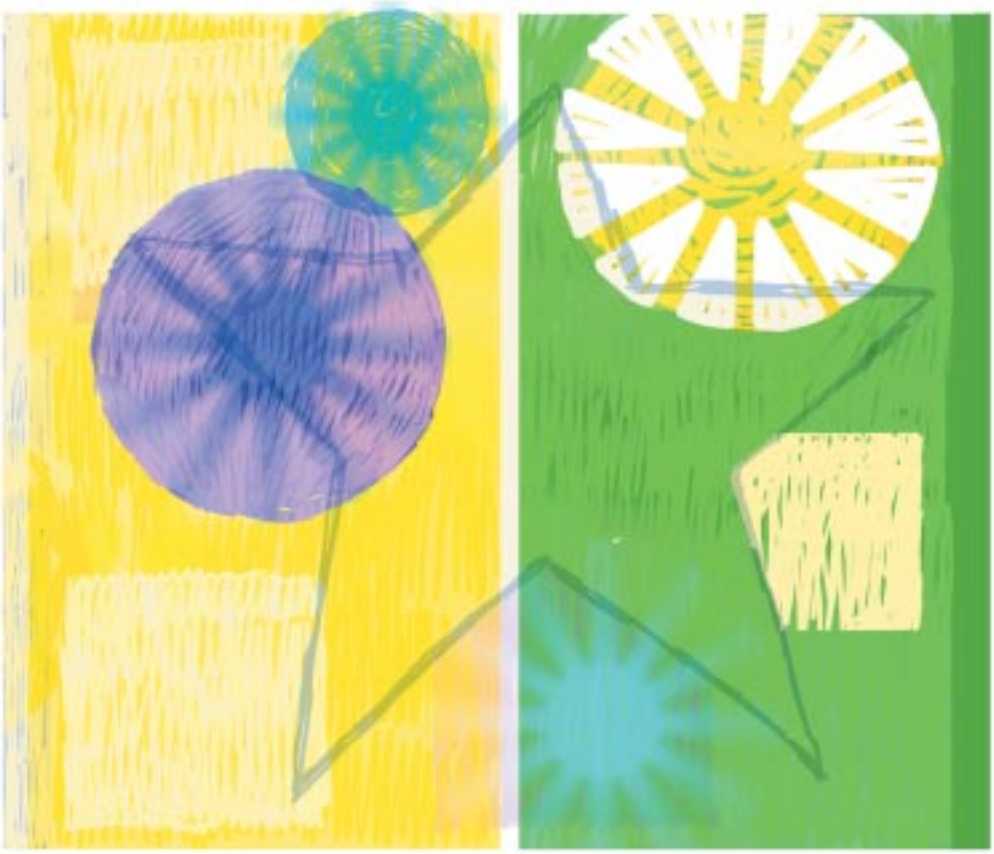
Learning *from* Each Other

Success Stories *and* Ideas *for* Reducing Restraint/Seclusion *in* Behavioral Health



American Psychiatric Association
American Psychiatric Nurses Association
National Association *of* Psychiatric Health Systems

With support from the American Hospital Association
Section for Psychiatric and Substance Abuse Services

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For an appendix of useful forms, assessment tools, and checklists, visit the web sites of the sponsoring organizations:

- www.naphs.org
- www.psych.org
- www.apna.org
- www.aha.org

When you click on their links to *Success Stories and Ideas for Reducing Restraint/Seclusion*, you will also find practical tools that have been shared by behavioral health experts from around the country.

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Introduction

It may seem a contradiction in terms, but this collection of experiences and lessons learned about restraint and seclusion is ultimately *not* about restraint and seclusion. The greatest lesson learned in gathering information for this publication is that devoting resources to understanding this area of care is truly about improving a facility's overall milieu and approach to a philosophy of care. For example, teaching staff de-escalation techniques to prevent the use of restraint/seclusion is really teaching staff a way of improving care and communication throughout the treatment program.

We have developed this dialogue with the field with extensive input from behavioral healthcare providers throughout the country — front-line staff members, clinical leaders, behavioral health administrators, and system executives who have been working to reduce the use of restraint/seclusion and to improve care within their facilities. We want to thank the members of the American Psychiatric Association, the American Psychiatric Nurses Association, the National Association of Psychiatric Health Systems, and the American Hospital Association Section for Psychiatric and Substance Abuse Services for sharing their experiences — and their challenges.

We hope that this publication will provide a framework for the leadership of behavioral healthcare facilities as well as their clinical and administrative staffs to discuss the issue of restraint/seclusion within the context of quality care. We want to share good ideas that have worked for others and that may help you to improve patient care.

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KEY

= a good idea

= a good idea specifically for child and adoescent programs

Chapter 1

The Importance *of* Focusing *on* Restraint *and* Seclusion

Restraint and seclusion, when used properly, can be life-saving and injury-sparing measures. These emergency measures aim to protect patients in danger of harming themselves or others and to enable patients to continue treatment successfully and effectively.

Because hospitals and other treatment settings serve individuals with severe mental illnesses and substance abuse problems who are, at times, dangerous to themselves or others, they must have strategies and policies in place for determining why, when, and how these measures will be used.

These are, however, measures that also have potential for injury — both of patients and of staff. They also have the potential for abuse, if used improperly.

The challenge is to find a balance that ensures safety while maintaining patients' dignity and avoids inappropriate use of restraint/seclusion.

> "Restraint and seclusion, when used properly, can be life-saving and injury-sparing interventions."
>
> —AHA/NAPHS Guiding Principles on Restraint/Seclusion

Some challenges that facilities face in achieving this goal include the following:

Behavioral health resources are limited. As dollars for behavioral health care have declined (more than 50% in the past decade),[1] treatment facilities struggle to re-allocate limited resources for critical functions (such as training). Decisions about what type of staff are necessary to carry out policies and procedures may need to be constantly re-evaluated as new regulatory requirements and evidence of best practice emerge.

Restraint and seclusion have become controversial issues. Intense media scrutiny has led to increased regulation and oversight. Providers now face a maze of local, state, and federal regulations — as

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[1] Hay Group. *Health Care Plan Design and Cost Trends — 1988 through 1998.* Prepared for the National Association of Psychiatric Health Systems and Association of Behavioral Group Practices. April 1999.

[2] Various sources including: Joint Commission accreditation standards on restraint/seclusion (www.jcaho.org); *Guiding Principles on Restraint/Seclusion in Behavioral Health Settings* of the American Hospital Association and National Association of Psychiatric Health Systems; and the American Psychiatric Nurses Association.

well as accreditation standards — related to restraint/seclusion — many of which have conflicting definitions and requirements.

But what is clear in all of these standards is a national intent to see that restraint and seclusion are used appropriately, as infrequently as possible, and only when less restrictive methods are considered and are not feasible.[2] Partially as a result of improved clinical options for treating behavioral disorders (including medications and de-escalation techniques) — and partially as a result of knowledge gleaned from the consumer movement, providers have a unique opportunity to work toward improved treatment milieus in which the need for restraint and seclusion is reduced.

Providers throughout the country have been working on strategies for minimizing the use of restraint and seclusion and for ensuring that, when used, they are used safely. Their experiences provide evidence of the benefits of taking a second look at your approach to restraint/seclusion.

Focusing on the Appropriate Use of Restraint/Seclusion Pays Dividends

- It **helps you focus on your mission** of quality patient care. If you picture how you would want someone of personal importance to you treated if admitted to your facility, you'll have a better appreciation of how you would hope that restraint/seclusion could be prevented or used only as necessary.

- It **helps you focus on your overall treatment philosophy and program.** By clearly identifying patients' needs, providers are challenged to design programs aimed at active, appropriate treatment.

- It **helps you recruit and retain high-quality staff.** In an era of staffing shortages, facilities with cultures that promote respect for individuals (including both patients and staff) have the advantage when it comes to recruiting and retaining staff. A culture that emphasizes autonomy and respect for the individual invariably results in an atmosphere where both patients and staff have a chance to develop to their full potential.

- It **reduces liability risk.** Injuries and deaths can have significant economic impact. Clear policies and procedures that are well-communicated, understood, consistently implemented, and continuously re-evaluated significantly reduce your economic exposure.

- It **can provide early warning of system-wide problems that need attention.** For example, high rates of restraint/seclusion should lead you to review your staffing levels, your staff education, and treatment program — all areas where shortcomings can be spotted and fixed before problems escalate.

