Irish Journal of Psychological Medicine (2024), **41**, 159–160
doi:10.1017/ipm.2022.42

CAMBRIDGE UNIVERSITY PRESS

Letter to the Editor

Impact of a high observation ward on seclusion and restraint episodes

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Further to the recently published study (Feeney *et al.* 2022) of restrictive practices before and after COVID-19, an observational study of seclusion and restraint practices at Sliabh Mis Mental Health Admission Unit in University Hospital Kerry was carried out in March 2021. The focus of this study, however, was on the use of restrictive practice in the months before and after the opening of a four-bedded High Observation ward.

Lower risk of being secluded has been shown to be associated with greater 'total private space per patient', higher 'level of comfort' and greater 'visibility on the ward' (van der Schaaf *et al.* 2013). Sliabh Mis Mental Health Admission Unit at University Hospital Kerry previously comprised of two general adult wards, with a mix of both single and dormitory style rooms and a total capacity of 34 beds. Patients of a broad range of ages with varied past experiences and philosophies at different stages of recovery are admitted from the county of Kerry. There is no direct access to a psychiatric intensive care unit. In April 2019, a High Observation ward, named the Brandon ward, was opened. This High Observation ward provides a lower stimulus environment with a higher nurse:patient ratio. There is capacity for four patients with single bedrooms, a day room and a courtyard. It is staffed by three nurses during the day and two nurses at night. The opening of these four beds coincided with a decrease of four beds on one of the existing wards. The existing wards functioned as Acute and Subacute wards after the opening of the High Observation ward.

A reduction in the use of restraint and seclusion at Sliabh Mis was noticed subjectively so we decided to carry out a retrospective observational review – comparing the use of seclusion and restraint in the 22 calendar months before the opening of the High Observation ward in April 2019 and the 22 calendar months after. April 2019 was not included in the comparison to allow a transition period. Ethical approval was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals and the data required was readily available in the seclusion and restraint booklets kept on the mental health unit. For one particular episode of seclusion, the minutes part of the time seclusion ended was blank and so the half hour mark was used in the analysis (i.e. XX:30). The Mann Whitney U test was used when comparing the two groups as the data was not normally distributed.

There were 213 episodes of seclusion from June 2017 to March 2019 with a total duration over the 22 months of 2,262 hours and 5 minutes compared with 69 episodes of seclusion from May 2019 to February 2021 with a total duration over the 22 months of 818 hours and 39 minutes. The total number of restraints from June 2017 to March 2019 was 285 and the total number of restraints from May 2019 to February 2021 was 106. The use of seclusion and restraint before and after the opening of the High Observation ward is shown in Table 1. Fig. 1 shows the trends of seclusion episodes/month across the two 22-month periods.

A reduction of 65% ($U = 30.5$, $p < 0.001$) was found in the median seclusion episodes/month on comparing the 22-month time periods, a reduction of 71% ($U = 61$, $p < 0.001$) in the median total duration of seclusion episodes/month and a reduction of 60% ($U = 68$, $p < 0.001$) in the median restraint episodes/month. There was a 32% reduction ($U = 7140.5$, $p = 0.724$) in the median duration of individual seclusion episodes but there was not a statistically significant difference between the 22-month time periods for this variable.

