Reducing Seclusion and Restraint for Improved Patient and Staff Safety

By Randall LaFond

About the Author

Randall LaFond currently serves as the Regional Director of Psychiatric and Behavior Service for Mercy Health Partners in Oregon, OH.

The reduction of seclusion and restraint has been a quality indicator in psychiatric services for many years. This project tracks a four-year effort at a five-unit, 65-bed psychiatric department operating within St. Charles Mercy Hospital, a 385-bed medical/surgical hospital, to improve patient and staff safety through efforts to reduce the use of seclusion and restraint.

Historically, the hospital's efforts to address seclusion and restraint had primarily focused on ways to train staff to use seclusion and restraint more efficiently. Addressing calls to improve staff and patient safety from the Ohio Department of Mental Health, the Joint Commission on the Accreditation of Health Care Organizations, consumer groups, and staff, the facility administrators made a commitment to reduce seclusion and restraint.

Administration's desire was to create a treatment environment and treatment culture that focused on *care, not control*. Administrators sought to foster a culture of care where seclusion and restraint was seen as a treatment failure, not as a treatment option, and where all staff focused on contraindications to safety and not merely violence prevention.

A major hurdle to this goal was alleviating staff resistance to the seclusion and restraint reduction efforts as a number of staff members felt the use of physical restraint increased their safety. Updating staff on the most current data throughout the test period allowed staff to alleviate their fears that their personal safety would be at risk.

An Industry Needing Change

National efforts to reduce the use of seclusion and restraint have been underway since the late 1990s after the *Hartford Courant* published a Pulitzer Prize-winning series uncovering 142 restraint-related deaths in the U.S. (Weiss, 1998). Shortly after this series was published, the General Accounting Office (1999) followed with a report, *Improper Restraint or Seclusion Use Places People at Risk*. In 2001, the Centers for Medicare & Medicaid Services (then the Health Care Financing Administration) issued final rules changing the Conditions of Participation for psychiatric facilities working with patients under age 21. These rules were updated again recently in 2006.

A literature review available from CPI (2006) shows several instances where the *Nonviolent Crisis Intervention®* training program, used as part of systemic improvement initiatives, was utilized in a variety of settings to successfully reduce and eliminate the use of seclusion and physical restraint.

Jonikas, et al. (2004) introduced a program to reduce physical restraint in

three psychiatric units of a university hospital. This program included providing the *Nonviolent Crisis Intervention®* training program to staff, as well as implementing an advanced crisis management program. These initiatives resulted in a 97–99% overall reduction in physical restraint use in the units.

A physical restraint reduction initiative at a public psychiatric inpatient service was documented by McCue, et al. (2004). The facility implemented six initiatives aimed to change staff behavior. These initiatives included adding a crisis response team, utilization of debriefing after each incident, daily review of physical restraint use, implementation of an incentive program for staff, stress and anger management training for patients, and staff training in the *Nonviolent Crisis Intervention®* training program. A 46% reduction in restraint use was recorded as a result of these six initiatives.

Petti, et al. (2002) presented a seven-year case study showing an effective set of initiatives aimed at decreasing seclusion and restraint at the Larue D. Carter Memorial Hospital in Indianapolis.

Smalls' (2004) unpublished doctoral dissertation tested physical restraint-reduction and reduction of restraint related injuries in an 18-month study conducted at the Hammond Developmental Center in Hammond, LA. Efforts to reduce restraint use focused on providing staff training in the *Nonviolent Crisis Intervention®* training program. Overall, a 94% reduction in physical restraint was noted. Correlation to the reduction of staff injuries was not supported, however, as there were no injuries attributed to restraint over the entire course of the study.

Jambunathan (1996) presented a pilot study to evaluate staff use of Crisis Prevention Institute (CPI) techniques. Results of the study showed that staff members utilizing CPI techniques were effective in resolving crises in 84.2% of the episodes observed.

Background at Mercy Health Partners

In past years, Mercy's psychiatric staff's initial response to angry, disruptive, delusional, or assaultive patients was often seclusion and restraint. Secluding and/or restraining patients became the norm. This most restrictive and traumatic intervention was viewed as a viable treatment option when other attempts to secure the patient or situation were not successful or not even tried. At the same time, injury to psychiatric staff was viewed as an unavoidable occupational hazard.

Historically, seclusion and restraint use has been tracked as a part of the departmental quality initiative because the reduction of seclusion and restraint was seen as a value. However, the staff perceived their safety was not being considered seriously by hospital or department administration.

In early 2002, the department began to investigate the connection between staff and patient injury and the use of seclusion and restraint. For many years, both staff injury and use of seclusion and restraint was an accepted and expected part of the facility's clinical milieu. In order for there to be a significant reduction in either of these areas, administrators recognized that they had to address both. Patient safety and staff safety were more closely related than often realized. In short, administrators realized that a change in the service culture was needed. Further, the facility also needed empirical data to either validate or dispel long-term perceptions and anecdotal information that described what type of patients were doing what to whom.