- It **offers a focal point for ongoing staff communication.** Because discussions of restraint/seclusion lead to discussions of system-wide issues, they offer a unique opportunity to involve staff throughout the facility in improving care.

- It **pays public relations dividends**. It's critical to be able to describe not only to patients and families, but to referral sources, payers, and policymakers how you use restraint/seclusion, your safety record, and how interventions focused on patient self-determination affect recovery outcomes.

Why Is This So Important?

- **It's the right thing to do.** Use of safe, least-restrictive physical interventions makes good clinical sense. In addition, many organizations have found that working to reduce restraint and seclusion use has helped them strengthen their clinical program by incorporating a broader range of interventions and therapeutic approaches.

- **It's the law.** Providers who serve Medicare and Medicaid patients are subject to restraint and seclusion requirements outlined in the hospital "Conditions of Participation on Patients' Rights" (see http://www.cms.hhs.gov/cop/2b.asp) and the regulations regarding facilities that serve the Medicaid under-21 population (see amendments to Medicaid's "under-21" rule in the May 22, 2001, *Federal Register* accessible at http://www.archives.gov under "Indexes and Table of Contents" for 2001 under "HCFA." The original rule appears in the January 22, 2001, *Federal Register*.) Providers are also subject to the "Children's Health Act of 2001" (P.L.103-610) which requires facilities subject to the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI) to report deaths related to restraint/seclusion to an agency determined by the Secretary of the Department of Health and Human Services. Various state and local laws also apply to restraint/seclusion.

- **Accrediting bodies, including the Joint Commission, will review** your policies, procedures, and outcomes related to restraint/seclusion. JCAHO standards have been extensively revised and updated in relation to restraint/seclusion.

- The demand for public reporting of sentinel events (including restraint/seclusion injuries and death) is growing. While some of this data is reported today, it is likely that **your facility's track record will come under increasing public scrutiny**.

With these "whys" in mind, the following chapters offer you the opportunity to enter into a dialogue with the behavioral health field as you evaluate your organization's approach to the use of restraint and seclusion.

Leadership *and* Culture

The Issue

The use of restraint and seclusion within an organization is inevitably tied to the vision and mission of its leadership. Whether adequate resources will be devoted, whether staff training will be perfunctory or given true priority, how quickly changes can be instituted — in other words, all the issues that can lead to true change — are related to the priority and understanding of the facility's clinical and administrative leadership.

> "..restraint and seclusion policies must be a system-wide resource priority. Adequate allocation of resources and appropriate decision-making guidelines within the institution must be in place."
>
> —AHA/NAPHS Guiding Principles on Restraint/Seclusion

Guiding Principle

"Seclusion and restraint use is influenced by the organizational culture of a setting that develops norms for how patients are treated. Seclusion and restraint reduction efforts must include a focus on necessary culture change." (*American Psychiatric Nurses Association Position Statement,* May 2000.)

The Challenges

Clinical and administrative leaders have learned that there are enormous challenges associated with initiating and *sustaining* reduced use of restraint and seclusion. Dealing with potential for violence within a culture that simultaneously demands patient and staff safety, as well as least restrictive interventions, requires highly developed and coordinated clinical and leadership skills. Without careful management, fears about safety, loss of control, and polarization of views can detract from quality care, decrease job satisfaction, and threaten the potential for real culture change. The responsibility of leaders is to help guide staff through the transition from *controlling* patients as a way to achieve safety to *partnering* with patients to ensure safety.

Take Action (Practical Tips)

By having patient-centered policies and mission statements, it is easier to justify — and advocate for — adequate resources to deliver services that minimize the use of restraint/seclusion. Such policies are based on the principle that **patients are participants in their own care**. Patients are people who are in need of a variety of different kinds of assistance to help themselves as opposed to being 'taken care of.'

Take advantage of decreasing lengths of stay to help establish a new culture. Said one facility leader, "We emphasize that patients are coming here to work. They're going to do something, they're going to get better, and they're going to get out of here fairly soon (even individuals with severe mental illness). We have worked very hard to do away with any kind of 'custodial' mentality. Without that kind of fundamental change, simply adding on management of aggressive behavior does not do much."

For children and adolescents, create a culture where staff members respond to what is "underneath" a child's behavior. Try to find the meaning behind a behavior, the message the child is sending. Do not just respond with the exclusive goal of stopping the behavior.

Put yourself in the patient's place. "Probably the biggest factor in minimizing the use of restraint," said one facility leader, "has been changing the culture of automatic patterns, such as:

'patient acts out = put him/her in restraints'

to

'patient acts out = what is happening, what does this person need?'

In other words, changing the restraint mindset is critical."

Brainstorm with your peers. One multi-facility system brought several of its facilities together to brainstorm about best practices. "The results have been phenomenal," they report. "We brought in our hospitals that had relatively higher rates of seclusion and restraint, along with those that had relatively lower seclusion and restraint rates. Just getting people together and having an open forum made the biggest difference. We found we did have the expertise collectively."

Establish a workgroup (within your system or with peers). "Early on we developed a seclusion/restraint work group, and this provided an opportunity for conference calls with representatives (both physicians and nurses) from each of these different campuses. Through ongoing dialogue, there was a sharing of different practices regarding seclusion and restraint, what was helpful, what wasn't. I think that has been very, very important in collaborating."

Be clear about the physician's leadership role and the role of all staff. One system outlines their expectations as follows:

- It is the physician's responsibility to lead the treatment team, and the team members' responsibility to support that leadership.
- The physician's attitude toward seclusion/restraint and toward alternative interventions is crucial to our success in striving to limit to appropriate clinical situations our use of seclusion and restraint.
- To achieve success in reducing our use of seclusion and restraint, physicians, and program medical directors must be encouraged to do rounds; attend treatment teams; meet with RNs and other staff; work with staff to develop a philosophy about the use of medications; and be receptive to input from nursing.

Leaders must uncover unspoken sanctions that inhibit cultural change. Do staff feel leadership expects to see "quiet shifts" rather than busy shifts in which patients and staff are actively engaged in patient learning? Is as much attention paid to situations in which restraint and seclusion is avoided as to situations in which it is used? Do performance measures focus on real opportunities for improvement or strictly on minimizing negative occurrences? Is exploration of expanded staff/patient choices and options a constant part of leadership dialogue with staff? Are performance appraisals based on maintaining the status quo or on recognizing staff willingness to truly change the culture?

Be sure to invest the time and energy in involving *all* your staff. One system organized a focus group of people with authority to make decisions from each of the departments (including psychiatry, psychology, nursing, security, and child-care workers). "We really did need to make sure that everybody was involved in the decision-making and vested in it," they said, "and that really took a lot of work to be able to have everybody see their piece in it."

Said another, "It was a corporate performance improvement project, and we met monthly and created a corporate compliance plan for seclusion and restraint. So it really came from the top (from the board of directors and the CEO and COO and the chief medical officer). We took the project on and went through policies, procedures, plans, performance improvement monitoring, training, etc. and brought it to the other facilities throughout the country."

Leaders must be in constant dialogue with staff. Leaders must help staff learn to reframe "either we restrain/seclude" to "how do we keep staff and patients safe while forging alternatives to restraint or seclusion?" Also, leaders need to reframe "least restrictive" to "most facilitative" to create new mindsets — making the healing relationship central to maximizing freedom and self-control, minimizing coercion and avoiding harm for all.

Track utilization to changed practice. One program anecdotally felt that a small percentage of **clients and staff** accounted for a disproportionate number of seclusions and restraints. To address this, the program created a database to track utilization by client and staff and developed an associated protocol to govern seclusion/restraint use. Utilization triggers within a specified time frame (e.g., more than three restraints in a week) were established for clients and staff, and any use by a client or staff that exceeds the trigger automatically initiates a review to determine the contributing factors related to the restraint use. The review often leads to either a change in treatment plans or staff retraining and supervision. ***Results:*** The program is able to identify and be much more responsive to the clients' continually changing emotional and behavioral needs. Staff members receive the support that they need to more effectively provide a safe and secure environment and to implement appropriate treatment programming for clients.

> Leadership means making change a priority not only for facility clinical managers, but also for CEOs and medical directors.