We compared our figures with the national data published by the Mental Health Commission in their reports on the use of restrictive practices in approved centres for 2018 and 2019 (2019b; 2020). Sliabh Mis is part of Community Healthcare Organisation (CHO) 4 so to look at the national numbers for CHO 1 to 9 excluding CHO 4 there was a 3% increase in seclusion episodes and 29% increase in the use of physical restraint in 2019 in comparison to 2018. At Sliabh Mis there were 129 seclusion episodes in 2018 and 49 seclusion episodes in 2019, a reduction of 62%. There were 166 episodes of physical restraint at Sliabh Mis in 2018 and 79 episodes in 2019, a reduction of 52%. This is an imperfect comparison as the High Observation ward was only functional from April 2019 onwards and so these figures may actually understate the change of practice. Needless to say, COVID-19 was not a confounding factor when comparing these particular years and so our results are not accounted for by its potential impact alone. Other potential confounding factors in our study include the fact that Sliabh Mis became more spacious following the opening of the High Observation ward and the designation of the existing wards as Acute and Subacute. Bed occupancy and daily staffing levels were not analysed but could contribute to the use of seclusion and restraint. It is possible that the High Observation ward and the Acute ward may have attracted or been allocated more experienced staff. Refurbishments took place at a time point between the 2018 and 2019 Mental Health Commission inspection reports (2018; 2019a) which may have caused some disruptions to the day to day running of the mental

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Cite this article: O'Donoghue J and Young M. (2024) Impact of a high observation ward on seclusion and restraint episodes. *Irish Journal of Psychological Medicine* **41**: 159–160, https://doi.org/10.1017/ipm.2022.42

Table 1. The use of seclusion and restraint in the 22 months before and the 22 months after the opening of the High Observation ward.

	Mean		Median		Std deviation		Minimum		Maximum	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Seclusion Episodes/month	9.68	3.14	8.50	3	4.487	1.983	4	0	18	7
Total duration of Seclusion Episodes/month (hours)	102.82	37.21	94.53	26.96	54.913	41.440	22	0	229.63	186
Restraint Episodes/month	12.95	4.82	10	4	8.272	3.111	3	1	32	15
Duration of individual seclusion episodes (hours)	10.62	11.86	6	4.08	14.081	17.995	0.17	0.75	96.58	87.75

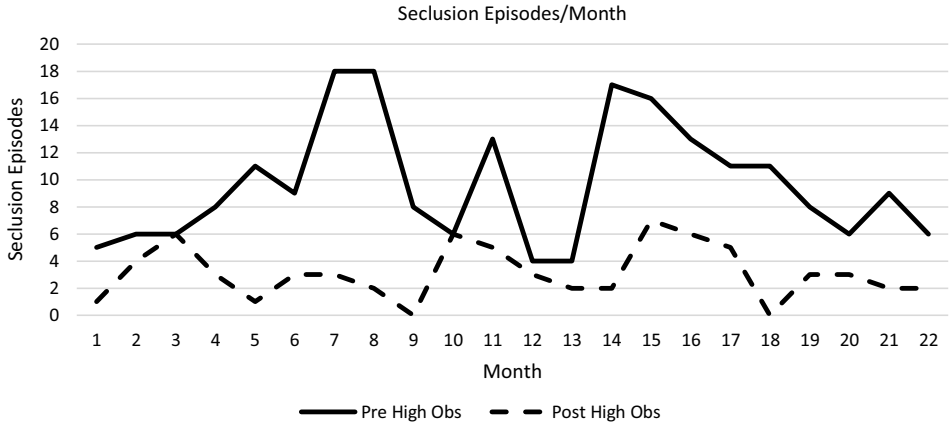

Fig. 1. The trends of seclusion episodes/month in the 22 months before and the 22 months after the opening of the High Observation ward.

health unit. It is a limitation of our study that an individual patient could be restrained or secluded on multiple occasions.

In practice, the High Observation ward with its low stimulus environment and higher staff:patient ratio offers itself as an intermediate step between the general adult ward and the seclusion room. Clear admission protocols and vigilance are required to minimise the risk of patients being treated in an unnecessarily restrictive environment. The opening of the High Observation ward at Sliabh Mis Mental Health Admission Unit coincided with a statistically significant reduction in the use of seclusion and restraint. It is the authors' opinion that consideration should be given to the further development of High Observation wards nationally.

Conflicts of interest. None

Ethical standards. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008.

The study protocol was approved by the ethics committee of each participating institution.

Financial support. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

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https://doi.org/10.1017/ipm.2022.42 Published online by Cambridge University Press