Kmett-Danielson, Madan, & Pelic, 2011). The model of Trauma Informed Care has a positive correlation to the reduction of restraint and seclusion. And, a critical component of this model is patient engagement, involvement, and inclusion of all patients at every level of care (Muskett, 2014).

**Cognitive Milieu Therapy Model.** This model of patient engagement focuses on active, structured, problem-oriented, psycho-educational, and a dynamic treatment form. This model in the psychiatric environment gives the patient the opportunity to find new alternatives to inappropriate patterns of reactions and to foster the development of new coping skills (Bak, Brandt-Christensen, Sestoft, & Zoffmann, 2012). The efforts of various healthcare professionals

are integrated so that patients can relate to a treatment plan which is developed cooperatively between the patient and the interdisciplinary staff. The approach incorporates motivational strategies and offers patients a range of cognitive and behavioral strategies, enabling them to deal with their mental health and substance issue problems. This makes it easier to engage patients in active participation in addressing their healthcare needs (Borge, Røsseberg & Sverdrup, 2013).

One core component of Cognitive Milieu Therapy is the schema-focused dialog between the patient and the nursing staff, in the situation before the use of restraints. This type of engagement was described as a positive experience that provided practical knowledge for the patient. Working through the problem motivated patients to establish new habits and provided opportunities for the personal development of healthy coping skills. This type of patient engagement is found to have a positive influence on the reduced occurrences of restraint and seclusion (Bak, Brandt-Christensen, Sestoft, & Zoffmann, 2012). One theme of patient engagement within Cognitive Milieu Therapy includes the instillation of hope, trust, and mutual goals of the therapy developed by the patients and the staff together. These qualities are also called “befriending” and seem to be important as a form of social support to keep up an active engagement of patients in mental health care (Borge, Røsseberg & Sverdrup, 2013).

**Tidal Model.** The Tidal Model develops a framework for nursing practice that seeks to engage with the person rather than the disorder. A core element to this model is empowerment. Empowerment is only possible when a patient is involved in their own care. By using their own language, metaphors and personal stories people begin to reclaim the meaning of their personal experiences (Barker & Buchanan-Barker, 2010). The process of engaging with patient takes place on three different domains: self, world, and others. The nurse evaluates each domain to increase awareness of the current situation to determine what needs to occur at that specific

moment. Upon its implementation on an acute psychiatric ward, this model of patient centered care has reduced the number of restraint and seclusion by 68% (Bak, Brandt-Christensen, Sestoft & Zoffmann, 2012). With the focus of recovery as the keystone of the Tidal Model, it is one approach to “enabling recovery and reclamation” for both the nurse and the person under their care (Barker & Buchanan-Barker, 2010). For nurses, using the Tidal Model made a positive difference to their practice, particularly in terms of a therapeutic engagement with clients.

**Other Therapeutic Considerations.** Engagement interventions that were noted to be independent from the above models and uniquely contributed to the reductions of restraint and seclusion. It is known that violent incidents are more likely to occur during unstructured periods and transitional times (Janner & Delany, 2012). The implementation of a daily structured schedule has been effective in reducing episodes of restraint and seclusion. Further findings suggest that frequent changes to physical characteristics of the therapeutic environment has had positive effects on engaging patient in the therapeutic milieu (Benson et al., 2011). Recovery oriented engagement techniques such as the use of electronics and technology have been proven to be effective. Disengagement during times of symptom resurgence may lead to increase stress and potentially unsafe or violent behaviors. The use of electronics has been noted to improve patient engagement (Dixon, Holoshitz & Nossel, 2016).

Additional literature suggests the use of peer support has positive effects on patient engagement (Dixon, Holoshitz & Nossel, 2016). For those who have difficulty adhering to or engaging in treatment may have trouble trusting perceived authority figures, the use of peer support serves as a role model for both hospitalized and non-hospitalized patients (Dixon, Holoshitz & Nossel, 2016). Providing sensory modalities such as sensory based tools or creating appropriate environments that engage the patient’s senses to reduce agitation and prevent the

escalation of aggression have had positive effects on the reduction of restraint and seclusion (Chalmers, Harrison, Mollison, Molloy & Gray, 2012). Other engagement practices focus on specific therapies such as pet therapy, therapeutic horseback riding, rehabilitations services such as music/art therapy, or cooking (Caldwell, Albert, Azeem, Beck, Cocoros, Cocoros & Reddy, 2014).