To this end, administrators started with a simple premise: the use of seclusion and restraint must be seen as a treat-

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ment failure, not as a treatment option. It is not a punishment for rule breaking or bad behavior. At the same time, though, violence against staff is not acceptable and will not be tolerated.

As the initiatives progressed, an informal and formal debriefing process for every incident of seclusion and/or restraint was also implemented. Informal debriefing occurs immediately after the incident and before the "all clear" is called. The formal debriefing is scheduled as soon after the event as possible and includes all direct care staff and security involved in the incident, nursing and security leadership, and psychiatric administration. Again, this is not a punitive review but an opportunity to improve processes.

In an effort to make early intervention and treatment much more effective, the hospital improved nursing assessments to include an 18-point assessment to aid in the process of early identification of patients that could be at risk for a violent episode. Rather than simply focus on a patient's potential for violence, staff were educated to focus on Contraindications to Safety that also included the environment of care, clinical practices and interventions, and administrative policies.

No special fiscal resources were set aside for this initiative. However, the department was given both the responsibility and the freedom to make any internal changes necessary in policy and/or procedure that would facilitate improvements in both patient care and staff safety. Staff training and the development of staff trainers proved to be the backbone of this effort. These costs were absorbed into the department and were seen as a part of annual staff competencies. This included the selection and training of two additional CPI Certified Instructors. These psychiatric staff members facilitate mandatory annual *Nonviolent Crisis Intervention*® training programs and act as internal staff resources. Staff also participated in an Ohio Department of Mental Health learning cooperative designed to foster a Violence and Coercion-Free Treatment Environment.

To ensure that efforts at the organization were effectively being implemented, the following data sets were complied:

- Seclusion and Restraint Specific Data
- Employee Incident Reports
- Code Violet Incidents Response Data

Seclusion And Restraint Specific Data

Episodes of seclusion and restraint, total time, and utilization rates were tracked. Seclusion and restraint are separate events, but they are documented as one occurrence.

In the baseline year of 2002, 83 episodes of seclusion and restraint were documented. (An episode is defined as the initiation of and each subsequent four-hour block of seclusion and/or restraint.) The total documented time was 220:03 minutes against 1606 admissions and a total of 16,054 patient days. This equates to an annual average of 34.26 minutes per 1000 patient hours.

The table on the next page demonstrates the reduction in seclusion and restraint time and minutes per 1000 patient days from 2002–2006. During the same period, patient admissions were up 23.4% and patient days increased over 8.9%.

Employee Incident Reports

Beginning in 2002, department-specific incident reports for *Risk, Security and Safety* were tracked. These types of incidents were split up into six categories and tracked on a monthly basis. These categories were *Risk with Possible Adverse Outcome, Security with No Adverse Outcome, Property Loss, Injury, Violence, and Property Damage*. The last three data sets, *Injury, Violence, and Property Damage,* are highlighted in the incident report because of their close relationship to the possibility of injury and the potential staff response of seclusion and restraint. These incidents included the date of the occurrence, client age, (when possible), client gender, and a brief note. Unit-specific data were also tracked, such as unit/department census, patient-to-staff ratio, and number of one-to-one patient to staff close observations.

Historical Data of Seclusion/Restraints
St. Charles Mercy Hospital

		Total Combined Episodes	Total Intervention Time	Total Patient Days	Mins/ 1000* Pt Hrs	Total Utilization Rate
2002	**Q1**	39	114:55:00	4,032	71.03	0.967%
	Q2	20	40:53:00	3,793	26.71	0.527%
	Q3	11	29:30:00	4,446	16.48	0.247%
	Q4	13	34:45:00	3,783	22.77	0.344%
	Total	83	220:03:00	16,054	34.26	0.517%
2003	**Q1**	15	42:40:00	3,858	27.48	0.389%
	Q2	15	50:24:00	3,552	35.36	0.422%
	Q3	21	57:29:00	4,340	33.00	0.484%
Reduction	**Q4**	18	56:05:00	4,268	32.83	0.422%
6.0%	Total	69	206:38:00	16,018	32.21	0.431%
2004	**Q1**	20	52:15:00	3,950	33.01	0.506%
	Q2	14	36:30:00	3,810	23.82	0.367%
	Q3	11	29:00:00	4,485	16.16	0.245%
Reduction	**Q4**	15	35:00:00	4,273	20.48	0.351%
28.4%	Total	60	152:45:00	16,518	23.07	0.363%
2005	**Q1**	8	21:00:00	3,839	13.68	0.208%
	Q2	7	17:40:00	4,515	9.63	0.155%
	Q3	13	34:00:00	4,491	18.93	0.289%
Reduction	**Q4**	25	58:30:00	4,218	34.55	0.593%
16.8%	Total	53	131:10:00	17,063	19.21	0.311%
2006	**Q1**	11	26:45:00	4,304	15.36	0.256%
	Q2	11	22:20:00	4,308	12.88	0.255%
	Q3	11	31:10:00	4,579	16.98	0.240%
Reduction	**Q4**	5	10:30:00	4,294	6.00	0.116%
32.7%	Total	38	90:45:00	17,485	12.93	0.217%

*Overall Reduction (mins/1000 pt hrs 2002–2006) = 62.3%

Over the four-year period, 465 incidents of *Risk, Security and Safety* were reported. The number of incidents as a percentage of total admissions ranged from a low in 2003 of 5.7% to a high in 2004 of 7.7%. The number of annual incident reports as a percentage of admissions remains fairly constant. Contrary to popular opinion, *Violence* specific incidents were not predominant. Incidents that involved a *Risk to Patient Safety* with a *Possible Adverse Outcome* made up 26% of the total. We were able to document that the number of incidents that were being reported remained fairly constant as the episodes and time of seclusion and restraint continued to decrease.

