MR-CRAS user manual

Basic data: Complete once in day, evening or night shift - **Complete on each checklist**

Initial or current reasons for mechanical restraint may include threats to / violence against clinicians/ other patients, vandalism, threats / self-harm.

Confounders, Risk and Parameters of alliance

All items in MR-CRAS are to be **observed every hour** in the shift. MR-CRAS is to be completed once an hour, within the last 10 minutes of said hour, by the clinicians member who has observed the patient during that hour.

If the patient is sleeping, mark with an S under "time" in each scale. If the patient sleeps for more than half of the relevant hour, mark with an S and no score is to be taken.

Confounders are defined as factors that make visible the underlying reasons for the patient's risk behaviour and alliance with clinicians, such as mental state, desire to remain restrained, compliance problems and abstinences or cravings. These confounding factors do not constitute criteria for whether or not the patient can be released from mechanical restraint. Confounder factors should passively bring to light, for clinicians, the underlying clinical issues that contribute to prolonging the duration of mechanical restraint, with the aim of evaluating and adjusting the treatment and care of patients.

All items in the Counfounders scale are to be assessed as present or not present. **If an item is observed as being present, mark with an 'x'.**

Item	Description
Abstinences or cravings	Abstinences or cravings resulting in risk behaviour and problematic alliance with the patient during mechanical restraint
Compliance problems	The patient doesn't take his/her medication, or takes it sometimes and not at other times.
The patient wants to remain restrained	The patient states that he/she wants to remain restrained
Delusions	Thoughts that are unfounded, unrealistic and idiosyncratic. The assessment is based on the thought content as it appears during the conversation and its impact on social relations, as described by the health care clinicians
Conceptual disorganization	Disorganized process of thinking, characterised by disruption of goal-directed thought processes, volatility, circumstantiality, irrelevance, loose associations, missing connections, blatantly illogical talk or blocked thought. The assessment is based on the cognitive verbal processes observed during conversation
Hallucinations	Oral information or behaviour that indicates sensory perceptions that are not caused by external stimuli and that seem to be auditory, visual, taste or touch impressions. The assessment is based on verbal description and behaviour during the conversation, as well as on reports from health care clinicians.

Risk is defined as factors that are seen in the patient's compensatory behaviour in response to frustration, and represents warnings of potentially violent behaviour or actual violent behaviour towards clinicians or the environment.

The items in the scale are scored by **marking with an 'x' if the behaviour is observed in the patient.**

If the behaviour is normally present in the patient, e.g., irritability, only mark with an 'x' if the behaviour worsens.

If the patient is unknown to the clinician, mark with an 'x' if the behaviour is observed.

Irritable	Becomes easily irritated and irascible. Unable to tolerate clinicians presence in the room
Boisterous	Noisy behaviour, characterized by, for example, loud shouting or loud vocalizing, vituperative, commanding, or rowdy behaviour
Threats of self-harm	The patients threatens to commit suicide or other ways of endangering his/her own life and health
Verbal threats	A verbal outburst that is more than just raising the voice and which is intended to humiliate or intimidate another person
Attacking objects	An attack directed at an object and not at the clinician. For example, the patient throws, overturns or destroys things in the room
Physical threats	Showing with clear body language that the intention is to threaten the clinician. For example, an aggressive posture, gripping the clinicians clothing, raise and threats with a clenched fist, etc.
Self-harm	The patient endangers his/her life and health, for example, suicide attempts, hitting his/her head against the bed, tearing his/her skin with the nails, etc.
Violence against clinicians	The patient reacts violently by, e.g., spitting, hitting out at and/or striking the clinician, or by throwing things at the clinician

The parameters of alliance is defined as factors relating to the patient's insight and ability to engage in contact and cooperation with the clinicians during mechanical restraint.

Items in the scale are scored **0, 1 or 2**, depending on whether it is observed and assessed that the patient, e.g., has no contact, a low degree of contact or a high degree of contact with clinicians.

The following gives examples of focus points within the no, low and high degrees of the four parameters of alliance. Examples in the, e.g., high scoring categories, are not requirements that must be met for a patient to be released from mechanical restraint. Examples are solely examples of no, low or high levels of, e.g., contact and the examples are not exhaustive!

NOTE If the patient exhibits behaviour that covers more than one scoring category, for example, both low and high degrees of contact, select the one scoring category that predominantly reflects the patient’s behaviour.