As with any model of engagement employed it is of the utmost importance that patient engagement should be authentic. Authentic patient engagement is a core component to any de-escalation response. Authentic engagement encompasses far more, involving stakeholders as full partners in all phases of research and as research funders increasingly require (Woolf, Zimmerman, Haley & Krist, 2016). Such engagement, although challenging, can enhance the quality and impact of studies on many levels, from ensuring that data is relevant to users' needs to elevating the moral plane of research by showing respect to patients and vulnerable populations, such as the psychiatric and mental health population. These engagement principle of authentic engagement is of growing relevance to healthcare systems and policy makers responsible for population's health (Woolf, Zimmerman, Haley & Krist, 2016).

### **Recommendations for Nurse Educator Practice**

Preventing the use of restraint and seclusion in an acute hospital setting requires inter-professional collaboration, and challenges the therapeutic de-escalation skills of nursing staff, physicians, other health care professionals, managers, patients and their relatives (Abraham, Köpke, Meyer, Möhler & Nürnberger, 2016). These challenges imply that competencies to providing engagement requires knowledge and skills building that include a variety of behavioral approaches and interventions, based on the patients' needs and diagnosis, to improve engagement in this population. When disruptive episodes are managed in a therapeutic way,

patients perceive that nurse have their best interest in mind and they develop a sense of security, hope and self-acceptance (Finfgeld-Connett, 2009).

Nurse Educator Core Competency VII: Engage in Scholarship states that nurse educators acknowledge that scholarship is an integral component of the faculty role, and that teaching itself is a scholarly activity. To engage effectively in scholarship, one must draw on extant literature to design evidence-based teaching and evaluation practices (NLN, 2013). Utilizing this principle, recommendations for Nurse Educator practice within the psychiatric clinical setting include the implementation of three key strategies, focusing on concepts detailed in the Engagement Model of care, for the minimization of use of restraint and seclusion on a locked psychiatric ward. These recommendations are outlined below.

**The Admission Process.** Patient engagement begin when the patient walks through the hospital doors and for most this means the emergency room. It is essential that the emergency department, professional mental health intake screeners and accepting MD collaborate with the charge RN of the prospective admission unit to inquire if the patient is an appropriate admit for the unit's acuity and milieu. Often patients are inappropriately placed on psychiatric wards which may lead to increased fear and anxiety for the patient. Proper patient placement is essential for mental health recovery. Patients need and have a right to feel safe and secure. Ensuring so will further facilitates their engagement in milieu activities and promote active participation in their individualized treatment plan. Nurse Educators role to initiate change includes locating and appraising relevant evidence to address the pitfalls of patient placement. Once evidence is obtained and synthesized, a change can be initiated by assessing the clinical environments for readiness to improve the admission and patient placement processes for the psychiatric population.

**Minimize the Power Differential: A Culture Shift.** Intentionally minimizing the power differential between staff and patients can help create and sustain a safer environment (Blair & Moulton-Adelman, 2015). In 2013, a Spanish hospital reported that after the implementation of an interventional program inclusive to patient engagement to reduce restraint and seclusion, the percentage of agitated patients increased while the percentage of aggressive patients decreased, which may indicate that intervention is more effective than prevention (Guzman-Para et al., 2016). Staff training should enhance a culture shift to promote the elimination of the inflexible adherence to authority. Recognizing the needs of patients and the situation prompts an interaction that varies. Nurses must craft a response that is based on the on the evolving nature of interchange, the nurses intuitive sense of what the patient's needs are at the specific moment, as well as how to move into a shared sense of where to go next (Delaney, Johnson & Shattell, 2017). Daily engagement, community meetings, finding commonality with patients and engaging patients in individual treatment goals provide structure and a forum to discuss daily concerns and unit expectations. The atmosphere of the daily reinforcement of community structure provides stability and emphasized safety, openness, enhances cohesiveness and enables patients to be heard (Blair & Moulton-Adelman, 2015).