Give staff real options. "I have consulted at several different hospitals. I think the hardest thing I saw was front-line staff just being told they can't use restraints

anymore but not really feeling they've been given any other options in its place." Staff members need the training, resources, and support to develop and utilize strategies in place of restraint or seclusion.

Do your homework, and be comprehensive in your approach. One facility not only reviewed their restraint/seclusion data, but they reinforced their findings with unit policy review and actual interviews with staff, physicians, patients, and families. Here's how they changed their practices. They:

- Abandoned a traditional approach to managing assaultive behavior and implemented a crisis prevention curriculum attended by all physicians, nursing and program staff, dietary and environmental staff, security, volunteers and emergency department staff at the time of hire and again annually. Included a "restraint skills" checklist.
- Focused on non-physical interventions as the norm.
- Developed a quick reference guide for staff containing information regarding prevention, intervention, and post-intervention.
- Asked patients about previous history of seclusion/restraints when admitted. Also asked specific questions of patients regarding approaches that assist them to remain calm.
- Developed a separate addendum for seclusion and restraint in the treatment planning policy.
- Mandated that *every* incident of seclusion/restraint be called to the attention of the nurse manager and medical director.
- Implemented the same process system-wide, including throughout the adjoining medical surgical hospital.

Communicate clearly your vision...not only with staff, but with families and patients themselves. Incorporate your policies into patient, family, and staff handbooks. Take the opportunity of a new staff's orientation and a new patient's admission to incorporate information on your philosophy and approach to restraint/seclusion.

Changing your language (both verbal and written) helps to change your thinking. For example, in one facility "show of force" has become "show of support" for the patient. By changing *force* to *support*, the terminology drives a philosophical change, which is more patient-focused and therapeutic instead of merely responsive to problem behaviors.

> "Policies and procedures should be reviewed and updated continuously based on clinical outcomes."
>
> —AHA/NAPHS Guiding Principles on Restraint/Seclusion

Communicate confidence in staff judgments. Leaders must convey that the use of restraint or seclusion is a clinical treatment crisis without conveying that the staff did something "wrong." Communicate that clinicians need to bring their best knowledge, skill, and effort to each circumstance at the time that seclusion or restraint is used. At the same time, invite staff to continue to explore ways to learn from each situation.

Changing the culture starts with the first encounter with a prospective employee. Be sure that recruitment materials, human resources staff, and all members of your organization are clear about your culture. Communicate your expectations, and hire those who will keep patients' needs and interests in clear focus. Ask questions of applicants that will help you determine whether their philosophy and experience with restraint/seclusion are consistent with your approach. Use your interviewing skills to help you understand whether an applicant's interpersonal style is accommodating rather than coercive, seeks to build on strengths, is open to ongoing learning, and values teaching rather than controlling patients. Sample interview questions might include, "Tell me about a time when you had to deal with someone who was angry. What did you do? What do you think contributed to success in working out this situation? What would you do differently the next time?"

Celebrate your successes and encourage each other regularly. Don't miss opportunities to acknowledge the progress you are making. For direct care staff, positive change may be very difficult and stressful. If leadership only focuses on reduced numbers of restraint or seclusion interventions as a measure of success, staff can become discouraged in their efforts to learn and use new interventions. Acknowledge the many ways staff members and patients are working to truly change the therapeutic culture. There will always be dynamic changes in patients, in staff, and in treatment methods. The work must be ongoing. Find creative, enjoyable ways to encourage and reward yourselves for building a stronger behavioral healthcare treatment program.

Acknowledge that you are in this for the "long haul." Sustaining changes made is as important as making them initially. "Over time, clinical focus has moved to other areas," said one provider, "yet it has been essential that we reserve energy for continuing to examine the way seclusion and restraint is used within our organization. As we hire new staff, we must be sure everyone continues to be up to speed. We are successfully using interventions to avoid the use of restraint and seclusion today that we would not have dreamed we would have been able to use a year ago. If we don't continue to grow, we will stagnate."

Case Studies

Creating a System-Wide Review Team

Involvement began from the top, with the CEO, chief operating officer, and chief medical officer. Their vision and direction provided the foundation for a system-wide organizational approach to seclusion and restraint that seeks to prevent, reduce, and ultimately eliminate the use of seclusion and restraint in our facilities. As a result of this commitment, our corporate Seclusion and Restraint Performance Improvement Project was initiated in July 2000. The team consists of a multidisciplinary representation from all of our acute care and residential

treatment facilities. A series of meetings have been conducted to review and act on the following: compliance with CMS and JCAHO, policy revisions, creation of forms and tools to enhance compliance, creation of a Corporate Compliance Plan for seclusion and restraint, training and orientation initiatives, monitoring, and evaluation, and support. These meetings continue in order to support, monitor and improve the process. They may be helpful to other organizations wishing to establish a corporate-wide initiative.

Results

Because of the Corporate Performance Improvement Project for Seclusion and Restraint we have:

- Set the tone throughout the organization
- Unified efforts and initiative
- Created the best practice based on a variety of inputs from our facilities
- Established consistent policies, procedures, training, tools, and monitoring
- Reduced the use of seclusion and restraint
- Increased and improved staff training on safe alternatives to seclusion and restraint
- Provided client and family education
- Achieved compliance with regulatory bodies

Reducing Seclusion in a Child/Adolescent Service

On our inpatient child unit (ages up to 12 years old), seclusion was used frequently for short periods of time. With the goal of administration to decrease the use of seclusion, the following changes were instituted:

- Philosophical and culture change from negative reinforcement to positive reinforcement such as spending more time with children, focusing on good behavior, and using seclusion as a last resort.
- Change in responsibilities — instead of a director level position with responsibilities for three child and adolescent units, we now have a nurse manager on each unit providing more "hands on" direction, support, supervision, teaching, and accountability.
- Increased programmatic structure and consistent interventions.
- Clinical and educational training for direct line staff every two weeks on symptoms, behaviors, and appropriate interventions.

Results

Seclusion episodes decreased 97% in two months.

Changing Practice in a Long-Term Child/Adolescent Service

This is a unit designed for the long-term care of children who suffer from a variety of severe and pervasive mental illnesses. Review of the data indicated that the rate of restraint and seclusion utilization for the year was quite high. As a result the following steps were taken:

- Unit leadership shifted perspective regarding the decrease of restraint and seclusion. This focus on solely "positive" outcomes for patients has assisted a culture change where there is low tolerance for "negative" interventions.

- Increased vigilance and review regarding any restraint episodes beyond an hour or greater than 2 hours in a 24-hour period.
- Introduced De-escalation Assessment for each child designed to illicit patient driven interventions for de-escalation and restraint reduction both in volume and in duration. This works part and parcel with individualized interdisciplinary treatment planning.
- Invited and utilized unit community input regarding cultural change toward decreased utilization of restraint and seclusion.
- Encouraged staff rethinking of de-escalation techniques and the use of PRN medication.
- Increased accountability for the management of the milieu for the mental health counselor staff through the assignment of a senior mental health counselor role.
- Provided feedback to milieu staff outlining the positive strides made.
- Clarified the philosophy of providing safety vs. control.
- Looked at other practice patterns in other institutions.
- Initiated daily discussion during AM rounds of any restraint and seclusion in the past 24 hours inclusive of the patient.
- Included expectations around restraint and seclusion with new admissions and prospective staff.
- Encouraged collaboration with and recognition of outside expertise regarding restraint and seclusion.
- Recognized the increased focus of standards and licensing agencies regarding restraint and seclusion.
- Provided staff education regarding clinical theories and how to implement them on the unit.
- Provided forums for open discussion regarding change and career choices regarding the mental health field.

Results

These ideas were introduced on the Special Care Unit toward the end of the 3rd quarter of the year. By the end of the 4th quarter, the episodes per 100 patient days had dropped 53%.

The staff has reported that this is a more positive place to work due to less paperwork and violence in the milieu normally attributed to restraint and seclusion.

Staff Education

The Issue

All staff members are responsible for knowing the broad range of clinical interventions appropriate for assisting patients to manage behavior at each point along the behavioral continuum. Well-planned, deliberate, regular education and review of interventions that are age- and need-specific are basic requirements of professional development.

