A Decade of Transformation: Seclusion and Restraint Reduction Techniques and Triumphs Ten Years Later

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Youngstown, Ohio
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Baseline

- 99 Seclusion Events recorded in 2000
- 35 Episodes of Restraint in 2000

- Average time in seclusion 10.85 hours
- Average time in restraint 7.16 hours

- Percentage of patients secluded 7%
- Percentage of patients restrained 2.75%
Impetus to Change/Early Solutions

- High incidence of S/R in our hospitals
- Hartford Courant Articles “Deadly Restraint” 1998

- 1999 HCFA Guidelines
- The Joint Commission

- Recognition of Dangerous of S/R based on Harvard Center for Risk Analysis data

- Begin S/R reduction initiative based on Pennsylvania State Hospital success

- Administrative Philosophy Change
  - Self vs. other control
  - Restraints as treatment failure
  - Least restrictive alternative philosophy
Core Components

- Implementation of CMS and TJ H standards
- Shift from Recreation Leisure Model to Psycho-education in Programming
- Re-education of Staff
  - Emphasis on dangers of restraint/reasons for regulations
  - Verbal skills emphasis
- Strict concurrent monitoring of performance
  - Use of CNS and restraint champions on off-shifts
Six Core Strategies for the Reduction of Seclusion and Restraint (NETI)

- Provide leadership and direction by setting up values, expectations, and clinical oversight
- Collect and Use data to inform practice
- Workforce development
- Use of prevention plans/self-management training
- Debriefing
- (Consumer involvement)
Unit Based Nursing Research

- Medications for behavioral emergencies: What works the quickest and the best?

- Can the BARS Scale be used to make decisions about the use of seclusion and restraint?
Transforming Mental Health Care in America

- Individualizing treatment planning
- Strengths/resilience focus
- Culturally sensitive care
- Enhancement of research base especially in area of trauma
- Advertise the real probability of recovery
- Education and workforce development
Additional Best Practice Methods

- Strict adherence to least restrictive alternative philosophy
- Recovery Model
- Trauma Informed Care/Crisis Management Plan
- Inclusion of patient perspective of restraint experience into staff education
- Concurrent auditing of charts
- Redefinition of dangerousness
- Application of Relevant DBT Principles
- Benchmarking with other Ohio Hospitals
What Staff Would Say

- Tolerance for disruptive behavior improved
- “I don’t want to mess up Joan’s statistics”
- The paperwork isn’t worth it!
  - “I’ll try anything to avoid the paperwork!”
Results

- We went from here to there....
Additional Benefits

- Acknowledgement of expertise by Medical Center
- Hospital-wide reduction in restraint use of 88%
- Improved coordination with the Emergency Room with creation of a specialized “Psych Section”
- Favorable Joint Commission Surveys
- Magnet Nurse Led Hospital Initiative
## Seclusion/Restraint SEHC

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2000</th>
<th>2003</th>
<th>2009</th>
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</thead>
<tbody>
<tr>
<td>Seclusion Events</td>
<td>99</td>
<td>41</td>
<td>6</td>
</tr>
<tr>
<td>Restraint Events</td>
<td>35</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Indicator</td>
<td>2000</td>
<td>2009</td>
<td>% Improvement</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------------</td>
<td>------------</td>
<td>---------------</td>
</tr>
<tr>
<td># SE events Per mos.</td>
<td>8.25</td>
<td>0.5</td>
<td>94%</td>
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<tr>
<td>Av Time in Seclusion</td>
<td>10.9 hrs</td>
<td>2.7hrs</td>
<td>75%</td>
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<tr>
<td># Pts Secluded per mos</td>
<td>5.42</td>
<td>0.5</td>
<td>91%</td>
</tr>
<tr>
<td>% pts secluded</td>
<td>7%</td>
<td>0.5%</td>
<td>93%</td>
</tr>
<tr>
<td># R episodes per mos</td>
<td>2.92</td>
<td>0.5</td>
<td>83%</td>
</tr>
<tr>
<td>Av Time in Restraints</td>
<td>7.16 hrs</td>
<td>1.5hrs</td>
<td>79%</td>
</tr>
<tr>
<td># Pts R per mos.</td>
<td>2.17</td>
<td>0.25</td>
<td>88%</td>
</tr>
<tr>
<td>% Pts Restrained</td>
<td>2.75%</td>
<td>0.26%</td>
<td>91%</td>
</tr>
</tbody>
</table>
Problems/Challenges

- Documentation lapses
- Police tactics/poor buy-in by Security
- Influx of Psych Patients in ER
- Conflict between needs of the hospital and Psych Unit
- More involuntary patients (40-60% of census)
- Increased seclusion/restraint outliers
- Difficult patient mix/closure of PIU
- Increase in assaults due to population served
- Aging workforce/burnout
- Resistance/realistic time constraints
Possible Solutions

- Mock Code Violet Drills
- Documentation Competencies
- Off-Shift seclusion/restraint champions
- Emphasis on Clinical Control of all Interventions
- Staff recognition for work under extreme circumstances
- Adoption of a team of trainers using the NAPPI Model
- Study with ER to look at appropriateness of admissions
- Possible development of a BERT Team
- Networking with CHP and OHA and APNA for best practice ideas
- Your ideas?????????
Slowness of the Process
Thank You from St. Elizabeth Health Center, Youngstown, Ohio

- We’re all in this together!