Code Violet Incidents Response Data

In 2001, the psychiatric services staff implemented a "Code Strong" protocol (Code Violet is the current term used within the hospital). This protocol alerted all staff to an emergency situation in any part of the department. Data specific to Code Violet included documentation of staff response times, compliance with process, and recommendations for improvement. Since staff response to a Code Violet usually resulted in an episode of seclusion and restraint, this information was closely scrutinized.

Quarterly compliance with internal processes and protocols for the years 2002–2004 varied between 85–95%. For 2005, compliance was between 98% and 100%. Ongoing staff education and focus on continued improvement must be credited for the change.

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Overcoming Faulty Assumptions

When the seclusion and restraint reduction initiative began, the hope was to improve staff and patient safety. Administrators tracked seclusion and restraint and hypothesized that there was a relationship between reduction of seclusion and restraint and safety. At the time, administrators could not articulate the exact nature of the changes required to improve the treatment environment and treatment culture. That insight came about halfway into the project. As the initiative moved forward, some commonly held beliefs that have been a historic part of the service line had to be challenged.

These beliefs included that: 1) seclusion and restraint are viable treatment options and were considered the best ways to assure patient and staff safety; 2) everyone assumed that psychiatric staff knew how to recognize, assess, and defuse potentially violent situations and also assumed all personnel were committed to the same vision of patient care; 3) everyone assumed that psychiatric patients are not responsible for their behavior; and, perhaps the most dangerous assumption, 4) staff injury is an expected part of working in this field.

Through the initiative, a number of improvements were accomplished, including a documented ongoing annual reduction of both the episodes and total time of seclusion and restraint, a documented reduction in violence-related incidents from over 5% of total admissions in 2002 to 1.9% of total admissions in 2006, consistently high levels of patient satisfaction, and improved compliance with internal departmental seclusion and restraint protocols.

Results

Given the performance improvements listed, the department has been able to successfully overcome some of the "unshakable beliefs" that had dominated our service line for many years. We now know that:

- Seclusion and restraint is not a treatment, it is a response when treatment breaks down. Intention is not to forbid staff members from using seclusion and restraint in the direst of circumstances, but rather to make seclusion and restraint an unnecessary option as a wider array of less intrusive options are made available.
- Reducing seclusion and restraint and keeping staff and patients safe is not only a clinical objective but also an administrative priority.
- An ongoing training process is the key to creating a Violence and Coercion Free Treatment Environment. Many staff did not know how to recognize, assess, or defuse potentially violent situations. Seclusion and restraint was used as a punishment for breaking unit rules. Power struggles and control confrontations were common.
- Psychiatric patients are held accountable for their behavior. Attacking or injuring a health care worker is not acceptable and will not be tolerated. Staff injury is also unacceptable. Patients are held accountable for their behavior up to and including legal prosecution. ◗

Citations

Crisis Prevention Institute. (2006). *Measuring Success: Evidence, research and the* Nonviolent Crisis Intervention® *training program*. Brookfield, WI: Author.

General Accounting Office. (1999). *Improper Restraint or Seclusion Use Places People at Risk.* Report to Congressional requesters. Retrieved March 20, 2006 from http://www.gao.gov/archive/1999/ he99176.pdf.

Jambunathan, J., & Bellaire, K. (1996). Evaluating staff use of crisis prevention intervention techniques: A pilot study. *Issues in Mental Health Nursing, 17*, 541–558.

Jonikas, J., Cook, J., Rosen, C., Laris, A., & Kia, J. (2004). A program to reduce use of physical restraint in psychiatric inpatient facilities. *Psychiatric Services, 55*, 818–820.

McCue, R., Urcuyo, L., Lilu, Y., Tobias, T., & Chambers, M. (2004). Reducing restraint use in a public psychiatric inpatient service. *Journal of Behavioral Health Services & Research, 31*(2), 217–224.

Petti, T., Somers, J., & Sims, L. (2003). A chronicle of seclusion and restraint in an intermediate-term care facility. *Annals of Adolescent Psychiatry, 27*, 83–116.

Smalls Y. (2004). *Utility of the implementation of programmatic systems to reduce and eliminate restraint use for the treatment of problem behaviors with individuals with mental retardation.* Unpublished dissertation. Retrieved February 20, 2006 from http://etd.lsu.edu/docs/submitted/etd-01282004-145119/unrestricted/Smalls_dis.pdf.

Weiss, E. M. (1998, October 11–15). Deadly restraint: a nationwide pattern of death. *Hartford Courant*.