Ensuring milieu safety in a forensic psychiatric unit

By Christine Chuah, BSN, RN

FOR THE PAST 5 YEARS, I’ve been working in a forensic psychiatric unit taking care of patients who have criminal charges pending when their mental capacity for being held responsible for these charges is in question. Patients are classified based on their level of criminal charges only and how violent they’ve proven to be. (See Legal classifications of forensic psychiatric patients.)

For staff members working on this unit, knowing the proper safety practices to use when a patient becomes combative or violent is essential. This article describes safety practices that help ensure safety for the staff and patients alike. These safety practices can also be applied by nurses working with potentially violent psychiatric patients in other settings.

Know the surroundings

Being familiar with the forensic psychiatric unit’s social environment, or milieu, is of critical importance. In our facility, two sides are kept separate: the dayside is used for waking hours and the nightside for bedtime hours. In our facility, the dayside consists of a dining room, computer room, interview room, music room, recreation room, living room, and laundry room. The dayside has two wall phones for patients’ use, and two bathrooms for men and one bathroom for women that must be locked at all times when not in use. Staff open the bathroom doors for one patient at a time as requested.

Mirrors made of plastic hung from the ceiling corners must be used so staff can see the entire room, including the corners. Because the ceilings are about 10 ft (3 m) high, patients can’t access the mirrors. Security cameras are also used throughout the unit so staff can see the dayside and nightside of the unit simultaneously. Patients must be observed closely to prevent them from trying to hide items that can be used as weapons or are considered contraband on the unit. (See On alert for contraband.)

The nightside in our facility includes a quiet room, lounge, restraint and seclusion rooms, patient bedrooms, and bathrooms. Staff should always know where patients’ bedrooms are so they don’t run down the wrong hallway during an emergency.

Patients have attacked staff during nighttime rounds. Every bedroom has a mirror on the ceiling to help staff see around the corners and locate patients who aren’t in bed without entering the room. All staff should be aware of possible hiding spots.

Units are locked for safety. If a patient’s behavior is escalating, one side of the unit can be shut down and made off limits until it’s safe for all staff and patients to move together to either the dayside or nightside.

Know the staff

While working on a locked unit, it’s very important to know the staff and how they interact with patients. Some staff members get along better with some patients than others, affecting the quality of communication. Staff members who have a good rapport with a particular patient take the lead in de-escalating the patient’s behavior when needed. It’s helpful to know which staff members are especially skilled at de-escalating particular situations. For example, if a patient is upset with a peer or a unit rule, the patient will work with direct care staff. A patient who’s upset about clothing or financial issues will work with his or her social worker. Anytime a patient is having a psychotic episode, the nurse will address the situation and notify the psychologist and psychiatrist as needed. If a situation is escalating, the nurse will activate the response plan, such as summoning help from staff on another unit or calling for security. Nurses need to be familiar with the

Legal classifications of forensic psychiatric patients

Patients are classified with a court-provided legal status and then are sent to the appropriate facility. These are the legal status classifications for patients treated at my facility in New York State:

- Not responsible for criminal conduct by reason of mental disease.
- Will have a 30-day examination performed by “qualified examiners” with the results being sent to the division of forensic services. The findings will then be transferred to the courts for review.
- Not fit to proceed with trial and hospitalized for restoration of competency.
- Temporary order of observation issued by local criminal courts for up to 90 days for restoration of competency.
- Commitment order for up to 1 year for indicted felony defendants for restoration of competency.
- Involuntary admission of presentenced inmate in local county correctional facilities.
- Transfer of involuntary patient to a secure facility.
know the patients

Know why your patients are being treated and what criminal charges are pending against them. This information should be provided prior to their admission or at the time of their admission. It's difficult for many nurses to adjust their thinking because they've been taught to generally believe patients. That can be a dangerous mistake in this environment.

Also become familiar with how your patients interact in the forensic psychiatric environment and in smaller groups. How do they see and interact with staff? Are your patients respectful to staff and others or do they try to act in an intimidating way?

As you become familiar with your patients, you'll be able to anticipate what upsets them and recognize behaviors they'll show before their behavior escalates. Remember that patients feel less secure when a peer's behavior is accelerating and threatening to staff or other patients. An individual situation can turn into a challenging group dynamic if it's not addressed quickly and appropriately.

The Individualized Crisis Prevention Plan (ICPP) is a form at our facility that all patients fill out at the time of admission to help ensure patient and staff safety. Patients describe what upsets them and what kind of behaviors they'll show when they're upset, such as pacing the halls, clenching their fists, or talking loudly. This form also indicates what helps them de-escalate when they're agitated, such as listening to the radio, reading, going to a quiet room, or exercising.

The ICPP also asks patients to indicate whether they prefer taking medication by mouth or injection and if they prefer restraints or seclusion when they're in crisis. It's extremely important for staff and patients to use the least restrictive interventions first when it comes to avoiding or managing a crisis situation. Using the least restrictive interventions can help to avoid further trauma to patients and staff.

medication tips

 Routinely assess and observe patients for medication adherence; failure to take medications as prescribed can lead to psychotic or disruptive behavior. Be alert for patients who “cheek” medication, which entails hiding medication in the mouth under the tongue or against the cheek instead of swallowing it; the patient can then discard the dose later. The nurse should inspect the patient’s mouth after medication administration; direct care staff can monitor patients after drug administration and make sure they don’t have access to the bathroom for 30 minutes or leave the area of supervision after taking a dose. Many patients don’t like how they feel on medication and may try to vomit if given the opportunity. Patients may not refuse their medication when they're court-ordered to take medication or when they're an immediate danger to themselves or others.

As always, assess your patients’ response to their medications. If the patient experiences adverse reactions to the medication, or the medication doesn’t have the intended action, document this as well and notify the prescriber.

Many patients are psychotic upon admission and some antipsychotic medications aren’t fully effective for 4 to 6 weeks. During that time, your patients can develop plans to harm themselves or others. Patients may throw things, swallow nonfood objects, or sexually assault other patients. They may try to injure staff or peers or try to set the facility on fire by causing electrical outages. Nurses need to be vigilant at all times.

restraint use

Forensic nursing can entail many situations in which physical and/or chemical restraints and seclusion are required. Applying restraints and using seclusion should be used only as a last resort. Nurses should follow...
facility policy and procedure regarding restraint use.5

Whenever a restraint situation is taking place, one person should be at each limb and another should supervise the patient’s airway. While the patient is in restraints, an assigned staff member sits with him or her; a nurse assesses the patient every 15 minutes. Once the patient is able to contract for safety, he or she can be released from restraints. When the restraints are released and the patient and staff are safe, a debriefing should always be performed. The restraint situation can be discussed and everyone involved can discuss what went well during the intervention and what could have been done differently.5 Using this debriefing keeps staff knowledgeable and allows everyone to have input. Document the incident.

Vigilant for safety
Be prepared to prevent or respond to escalating situations. Following the advice presented here can help to keep yourself safe as well as other patients and staff. For more information about forensic psychology, see the American Board of Forensic Psychology’s brochure at www.abfp.com/brochure.asp.

REFERENCES

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