Guiding Principle

"Hospitals and other treatment settings must ensure that staff are well-trained and continuously educated regarding the proper use of restraint and seclusion. Detailed policies, procedures, and systems must be developed with input from physicians and other mental health professionals, and they must be understood and followed by all staff. Areas include:

- assessment and crisis prevention techniques
- use of least restrictive methods
- how to employ restraint and seclusion safely (including understanding the risks and benefits of either intervening or not intervening)
- a process for continuously reevaluating the need for restraint or seclusion
- a process for continuous monitoring to ensure the patient's safety and other needs are met."

(American Hospital Association/National Association of Psychiatric Health Systems *Guiding Principles on Restraint and Seclusion for Behavioral Health Services,* February 25, 1999)

"Staff should be thoroughly trained and have demonstrated competence in the application of safe and effective techniques for implementing seclusion and restraint for the patient populations under their care. The techniques used should be approved by the medical staff." (American Psychiatric Association/American Academy of Child & Adolescent Psychiatry/National Association of Psychiatric Health Systems *Joint Statement of General Principles on Seclusion and Restraint,* May 1999)

The Challenges

Staff members have many different levels of knowledge and skill regarding management of

behaviors and come from various cultural and educational backgrounds as well as philosophical and clinical orientations. All this must be recognized, appreciated, and directed toward a coherent, consistent approach to helping patients manage behavior. Constant staff turnover contributes to the need for frequent training opportunities and ongoing team building. Because attitudes and behaviors are influenced by experience, there is a need for regular re-examination of approaches and reflection on practice. Policies, procedures, practice standards, program design, and patient needs constantly evolve and change requiring continuing attention to the educational needs of staff.

Take Action (Practical Tips)

Staff members need to read and reread policies. "We have wonderful policies about how to use de-escalation techniques, how to implement restraint and seclusion procedures, and so forth," said one provider. "However, we have found we need to have all staff deliberately re-read them on a regular basis—not just after we have had a problem. In the midst of a crisis is *not* the time to pull out the policy manual to see what it says about how to deal with the crisis."

A stable, mature staff is key. Staff familiarity with the patient and familiarity with the facility's training program have been identified as factors in reducing seclusion and restraint episodes. Mature staff contribute a great deal to the therapeutic environment. "This has caused us to look more carefully at ways to retain good staff through human resource policies, including competitive salaries," said one provider.

Staffing to acuity pays off. Although it may cost more, staffing to acuity (adding staff to meet the needs of patients who are at high risk or who are at a high level of care) is a good investment in the long run. Even if staff members are well-trained, there must be adequate numbers of them with the appropriate skill mix to deliver quality care. "It is a constant challenge for us," said one provider.

Investing in training makes a difference in restraint/seclusion rates. "One of the hospitals with which I am familiar felt the only thing they could do to minimize the use of restraint/seclusion would be to double their staff. 'If we double our staff,' they thought, 'then we could control the situation.' That facility still was operating under a control model. Of course, some hospitals did shift staff around, putting extra staff on at certain times of the day and so forth. However, most of the hospitals I know that have successfully gotten their rates down did not have to significantly increase staff costs. **They increased training costs, but they didn't have to increase numbers of staff."**

Training equals results. One facility developed an extensive staff competency package that must be completed by all nursing staff within six months of employment. This helped the facility to reduce the percentage of patients in restraint or seclusion by 82% over three years.

Develop a competency-based education program for interdisciplinary staff. The competency based education program is designed to integrate two models of thinking: 1) **understanding the cycle of violence** and the different points along the continuum where patients may be, so you can target your interventions based on their needs, and 2) **a self-awareness model**, which says that staff need to be aware of their own triggers, what sorts of buttons they have that can be pushed by patients, what staff reactions can be, and how all these things can feed into an episode that can escalate quickly and that could have been de-escalated in other ways.

Truly involve all staff. "All of the clinicians involved with the inpatient units go through our specific training. The response so far has been very positive," said one provider who has taken this approach. "The important change, though, is the fact that it was not the nurses and the physicians alone (we were successful in incorporating our physicians into the training program). Our program also involves the social work staff, the therapeutic activity staff, and the security staff. That was a major change—getting everyone to buy in. One thing that has come out of that crisis prevention training, which has been very encouraging, is the collaboration and exchange of views and ideas between the disciplines in the training. We've made it into a required program, but we've done that in a friendly way. As time has gone on, the comments have become increasingly positive—about both the didactic and the experiential part. **Staff have really worked together** to learn different techniques and approaches to deal with crisis situations."

> With retraining and sufficient feedback, staff members feel more competent in their techniques and they're less likely to engage in restraint/seclusion because they feel equipped to handle the behaviors clients present.

Define clear objectives for your training program. "We have clear objectives for the program, and we start by teaching the philosophy," said one facility leader. "We discuss the factors influencing aggression and ways to predict and prevent aggressive events. We follow a series of warning signals that we can see in a patient and try to intervene early. We identify alternatives to restraint and seclusion including verbal de-escalation techniques. The actual physical demonstration comes last."

Be sure the training program you choose or design is consistent with your organizational philosophy and culture. Training programs should emphasize the kinds of de-escalation, negotiation, and problem-solving techniques that you will ask your staff to use. Actual restraint and seclusion techniques are an important part of the training, but they should be in the context of an entire approach to behavioral interventions.

Require staff to demonstrate their competency on an ongoing basis. "All of our staff have to complete, and then demonstrate the skills they have learned on the unit in 'real-life' situations. This includes *all* their skills, from early intervention through physical techniques. We require staff skills to be reevaluated and approved on a regular basis. We feel this assures that staff are working to maintain and expand their skills."

Work out a training schedule that makes sense for your facility. Schedules may differ, but everyone should have access to the same amount and quality of education.

Consider two-stage initial training. In one facility, after new staff receive extensive orientation training, "we pull them back after three months for retraining. After they've had experience, they really can see how the information we gave them could be applied. It's only after they've had a couple of months on the job that they can really begin to catch themselves getting into power struggles, or to see some of the milieu management issues that they do have control over. We found

that staff listen very differently once they have been here for a while and have some experience. They're able to integrate experience with knowledge. That second session is *very* productive."

Feedback to staff is essential. "One of the things that we feel is so integral in training is the supervisory feedback. We try to make sure that training is *not* just going to a classroom, passing a test, and then going out into the milieu. Constant feedback and, particularly for new staff, being able to have the supervisor or senior staff member act as a **mentor**, is very important. A mentor can help new staff be more aware when they are getting into power struggles or other situations that could lead to difficulties. When staff are provided retraining and are getting sufficient feedback, they feel more confident and competent in their techniques and they're less likely to use seclusion or restraint. They feel as though they are equipped to use a whole range of interventions to handle the behaviors that the clients present."

Establish triggers for staff and offer a mentoring program. "If a staff member exceeds a certain number of restraint or seclusion initiations, a review is done immediately," says one facility leader. Actions may involve establishing a mentor, further training, examining the situation in which that staff member is working, or trying to better understand the personal triggers of that staff member.

Include new physicians in staff training. Start with the residents. They're in the same position as younger staff and, when they start practicing, they take their cues from what's around them. Residents can be extremely busy and overwhelmed. They often struggle to find time to talk with patients about their past experiences with seclusion and restraint and their current concerns and need for support. Residents will form their approach to restraint and seclusion from the model they experience early in their career.

Consider doing "restraint rounds." Throughout one general hospital, a nurse educator makes "restraint rounds" each week, going from bedside to bedside, discussing each patient with the unit staff. "We have found many times this has helped to reduce the restraint use by educating the staff and raising their level of awareness," says the facility leader.

In addition to in-service trainings, consider making education available round-the-clock through the Internet, videotapes, or self-learning modules (including reading assignments with exams). These allow staff to go through mandatory education at their own pace and in their own time. "We have found that a multi-modal approach, which allows people, in essence, to choose what works for their style of learning, has worked best," says a provider using all of these techniques.

> In addition to the in-service trainings, consider making education available round the clock through the Internet, videtotapes, or self-learning modules.

Try role playing. Let your staff practice de-escalation and restraint/seclusion techniques with their peers. It will give clinicians a better appreciation for the patient's perspective on the experience. Additionally, role playing is an extremely effective technique for teaching staff to

recognize cultural influences on patient behavior and for uncovering how their own culture influences their response to emergent behavior.

Think carefully about the hidden costs of agency and per-diem staff who do not have the benefit of your specialized training programs. One factor that helped a facility reduce its seclusion events to near zero was the simple act of filling vacancies to decrease the use of agency and per-diem staff.

