Louise Clark wants to see a culture change in nursing and she does not mince her words. ‘Unacceptable control over patients and negative staff attitudes are still present throughout the NHS and must be challenged,’ she says. ‘The problem is most serious in some mental health and older people’s wards, but anyone going into hospital can become a victim of restrictive practice.’

A nurse consultant in acute and restrictive practice at West London Mental Health Trust (WLMHT), Ms Clark says the concept of challenging behaviour is more accurately described as ‘what the staff consider challenging’.

‘It does not always involve aggression and is often not intended by the patient,’ she says. ‘It’s just a form of communication, indicating that a person’s needs are not being met. It can result from staff being authoritarian or irritable and imposing rigid rules and routines. Patients are frequently told when to get up or have a cup of tea, and there are some bad attitudes out there. That’s why people get aggressive.’

Ms Clark has been nursing for 40 years. She trained and spent many years in adult, learning disability and mental health nursing, and 14 years as a lecturer at the Florence Nightingale Faculty of Nursing and Midwifery, where she remains a visiting lecturer. She says: ‘It’s important that experienced nurses are out there working with younger or less experienced nurses.’

Unacceptable variation
Ms Clark became an honorary nurse consultant at WLMHT in 2014, working for the trust 1 day a week based on Askew ward, a male psychiatric intensive care unit (PICU). After fulfilling her brief to develop a PICU outreach team, she was appointed full-time.
In 2015, a Care Quality Commission report found that the trust had ‘an unacceptable variation in the use of restraint, including a high use of prone restraint’.

Ms Clark’s remit was to raise standards and establish the trust as a national leader in the reduction of restrictive practices. ‘WLMHT was ahead of its time in reducing restrictive practice,’ she says. ‘I was so impressed with the caring attitudes of staff.’

Support plans
Although Ms Clark works across WLMT local services, her clinical base is on Askew ward, where she has developed a seven-person intensive care outreach team. ‘When we get a referral, they assess the patient and put in place support and management plans. We’ll do anything to avoid people being admitted to a restrictive environment such as PICU,’ she says.

Each ward has ‘reducing restrictive practice champions’, trained in challenging restrictive practices in their area of work. Ms Clark uses the bio-psycho-pharmaco-social model, an approach that considers biological, psychological and social factors in human functioning.

She says: ‘A common error with mentally unwell patients is to assume a direct link between the diagnosis, its primary symptoms and disruptive behaviour.’

She believes that so-called challenging behaviour can be reduced if staff are attentive to all a patient’s needs. For example, they should ask if the patient is physically ill, getting enough exercise, or is dehydrated or constipated. They should also consider the patient’s environment and ask if there is overcrowding or a lack of fresh air or privacy, she says.

Counterproductive
‘If you are kind to patients and treat them with respect and dignity, there will seldom be a need for restraint or seclusion,’ she says. ‘I simply don’t accept that nurses lack the time to ask these questions.’

All forms of punishment are counterproductive, she insists. ‘The person being punished will avoid the nurse, suppress the behaviour or act out other destructive behaviours. Above all, it isn’t ethical.’

To the range of tactics usually considered punishments, such as shouting, threatening, aversion strategies, using restrictive clothing and physical persuasion, Ms Clark adds ignoring, withholding items the person should have access to, or insisting they fix something they have broken.

There is plenty of evidence to back up Ms Clark’s approach. In 2013, the RCN published guidance on the need to minimise restrictive practice, and a similar report was issued by the Department of Health the following year.

Some of what is covered in these reports is simply good practice: seclusion rooms must meet the required standards, restraint must be a last resort (preferably not in the prone position), restrictive interventions must be documented and physical health observations taken after a patient has been given an injection to manage disturbed or distressed behaviour.

Ms Clark says: ‘Attitudes are changing, but there is a lot of work to be done to move services away from “control” towards “structure”. There will always be a few staff who think they know what is best because they have been doing things badly for far too long. I’m loving having the opportunity to work with lots of dynamic nurses who invigorate me and support the end of restrictive practices and controlling attitudes.’

‘If you are kind to patients and treat them with respect and dignity, there will seldom be a need for restraint or seclusion’

Louise Clark

Alison Whyte is a freelance health writer