Furthermore, nurses must be mindful of the choices they make when denying patient less restrictive items. At times the power struggle is not worth the increase risk of a patient becoming increasingly agitated which may result in a violent episode. Situations like these can be avoided especially if the request is minimal and reasonable.

Nurse Educators have the capacity to inform, influence, and assist health care professionals to gain competence by providing educational coaching. Guided by the principles outlined in the Ottawa Decision Support Framework, decision coaching recognizes patients in

decisional conflict and intervene by guiding them through the decision-making process with an overall goal of supporting and engaging patients to be involved in their decision making (Stacey, Murray, Legare, Sandy, Menard, & O'connor, 2008). Coaching staff to acknowledge and assess the patient's current decisional conflict and related modifiable knowledge deficits, values, and current needs encourages health care staff to make more supportive patient decisions for the psychiatric patient. Nurse educators serving in the role of decision coaches facilitates shared decision making between healthcare staff and patients.

**Leadership Approaches: Shared Decision Making and Enhancing Workforce Development.** Empowering staff to own their practice and the commitment to do so from the leadership and management level. It is crucial for staff to feel empowered in terms of decision making when acute situations occur. Leaders must also be able to intervene and empower in such ways that they do not override judgment by staff, but rather support and promote sound problem solving ideas (Blair & Moulton-Adelman, 2015). It is suggested that leadership and management make attempts to “witness or observe” an event as a core activity to identify an action plan or resources to minimize restraint and seclusion (Riahi, Dawe, Stuckey & Klassen, 2016).

Enhancing workforce practices ensures that staff are supported and are educated on the most up to date information on de-escalation strategies and the prevention of violent behaviors on psychiatric wards. As staff assaults are becoming more prevalent it is further recommended to include the implementation annual assault crisis training, not only for staff but for patients who witness these events while on the unit. Further recommendations include facilitating a training program to includes hospital security and all psychiatric unit staff to ensure that best



practices are utilized when engaging with violent and aggressive patient behaviors. Engaging staff at all levels is a critical component in the shift towards culture change.

Nurse educators have a role in promoting improved patient outcomes with evidenced based practices and competencies. Developing supportive learning environments for staff and patients is essential with the psychiatric ward. Embedding a nurse educator to collaborate within the administrative organizational structures optimizes a potential for sustainability within the psychiatric department.

### **Summary**

The literature suggests there are many evidenced based models that focus of patient engagement strategies to facilitate the reduction of restraint and seclusion. In each model the interventions are indicative of organizational and leadership changes, enhancements of staff training and development with a focus on prevention and creative ways to engage and de-escalate the aggressive patient during an acute behavioral emergency. Although the utilization of patient engagement in each model has a positive correlation in the reduction in the number of episodes of restraint and seclusion, the restraint and seclusion usage has not been fully eliminated, and at times unavoidable, within the high-acuity in-patient psychiatric wards.

### **Conclusion**

The implementation and utilization of any model of patient engagement may help nurses to support their patients in their transition from being overwhelmed by the impact of illness to taking the lead again in directing their lives and coping with the consequences of illness.

Therapeutic relationships on acute psychiatric wards distills the importance of patient-centeredness, therapeutic listening, and responding to the patient's emotional needs as critical relationship strategies that support patient engagement (Delaney, Johnson & Shattell, 2017).

Enhancing nurses' patient engagement support skills as individuals and as self-regulating professionals, nurses can make important differences in the reduction of restraint and seclusion.

Psychiatric patients respond positively when encouraged to participate and engage in their care. This engagement response leads to decreased anxiety and fear resulting in decreased episodes of aggression, and ultimately, decreased incidents of restraint and seclusion.

Therapeutically managing aggression within mental health practices is challenging.

Administration, leadership, nurses and support staff are encouraged to implement or enhance their current model in use to further promote efforts of patient engagement to better inform their practice.

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