Reducing Restrictive Practice QI Collaborative

IMPROVING MENTAL HEALTH SAFETY
Reducing restrictive practice

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Change idea: *Prescribing PRN and regular benzodiazepines in line with the least restrictive approach*

Predictions

- Are we over using oral PRN benzodiazepines? Hence low use of IM rapid tranquilisation (RT)?
- Are benzodiazepines being prescribed/used as a threat/perceived threat? Does IM RT need to be prescribed if hasn't been required over the last two weeks?
- Is there a mechanism in place for PRN to be reduced and stopped if patients aren't using it?
- How many patients are on regular benzodiazepines, dose and how long for?
- Are we working proactively to minimise the use of 'chemical restraint'? Chemical restraint referring to the use of medication for the primary purpose of controlling someone's behaviour

Plan

Examination of the dose, frequency and reduction of both oral and IM, PRN and regular benzodiazepines for the 10 patients on the PICU ward over a two week period, we will use JAC to examine PRN and regular benzodiazepines separately.

- We will look through the last two weeks and note the total dose given to patients through regular or PRN prescription
- We will create a line graph to show the dose of regular prescribed clonazepam throughout admission, to see whether there has been a reduction or attempt of reduction.
- As well as a line graph to show the frequency of patients taking PRN clonazepam and at what dose.

The only oral PRN benzodiazepine prescribed for the patients on the ward is clonazepam, so the PDSA will be based on this.

Do

Regular Oral Clonazepam

- Only 4/10 patients were prescribed regular clonazepam, 3 out of the 4 took an average of 2.2mg over a 24 hour period (BNF max. 4mg/24hrs)
- 50% of the patients that are prescribed clonazepam, their dose has been reduced since admission