Involve patients in your staff training. "In our residential treatment facilities during orientation, we include an appropriate patient to address the orientation group and let them know what their perception of care and their perception of staff is. If they have been secluded or restrained, we ask them to share their feelings about it."

Organizational involvement must also come from the corporate level. "We have involved our total organization in the seclusion/restraint issue by chartering a Seclusion/Restraint Task Force as an arm of our Corporate Quality Improvement Program. Task Force members are from both the corporate and facility-level staffs. The Task Force completed a comprehensive review of the literature, as well as a survey of state and federal statutes governing restraint and seclusion use with the various client constituencies who receive care through our corporation. Several presentations have been made to the Corporate Board to involve them in finding new solutions to the management of this high-risk and problem prone area. An external professional review of the crisis prevention program was completed, with recommendations for value-added modifications to the program. Facility-level performance improvement activities have involved line staff in collecting and reviewing seclusion/restraint data, as well as benchmarking the performance of their units across the corporation." ***Results***: "The work of the Task Force and the correlative activities at the facility and unit levels have resulted in continued decreases in the use of these procedures, as well as low levels of both client and staff injuries when they must be utilized. Our Board has remained very involved and supportive of ambitious training agendas at the facility level and has been very impressed by the demonstrated awareness of seclusion/restraint reduction strategies at the line level."

If possible, explore the feasibility of coordinating training programs in your region with other providers. About 20 different psychiatric facilities in the southern California region are all using the same kind of program. Staff who go from one facility to another have been trained in the basics of the same model. ***But a caution:*** Knowing the techniques does not necessarily provide the team cohesiveness that is necessary to successfully implement a program of restraint reduction. Staff must be integrated into the team in each facility in which they work. "We also need to be aware that each of the settings where restraint is used has different regulatory requirements. For example, in the three different settings that I have worked in where restraint is used (mental retardation and developmental disabilities, inpatient, and residential treatment), each has incorporated different content into their restraint courses, based on regulatory requirements."

Establish a professional development plan for each staff member. Hold staff accountable for their performance. Providers have a responsibility to orient each staff member to the philosophy of the organization and the therapeutic milieu as well as to provide ongoing supervision and training. Likewise, **staff members have the responsibility to make their educational needs**

known, to explore their personal attitudes toward the use of restraint and seclusion, and to take advantage of the training opportunities provided. This includes seeking supervision when necessary to help resolve difficulties they are having in working within the organization's expectations. Assessing staff compliance with their professional development plan should be a regular part of performance review.

Chapter 4

Assessment, Treatment Planning, *and* Documentation

The Issue

Each patient has a unique history and unique needs. He or she deserves highly individualized treatment. Thorough assessment and individualized planning serve as the basis for the delivery and evaluation of all care. Attention to patient-specific approaches to the prevention and management of behavioral emergencies is integral to each patient's treatment experience.

Clear and thorough documentation of assessments, treatment plans, progress notes, and discharge plans is a hallmark of professional practice. Documentation is a tool for communication among the treatment team members and provides data on which to base the evaluation of care. Careful recording of the events related to a behavioral emergency is a requirement of all standards-setting bodies as well as a dictate of good clinical care. Such documentation creates a record of clinical observations, decision-making, interventions (actions), and outcomes.

> "Clients have the right to be treated with respect and dignity in a safe, humane, culturally sensitive and developmentally appropriate manner that respects client choice and maximizes self determination."
>
> —American Psychiatric Nurses Association

Guiding Principles

"Our goal is to ensure the provision of medically necessary psychiatric treatment in an environment that is safe for patients and staff." (American Psychiatric Association/American Academy of Child & Adolescent Psychiatry/ National Association of Psychiatric Health Systems *Joint Statement of General Principles on Seclusion and Restraint,* May 1999)

"A patient's overall treatment is based on a comprehensive, individualized treatment plan that includes appropriate patient and family involvement." (American Hospital Association/National Association of Psychiatric Health Systems *Guiding Principles on Restraint and Seclusion for Behavioral Health Services,* February 25, 1999)

"All aspects of the seclusion and restraint episode, including the behaviors and events leading up to it, the less restrictive interventions employed, the care provided during the episode and the

release from seclusion or restraint are recorded in the clinical record." (American Psychiatric Nurses Association *Standards of Professional Performance,* May 2000)

The Challenges

Assessment is an ongoing process based on a body of patient-specific information that is constantly being augmented and refined. At the time of admission, patients and their families may have a difficult time giving all the information necessary for treatment planning. However, when the potential for a behavioral emergency exists, this potential should be anticipated as much as possible and addressed with treatment interventions that are an evolving, flexible part of the individualized plan.

Documentation is labor-intensive and competes with many activities in a demanding clinical environment. Providers must identify essential elements of documentation without creating systems that are unnecessarily cumbersome and take an inordinate amount of time away from clinical care. Developing and teaching methods of efficient documentation that meet all clinical and regulatory requirements is a constant challenge. A process must be established for auditing documentation for content and completeness.

> "A patient's overall treatment is based on a comprehensive, individualized treatment plan that includes appropriate patient and family involvement."
>
> —AHA/NAPHS Guiding Principles on Restraint/Seclusion

Take Action (Practical Tips)

On admission, assess for potential anger management problems. Questions about a patient's anger management history and current concerns should be part of every assessment. Questions should be asked in an age-specific and clinically and culturally appropriate manner.

Establish a restraint risk procedure. One facility's Seclusion and Restraint Project Team reports that all patients on admission are assessed for physical and/or emotional conditions that may place them at potentially increased risk if physically held or secluded or restrained. Patients with pre-disposing risk factors are specifically identified:

Assessing Restraint Risk Factors

a) Pregnancy
b) Asthma
c) Head or spinal injury
d) History of fracture
e) History of surgery
f) Seizure disorder
g) Abuse — physical/emotional, sexual, rape

Identify triggers that can help you better assess and respond to individual needs. "One of our centers," said a system leader, "developed an assessment system that identifies behaviors that, for an individual client, are warning signs of escalating behavior. We include these in the treatment plan along with a description of his or her baseline. If a client exceeds that baseline within a certain time frame (for example, let's say they identify that one particular client whom they anticipate, based on historical information, may average three verbal outbursts a day is, in fact, exceeding that number on a given day) it immediately requires a review. Staff members look at the whole situation to see what stresses, crises, or transitions might be causing the escalating behavior. This mechanism helps them identify when they need to adjust something, and they're able to be much more responsive to the individual's changing needs."

Involve patients in treatment planning — you may gain a different perspective on what you're doing. "The few patients whose behaviors result in the majority of seclusion and restraint are very constructive when we ask them to brainstorm an alternative. This then becomes part of their revised treatment plan," said a clinical leader. "The beauty of that, of course, is that it puts the locus of control back where it's supposed to be — on the patient."

Ask the hard questions up front. "Now all the staff members think to ask patients with a prior history of hospitalization if they were restrained during their previous stay," says one facility that does this. "We ask them to describe their perception of the event. We ask them if they think it was necessary to keep themselves or others safe. Then we ask if they were told the reason for the restraint. We do this across all of our facilities — our acute care, as well as our residential."

Ask patients at a clinically appropriate time if they have an advance directive. This information may assist in making a treatment plan that incorporates patients' wishes. Advanced directives most typically deal with decisions regarding life-sustaining medical interventions. While not yet widespread, some facilities are also beginning to use the concept of *advanced directives* related to the use of restraint. This may be a tool patients want to explore. At one facility, patients discharged from the hospital or who, as outpatients, are well enough to make informed decisions, are asked to specify future wishes regarding the use of restraints.

Involve parents and children from the beginning. "What is very successful is the amount of emphasis we place on having the children and the adolescents — as well as adults — be part of the treatment planning process itself from the very beginning and the emphasis that's put on them truly participating in developing their goals. It also gives the clients a clear understanding of what the overall expectations of the treatment program are."

Use field testing and feedback to help design processes and forms that work. In one organization where staff must train both behavioral health and general healthcare staffs, an integrated document has been developed, tested, and is being continuously updated to help facilitate documentation *and* decision-making on restraint/seclusion. Before the form gets final approval, it is field tested to get feedback "because things that looked absolutely self-evident to all of us who designed it weren't." "We did this to fine-tune our questions," they said. The integrated form incorporates items to help the nurse implementing a restraint order coordinate information on:

- whether this is a medical/surgical intervention or a behavioral intervention
- the physician assessment
- the physician order
- the flow sheet

Be sure to document what was tried *before* restraint or seclusion was needed.