Score 0 = No degree	**Score 1 = Low degree**	**Score 2 = High degree**
Is there contact with the patient?		
In no degree, when the patient, for **example**: Is dismissive of contact/boycotts contact – does not respond to enquiries No eye contact – the patient is lying down with eyes closed, the patient pretends that he/she is sleeping Hostile gaze Is unpredictable	To a low degree, when the patient, for **example**: Responds to enquiries but is taciturn Uses coarse language/is condescending Is guarded Dominates the contact The patient splits between clinicians he/she likes and dislikes Is elusive Is introvert in his/her contact Not accommodating Fluctuates in the contact, e.g. hot-headed, from talkative to suddenly being vituperative, from neutral to aggressive, inconstant issuing threats, from having contact to getting very heated minutes later, fluctuating regarding compliance with agreements Eye contact is reduced	To a high degree, when the patient, for **example**: Responds to enquiries, reaches out to have contact. Good formal contact, participates in conversations with clinicians Good eye contact Is stable in the contact Engages in positive contact, for example, being polite, calm/relaxed, quieter/low-key, friendly, accommodating, present in his/her contact, listens to clinicians, for example by entering into agreements The patient is predictable The patient can cope with shifts in the contact with clinicians and/or be in contact with more than one person at a time
Is there cooperation with the patient?		
In no degree, when the patient,	To a low degree, when the	To a high degree, when the

for **example**: Cannot enter into agreements Does not comply with agreements Will not cooperate	patient, for **example**: Can make agreements, but finds it difficult to take one thing at a time, with a view to keeping agreements realistic Can stick to what is agreed, but wants to discuss framework for the agreements Inconstant in cooperating to comply with agreements. For example, the patient enters into verbal agreements, but does not comply when it comes down to it Can cooperate, but not across clinicians, and with only one person at a time	patient, for **example**: Can make and stick to agreements, also across clinicians, e.g., around taking medication, being released from the restraint to go to the toilet/have a bath, or other liberties, without being externalising , but with quiet and calm talking, and can tolerate guidance and limit-setting in this regard The collaboration is stable
Can the patient's behaviour be corrected?		
In no degree when the patient, for **example**: Cannot be corrected in his/her behaviour Unrestrained/unpleasant behaviour Does not comply with requirements Does not tolerate refusal without getting heated, aggressive and being a danger to others Cannot defer own needs	To a low degree, when the patient, for **example**: Is hard to correct Is more correctable Does not comply with all requirements Tolerates, but does not understand, refusal Is commanding/demanding Has a lot of wishes and needs Has a lot of things he/she wants to do Has difficulty deferring own needs	To a high degree, when the patient, for **example**: Can be corrected in his/her behaviour, e.g., noisy behaviour or that the patient's needs/wishes can be corrected, in that the patient understands and can tolerate refusal and defer own needs Compliant
Does the patient have insight into his/her own situation?		
In no degree, when the patient, for **example**: Has a lack of insight into the reason for the mechanical restraint Denies violence Disclaims the responsibility for what has happened	To a low degree, when the patient, for **example**: Understands the reason for the mechanical restraint Does not distance him/herself from what has happened Shows a lack of empathy Belittles what has happened Ignores own behaviour	To a high degree, when the patient, for **example**: Has insight into the reason for the mechanical restraint Insight is not always possible for the patient. Understanding – as a certain degree of clarity – is an alternative. It is possible to talk with the patient about

	Justifies his/her actions	the episode. The patient can, for example, understand why he/she is mechanical restrained, and the behaviour clinicians expect of the patient to be released from the mechanical restraint, the patient can be realistic about his/her situation and what has to happen Dissociate from what is wrong to do or what the patient has done Takes responsibility for what has happened

Comments (see checklist) – This field can be used, for example, to make a short note about whether the patient habitually (when not restrained), scores 0, 1 or 2 in relation to contact, cooperation, insight and the extent to which the patient's behaviour can be corrected.

For example: The patient is usually guarded in his/her contact (low degree of contact) or, on a daily basis the patient finds it difficult to defer own needs (low degree of ability to correct own behaviour). These two examples are not exhaustive.

Agreements Form (see checklist) – here, the agreements made with the patient during the shift are recorded and the patient's level of adherence with agreements is evaluates. This could be agreements, for example, about release from restraint to go to the toilet/smoke.

For any questions on content or use of the MR-CRAS checklist, please contact Lea D. Nielsen: ldni@ucsyd.dk

Last updated in december 2017