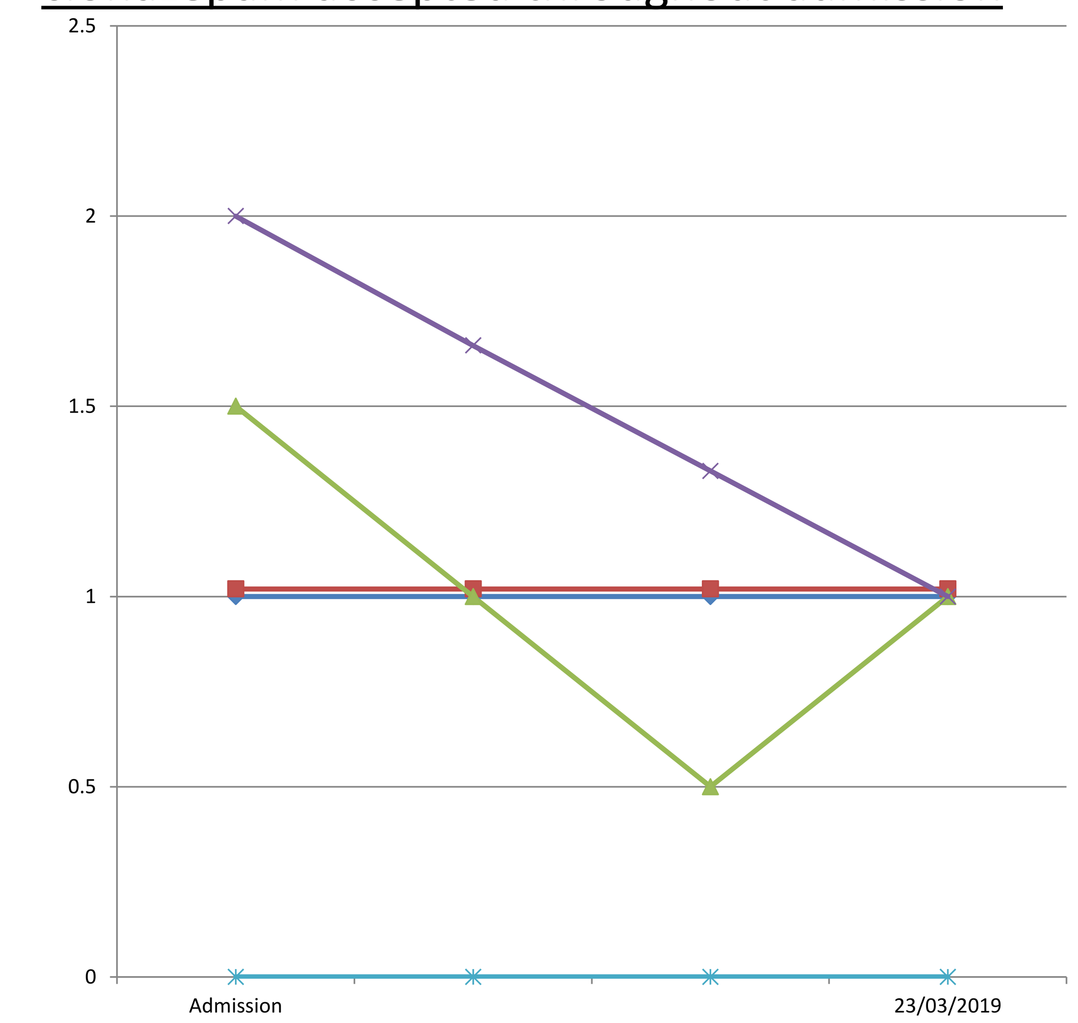
PRN Oral Clonazepam

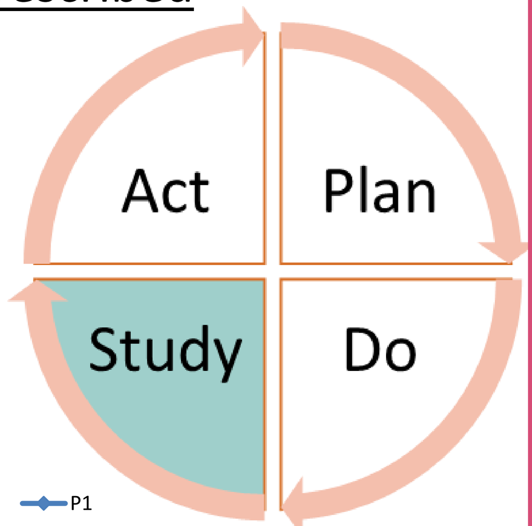
- Only 3/10 patients were prescribed PRN clonazepam however have not used it in the last two weeks
- 3/10 patients are not prescribed PRN clonazepam
- Out of the 4 patients that utilise their PRN clonazepam – throughout the two weeks an average of 0.5mg was taken over a 24 hour period

IM RT Lorazepam

- 4/10 patients are prescribed IM lorazepam however 0/10 patients have utilised this in the last two weeks

A line graph to show the dose (mg) of regular prescribed clonazepam accepted throughout admission





Study

- The data suggests we are not over using oral PRN benzodiazepines (clonazepam) as on average patients only take 12.5% of the BNF maximum over a 24 hour period.
- Medication can be construed as being prescribed as a threat as PRN benzodiazepines are prescribed when not being utilised, however total use of benzodiazepines suggests they are not being used as a threat. This is also evidenced by low use of physical restraints.
- It would be least restrictive to discontinue prescribed RT and PRN clonazepam if patients have not required it in the two weeks.
- P3 and P4 prove regular clonazepam is monitored effectively as the data shows an attempt at a steady reduction, P3 prescription is reduced and then increased to find the individuals therapeutic dose.
- The use of PRN benzodiazepines is currently low, however can we lower it further safely?

Act

The next step following this PDSA would be to discuss with the Multidisciplinary team about reducing restrictive practice by:

- Stopping the prescribed dose of IM RT when patients do not require it – to be inputted on the ward round template and rationalised weekly?
- Evidencing attempts to reduce patients regular clonazepam
- Creating a mechanism to stop or reduce PRN benzodiazepines if patients are not utilising them – ward round?
- If patients are requesting/being offered PRN clonazepam frequently should it be prescribed regularly?
- Expanding the role of the pharmacist/nursing team in reviewing and monitoring the use of benzodiazepines. Are they being used as per prescription? Agitation or insomnia?
- Sharing this data with other wards and comparing results and findings
- Evidence implementing more talking therapy and less medication as suggested by Wilson et al in their qualitative study on how to reduce physical restraints?
- Patients rated 'distraction' highly as a need during a psychiatric emergency - are we, and if not, how could we ensure this is being implemented?
- How do the results correlate to episodes of restraints, IM RT and seclusion?

Following this PDSA, we could repeat the data taking into account the steps above and compare our findings.

All teach, all learn

We are working towards avoiding over sedation in patients and benzodiazepine prescriptions, whilst maintaining the safety of both the staff and patients on the ward. It is important to work proactively to reduce restrictive practice with the administering of IM RT. Finding a therapeutic dose of benzodiazepines will reduce overall use of seclusion, restraints, and RT, whilst working carefully to minimise sedation and a tolerance build up. We can now examine how the use of PRN and regular clonazepam correlates to the use of seclusion, restraints, and RT. NICE (2015) guidelines state it is important to maintain the safety of everyone whilst keeping patients calm (not asleep)!

A line graph to show the dose (in mg) of PRN clonazepam administered to patients over a two week period