Consider packaging forms to make them "user-friendly." One facility developed a restraint toolkit that incorporated documentation forms. As part of this, the physician's order form was made into a sticker. Making the form easy to use — and hard to lose — helped to facilitate documentation compliance. All forms are kept together to ensure that nothing is overlooked.

Explore and document the anticipated and actual role of the family (adults as well as children). Areas you will want to document include:

- how you shared/discussed your policies related to restraint/seclusion with the family,
- families' suggestions of ways to calm and support their family member at a difficult time
- families' wishes related to restraint/seclusion
- families' response to a seclusion or restraint episode
- patient and family teaching needs and interventions

Make forms easy to use. One facility developed forms for physicians and nurses to use any time a seclusion or restraint incident occurred. The forms were placed in a packet that contained all of the documentation tools necessary for the event. The forms themselves streamlined critical documentation that needed to flow clearly throughout. ***Results:*** "The forms provided all of the necessary cues for thorough care of the patient and decreased associated anxiety and frustrations of the care providers because they no longer fear doing insufficient documentation."

Consider helping children make an "Intervention Box." During the assessment process we help children and young adolescents choose items they would like to put in their "intervention box." It is a cigar-sized box into which the patient can put things such as coloring books, writing paper, or a ball to squeeze. The kids have been very inventive about what they put in their box. When they are beginning to feel stressed, the children talk with the staff about what they are experiencing and ask the staff to get the box for them. The process initiates staff intervention while the child is learning to help him or her self.

Milieu Management *and* Early Intervention

The Issue

Treatment in the psychiatric environment involves caring for patients both individually and in the context of a therapeutic milieu. Such treatment focuses on using the range of interpersonal situations found in a shared living/group experience for treatment purposes.

Within the milieu, prevention and early intervention are critical tools. Without deliberate and persistent attention to the highly varied and challenging clinical needs of the patients for whom we care, we will miss the opportunities to intervene early in helping patients change behavior patterns.

Guiding Principles

"The provision of optimal psychiatric treatment, including appropriate use of psychosocial and pharmaco-therapeutic interventions, is an important component of a strategy to reduce the use of seclusion and restraint." (American Psychiatric Association/American Academy of Child & Adolescent Psychiatry/National Association of Psychiatric Health Systems *Joint Statement of General Principles on Seclusion and Restraint,* May 1999)

"Restraint and seclusion should be used as infrequently as possible, and only when less restrictive methods are considered and are not feasible." (American Hospital Association/ National Association of Psychiatric Health Systems *Guiding Principles on Restraint and Seclusion for Behavioral Health Services,* February 25, 1999)

"Hospital and behavioral healthcare organizations and their nursing leadership groups must make commitments of adequate professional staffing levels, staff time and resources to assure that staff are adequately trained and currently competent to perform treatment processes, milieu management, de-escalation techniques and seclusion or restraint." (*American Psychiatric Nurses Association Position Statement,* May 2000)

> …restraint and seclusion should be used as infrequently as possible, and only when less restrictive methods are considered and are not feasible…

The Challenges

Current treatment environments are very challenging for both patients and staff. Short lengths of stay lead to a constantly changing milieu with high patient acuity. The environment is characterized by complex dynamics requiring sophisticated assessment and rapid decision-

making. We must maintain a safe but least restrictive environment for all patients, while caring for patients whose behavior may become highly disruptive or dysfunctional.

Take Action (Practical Tips)

Individualized care is the goal. Empower, actually insist, that staff not be rigid with the rules. Individualized care is always the goal.

Understand the stressors that trigger behaviors that lead to restraint/seclusion. "We're finding," said one provider, "that these triggers are often tied to being in the hospital. They're very much things that are under our control such as whether the program has too much free time, whether the level systems that we utilize for patients — especially children and adolescents — make any sense or are perceived as punitive, whether patients can find privacy when they need it, whether there are sufficient opportunities for physical activity, among others."

Listen to patients' concerns — especially children's concerns — about being out of control. "The feedback we received," said one provider, "was that patients felt safer knowing that staff are able to restrain a patient than they were with an individual who was left to be out of control. It was less traumatic than we had expected for them to see an out-of-control patient being restrained. They actually felt safer and more secure. One of the things that a lot of patients (especially children and adolescents) rely on is the staff keeping them safe. If they feel as though the staff can't do that, it causes an escalation of behaviors in and of itself."

Consider the impact on other patients when one individual is out of control. Very often the staff may be focused entirely on the current crisis, and there isn't someone to be immediately available to all the others. It becomes important to ensure that you have a system in which there is a staff member identified to go around quickly through the unit to touch base with all of the other people, to respond to someone who seems distressed or has a question… because you never know what a patient's response is going to be when he or she sees another patient having difficulty. The whole community needs to debrief.

Don't let numbers be the only factor in your decision-making. Staff may be so focused on reducing the number of seclusions and restraints that they forget to take a look at what the impact on the milieu has been. If the focus is strictly on the numbers and not on improving the environment overall, it can have a detrimental effect. Staff members need to feel that they have the ability to control an individual when the need arises.

Registered nurses are essential to leading and sustaining a cultural change. The tone of the milieu must be set and reinforced with every nursing action in the acute care setting. Assessment and re-assessment (both of individual patients and groups of patients) are dynamic processes and key to the prevention of circumstances that give rise to behavioral emergencies. The foundation that registered nurses have in biological and psycho-social sciences prepares them to rapidly synthesize the complex factors involved in rapidly evolving behavioral emergencies. Their consistent presence in the therapeutic program makes it possible for them to identify the individualized behavioral cues of patients and to immediately engage, and stay engaged, to the point of crisis resolution.

Milieu management must be active—not reactive. There needs to be a balance between structured therapeutic sessions, recreational and socialization activities, and rest. An environment that is too stressed on one hand or one that is not structured enough on the other hand can increase a patient's anxiety. That anxiety can be acted out in non-productive or dangerous ways.

Behavior never occurs in a vacuum. "We found that when we looked at the 'context' of behavior it was usually the result of the interaction of many things," advises a facility leader. "When we began to analyze what was going on in the environment around a patient, what other stressors he or she has to deal with, and what the obvious and not-so-obvious precipitants to the behavior were, we became much better at anticipating an out of control episode."

Reassess the milieu frequently. "Given the high acuity of the environment, we found that we needed to make reassessment a way of life—not something that was done once a day or once a shift. Any change or disruption on the unit—from the admission of a patient who is having a hard time maintaining control to new staff at the change of shift—can have a significant affect on the tone of the unit. We have made it an expectation that staff constantly communicate their observations of the changing needs of the milieu with each other. If necessary we call a mini staff meeting to organize our resources, to identify which patients are having a difficult time, and to plan interventions. These interventions may include things such as one-to-one time with specific patients, a change in the unit schedule to include more (or less) structured activities, or re-deployment of staff."

Consider assigning a "milieu manager." The job of a "milieu manager" in one unit is to make sure that areas of the unit, such as the dayrooms, are always monitored and that an adequate number of staff remain on the unit during lunch or dinner breaks. This person also attends to changes in the milieu tone so that staff intervene before things get out of control.

Include patients in validating observations and planning interventions as much as possible. Patients often are acutely aware of changes in the milieu and are very able to help plan appropriate interventions. "We found it to be a very helpful therapeutic tool to call patients together when we were sensing a change in the treatment environment and to invite their participation in understanding and managing it."

Make levels attainable. In any level system, ensure that achievement of the highest level is attainable quickly, certainly well within the average length of stay. "We changed our policy of requiring patients to be on a level, especially a 'safety level', for a fixed 24 hours. Our use of '24 hours' of restrictions not only does not appear to be necessary, it actually appears to increase the probability of undesirable outcomes."

Review the rules from the patient's perspective. "We asked patients to help us review our rules and how we present them. We all agreed we generally had too many rules. We worked with patients to identify the rules that were really necessary for the safe and therapeutic functioning of the unit."

Time-outs are not indicated for everyone. Acknowledge that, while time-out may be useful for the over-stimulated patient, it is not a productive experience for under-stimulated or manipulative patients. Identify who would benefit from active engagement in a meaningful activity.

Use all time therapeutically. Ensure that the program provides appropriate and adequate therapeutic services. Individualize the patient's treatment plan to provide for the clinically appropriate balance between structured and non-structured activities. Provide therapeutic groups days and evenings, Saturdays, Sundays, and holidays. Accommodate various tracks and group sizes depending on the mix of patients and the therapeutic activity provided. (For example, in one facility during visiting time, there are at least two groups — those who have visitors and those who don't.

> Include patients in validating observations and planning interventions as much as possible.

Offer patients choices. "Instead of issuing consequences, we're giving some choices," said one provider. "We say to patients: 'you kind of went off there. It was a bad situation for you and everyone else involved. But together we can make choices. We can give you some more structure, if you need that. Or this afternoon, in anger management group, we can role-play a different outcome to the same type of trigger that set you off.' This has therapeutic value for the whole unit, because it is an opportunity to learn, and a chance to work through a situation that affected everyone."

For children and adolescents, interrupt behaviors before they escalate. Understand the child's reaction to stimulation and learn how to regulate stimulation to help the child keep control.

Evaluate your own facility's experience for signs of peak problem areas. For example, "our data indicated that new admissions required seclusion/restraint in a greater proportion than patients that had been here a few days," said one provider. "We developed guidelines to try to gain control over behavior *before* the assaultive behavior occurred." ***Results:*** "This effort has demonstrated a significant decrease in episodes, in part due to medication intervention early in the admission process to decrease anxiety."

Focus on de-escalation techniques. Assist staff in learning a variety of approaches — and how to use these techniques at early signs of escalation. Techniques can include such things as:

- problem-solving techniques,
- effective communication skills,
- anger management strategies
- stress reduction

In one facility, **"we discuss the following list of alternatives to the use of restraint of seclusion with patients and, whenever possible, solicit their preferences:"**

- ventilation of feelings
- separating patients

- use of substitute activity
- one-to-one session
- clear, firm limit setting
- offering privacy
- use of quiet area or quiet room
- offering medication.

Seek out alternative ways of dealing with escalating behaviors.

- ***Treatment malls*:** In an effort to more actively engage patients in their recovery process and decrease aggression, a structured, supportive, centralized rehabilitation and training model was developed in the form of treatment malls. The model's milieu was based on the principles of psychosocial rehabilitation which provided for patient self-determination in an almost "community college" type atmosphere which offered engagement for all of the patients. Patients moved about more freely with greatly increased access to numerous campus locations, and their "home" unit was used for evening activities and sleeping. ***Results:*** Since this began more than five years ago, the incidence of seclusion/restraint has decreased 89% while staff injuries have decreased 63%.

- ***Low stimulus areas:*** For patients who struggle with persistent symptoms and have short attention spans, frustration and aggressiveness can be easily triggered. In an effort to actively involve these patients and control for sensory overload, a special low-stimulus area was developed. The milieu includes restful sounds, fountains, soothing lights, mobiles, and a number of small rooms for self time where reading, listening to music, visiting with a peer and a host of other activities occur. Group participation is kept to low numbers and only last for 30 minutes at the most with much flexibility based on individual needs. ***Results:*** Even some of the most severely compromised patients remain engaged and actively participate. Because **the focus is process and not task oriented**, both patients and staff function with a greatly reduced stress level that is yielding more positive outcomes.

- ***Art activities and art therapy.*** With patients who are particularly disturbed, somewhat non-communicative, and potentially violent, many programs find that art therapy can be a useful intervention. In the absence of an art therapist, some clinicians have found that simple art work with crayons can be a practical means to assist such patients in communicating their feelings.

Track your data for signs of changes you can make. Says one facility, "We were able to trend an increase in physical managements to early morning hours as the residents were starting to get up. The Director of Patient Care Services reviewed staffing patterns and adjusted shifts to bring extra staff starting at 6 am." ***Results:*** "We noted a significant decrease in the use of physical management especially on our Latency unit."

Focus on prevention. "We introduced the role of Crisis Intervention Specialists — one per shift," said a facility leader. "Additionally, all clinical staff receive ongoing behavior management training. Early on, the Crisis Intervention Specialists identify potential crisis situations and utilize a varying degree of alternative measures to maintain a therapeutic environment." ***Results:*** A safer environment for patients and staff.

Have a clear plan for adequate and appropriate psychopharmacology. Given the patients' illnesses and their acuity and the limited inpatient time available, timely, adequate psychopharmacology has increasing importance. Here's how one system outlines their strategy:

Using Psychopharmacology Appropriately

We use the following interventions:

- Staff education that focuses on the role of medication as a part of a highly individualized, integrated treatment plan. Effective psychopharmocology requires a partnership among the physician, patient, and staff aimed at helping patients learn to use medication to appropriately manage symptoms and behaviors.

- Patient and family education as to the efficacy and necessity of medication. This also facilitates obtaining consents and compliance.

- Monitoring of effectiveness of routine medications. Are there periods when the patient's behavior indicates that the type or dose or timing of the medication are not effective?

- Reassessment of the patient's condition and treatment regime at the time of each use of an extra or immediate dose of medication.

- Analysis of possible missed opportunities for use of other interventions and modification of the treatment plan when emergency use of medication has been necessary.

Reinforce messages. Use erase boards to reinforce safety goals with messages from staff or the patients themselves. These may include phrases such as, "Safety first," "It's okay to ask for help," and "I'm here to learn new ways to help myself." Also use audiotapes, which may include the patient's choice of soothing music, relaxation exercises, or a tape of staff talking about a specific subject related the patient's difficulties.

Provide a place to wait. Have a set of "safety chairs" outside the nursing station where patients are asked to sit and wait for assistance, in the event staff are involved with other patients. "This is a very effective intervention for patients to learn to delay outside assistance but trust that assistance will arrive," says a facility leader who uses this technique. "Staff will acknowledge the patient is waiting, do a very rapid assessment of the patient's needs, and estimate how long before someone can spend individual time with him or her. Any available staff member is expected to address the needs of these patients. Often, just knowing there is a process for getting help lessens the intensity of the situation for a patient."

Discuss safety at every opportunity. In community meetings, one-to-one contacts, and therapy sessions, the basic rules of safety must be discussed. "We convey that the staff is here to help in the development of strategies to de-escalate overwhelming feelings and to modulate their intensity," says one clinician. "Staff enlist patients to share safety techniques with each other."

Use the milieu to address cultural issues. In addition to being challenged to address the ways patients from different cultures interact in a milieu environment, we found ourselves addressing "new culture" issues related to gangs and other very powerful peer influences. As these issues arose in group, we found the patients /residents themselves were the most effective in developing cultural education for other residents and staff. Patients made posters, gave short presentations, and lead discussions to help identify ways to show respect, avoid disrespect, and recognize diverse needs. We developed an outline to guide the project that focuses on healthy ways to be part of a diverse group. Staff members with the same cultural or spiritual background were part of the team or workgroup to act as positive role models.

Case Study

> **For Children and Adolescents: "New Directions" Program: Giving Praise**
> Researchers at one facility developed a training curriculum called New Directions, which provides staff with essential skills in providing praise, making requests, using a teaching moment, and using a corrective teaching moment. In the course of training staff in these skills we noted how infrequently individuals remember to give praise or even know how to give praise appropriately. Staff must associate what the praise is for with the behavior that the resident is being praised for. In this way they know to repeat it, so that there is some reinforcement for repeating a specific behavior. We all very commonly say thank you for something, but we often do not a) identify the individual by saying the name, and b) identify what the behavior is we're thanking them for. Examples are statements like, "You did a really great job making the bed" or "You did a really great job in following directions." Very specific strategies on providing praise and making requests have really helped staff in diverting situations that would require seclusion and restraint.

Debriefing

The Issue

The debriefing session is a powerful opportunity for everyone (including the patient) involved in a crisis episode to examine and share feelings and perceptions about the incident. It is an opportunity to review clinical data, to revise the treatment plan, and to identify opportunities for performance improvement. The debriefing session must be highly individualized to the needs of the patient and must, either at the same time or in a separate session, provide the staff with the opportunity to process and learn from the event.

Guiding Principle

"A debriefing should follow each episode of seclusion or restraint. The debriefing should include an assessment of the factors leading to the use of seclusion or restraint, steps to reduce the potential future need for the seclusion or restraint of the patient, and the clinical impact of the intervention on the patient." (American Psychiatric Association/ American Academy of Child & Adolescent Psychiatry/National Association of Psychiatric Health Systems *Joint Statement of General Principles on Seclusion and Restraint,* May 1999.)

> "One of the areas that is going to be very interesting to me is the impact on staff as we really see, hear, and reflect on the experience that patients have in seclusion and restraint…as we become more effective in eliciting from them what the experience is and what led up to it…"

The Challenges

Regulatory and accrediting standards set prescriptive requirements that must be met without losing sight of the individualized needs of the patient. Clinical judgment is essential in determining the composition of the group involved in the debriefing session, timing, focus of the discussion, and goals. Ways of incorporating all involved persons (including, when appropriate, the patient community) must be considered. The special needs of children and parents or guardians must also be considered.

Take Action (Practical Tips)

Debriefing is a teaching moment. It models for everyone, including direct care staff, how to work with individuals who are engaging in inappropriate behaviors, to help them identify what those behaviors are, and to problem-solve and identify how to do something better and differently.

Crisis is a great opportunity to learn…about the patient, about ourselves, and about the environment.

Use debriefing as a way to help staff deal with their own fears. It's very helpful to leave a debriefing session knowing that the next time a situation comes up with a particular patient or a similar set of circumstances, the staff has other options ready to use before they revert to seclusion or restraint. Staff members come to understand that their feelings of being threatened are, in fact, acceptable and other people have similar experiences.

Follow debriefing with a "critical incident review." "In our facility, the key players in the incident are included as well as senior administrative, nursing, and medical staff," reports a facility leader. "We look more broadly at the circumstances, not just at that specific incident or that specific patient. We put it in the context of background…the entire treatment program, precipitating events…and try to learn from that so that those kinds of things can be avoided for the future or we could head them off earlier."

If you are involving patients in the treatment planning process from the very beginning, then debriefing doesn't seem like a separate act. It's just one more part of the treatment planning process.

Focus on peer review. "We have seen our medical directors get together and do some very serious work on peer review of the cases where, as I think many are seeing, a very few patients account for the majority of seclusion and restraint," said one system leader. "We're beginning to implement peer review on those cases, finding out there are better things we can do with treatment planning and seeing some significant reductions in the use of restrictive interventions."

Give staff permission to be honest about their feelings. It is hard for staff members at times to admit how afraid they are or how seriously a patient situation affected their emotional health. Many staff are concerned that they will be viewed unfavorably by their supervisors or peers if they are "too honest" about their response. "We encourage staff to make use of our on-site employee assistance program and other sources of support," reports a facility leader. "We recognize that we have a responsibility to keep our staff safe — both physically and emotionally."

> Crisis is a great opportunity to learn…about the patient, about ourselves, and about the environment.

Have clear strategies for discontinuation of restraint or seclusion. Said one provider, "I think the biggest thing that is making a difference is how we are processing the person out of seclusion and restraint…we take the time to acknowledge that this was a traumatic event and take the opportunity of the crisis to capitalize on the fact that the person is probably open to change at that point." This is when debriefing actually starts.

Case Study

Psychologist Debriefing

We encourage the staff to debrief with a staff psychologist after seclusion/restraint incidents occur. This has been very beneficial to the participants. We have a Psy.D. provider who has had considerable experience in critical incident debriefing. Staff have developed a trusting relationship with him and over the past year seek his advice and counsel in many instances when the milieu becomes tense due to patient behaviors that are threatening or might become aggressive. He helps staff examine the relational and interactional dynamics in order to avert or reverse situations that might otherwise result in seclusion/restraint use.

Debriefing Framework

- Each debriefing must elicit the patient's perspective.
- Each debriefing must attempt to identify the pattern of events that led to the need for seclusion or restraint.
- The debriefing should be timed so that the patient can receive maximum benefit from the experience.
- Debriefing with the patient is *not* a matter of punishment, scolding, or fault finding. We must ask the patient what could we have done (or perhaps not done) differently to allow him/her to have maintained control.
  - What teaching, coaching, prompting could we have done?
  - How did our program or routine or rules contribute to the undesirable outcome?
  - What prevented us from being successful with the patient?
  - We must identify that missed opportunity, that point in time, that circumstance, where we may have been able to do things differently.
  - What could be helpful in the future.
- Each use of seclusion/restraint must consider the accuracy of the diagnosis, the appropriateness of the psychopharmacology, are the other interventions on the treatment plan.

Helpful Resources

Restraint/Seclusion Standards

The official standards of various accrediting and regulatory bodies include requirements on restraint/seclusion. Here are links to major sets of standards and laws affecting behavioral healthcare providers:

- Joint Commission on Accreditation of Healthcare Organizations. See www.jcaho.org for access to infromation regarding ordering specific manuals.

- Centers for Medicare and Medicaid Services:
    - Medicare Hospital Conditions of Participation on Patients' Rights. See www.cms.hhs.gov/cop/2b.asp.
    - Medicaid regulations for the "under-21 population." See the May 22, 2001, *Federal Register* (accessible at www.archives.gov) for amendments. The original rule appears in the January 22, 2001, *Federal Register*.

- American Psychiatric Nurses Association standards. See www.apna.org.

- "Children's Health Act of 2001." Public Law 103-610. See http://thomas.loc.gov/.

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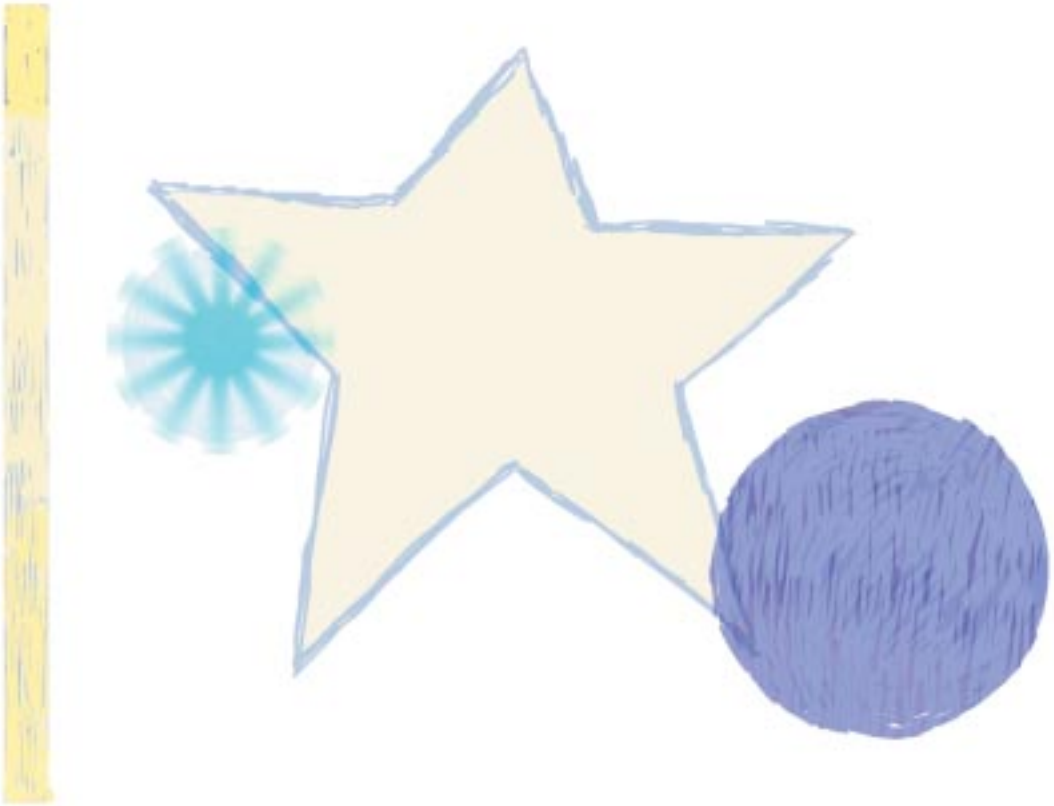
For an appendix of useful forms, assessment tools, and checklists, visit the web sites of the sponsoring organizations:

- www.naphs.org
- www.psych.org
- www.apna.org
- www.aha.org

When you click on their links to *Success Stories and Ideas for Reducing Restraint/Seclusion*, you will also find practical tools that have been shared by behavioral health experts from around the country.



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