



NATIONAL TECHNICAL ASSISTANCE CENTER

SIX CORE STRATEGIES© TO REDUCE THE USE OF SECLUSION AND RESTRAINT PLANNING TOOL

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(From the NTAC/NASMHPD Training Curriculum to Reduce the Use of Seclusion and Restraint in Mental Health Facilities, Draft, May 2005)

Purpose: For use as a template or checklist that guides the design of a seclusion and restraint (S/R) reduction plan that incorporates the use of a prevention approach, includes the six core strategies to reduce the use of S/R© described in the NASMHPD curriculum, and ascribes to the principles of continuous quality improvement. Also may be used as a monitoring tool to supervise implementation of a reduction plan and identify problems, issues, barriers and successes. Best used as a working guide by an assigned Performance Improvement/Seclusion and Restraint Reduction Team or Task Force.

Note: The word *consumer* is used in this document to include adults and children/families.

*Seclusion/Restraint Plan Template or Monitoring Tool Draft Instrument
(Each item needs to be demonstrated through documentation, leadership activities,
staff interviews, review of policies, or other relevant ways.)*

STRATEGY ONE: LEADERSHIP TOWARDS ORGANIZATIONAL CHANGE

GOAL ONE: To reduce the use of seclusion and restraint by defining and articulating a mission, philosophy of care, guiding values, and assuring for the development of a S/R reduction plan and plan implementation. The guidance, direction, participation and ongoing review by executive leadership is clearly demonstrated throughout the S/R reduction project.

1. Has the facility reviewed/revised facility mission statement, philosophy and core values to assure congruence with S/R reduction initiative? (For example, referencing S/R reduction as congruent with principles of recovery; building a trauma informed system of care; creating violence free and coercion free environments; assuring safe environments for staff and consumers; and facilitating a return to the community.) This step must include an organizational values exercise where values statements are cross-walked with actual clinical and administrative practices to assure for congruence.
2. Has the facility developed a facility S/R policy statement that includes beliefs to guide use and is congruent with mission, vision, values and recovery principles? (As above, this statement would include statements such as S/R is not treatment but a safety measure of last resort; that S/R indicates treatment failure; and facility's commitment to reduction/elimination etc. There are examples of policy statements available to review.)

3. Has the facility leadership developed a individualized facility based S/R reduction action plan based on a performance improvement and prevention approach as the overall umbrella including the assignment of a S/R reduction or PI team; the creation of goals, objectives and action steps assigned to responsible individuals and noted due dates; and are there consistent reviews and revisions with senior executive oversight and review? (See policy statement, policy and procedures, actual plan.)
4. Has leadership reviewed and analyzed their S/R related data in an effort to discover critical details of events such as time of day, location, points of conflicts? Has leadership determined data driven hospital goals to reduce S/R? (See data component for specifics.) (This objective basically is leaderships' commitment and intention to use and monitor real time data in the reduction efforts.)
5. Has the leadership committed to create a collaborative, non-punitive environment, to identify and work through problems by communicating expectations to staff, and to be consistent in maintenance of effort? (This step may include a statement to staff that while a individual staff member may act with best intent, it may be determined later that there were other avenues or interventions that could have been taken. It is only through staff's trust in leadership that they will be able to speak freely of the circumstances leading up to a S/R event so that this event can be carefully analyzed and learning occur. However, the rules defining abuse and neglect are clear and the previous statement does not lift accountability for those kind of performance issues.)
6. Are all staff aware of the role of the CEO/Administrator to direct the S/R reduction initiative? (This will include senior level involvement in motivating staff including and understanding and commitment from the facility medical director. A "kickoff" event for the rollout of this initiative is recommended or a celebration if facility is already involved in a reduction effort. This steps calls for active, routine and observable CEO/Administrator activities including the inclusion of status report at all management meetings.)
7. Has leadership evaluated the impact of reducing S/R on the whole environment? (This includes issues such as increased destruction of property; extended time involved in de-escalation attempt, additional admission assessment questions, debriefing activities and processes to document event, etc.)
8. Has the leadership set up a staff recognition project to reward individual staff, unit staff and S/R champions for their work on an ongoing basis?
9. Does the leadership approved, S/R reduction plan delegate tasks and hold people accountable through routine reports and reviews?

10. Has leadership addressed staff culture issues, training needs and attitudes? (See Workforce Development.) (Leadership will assure for staff training and development in knowledge, skills and abilities, including choice of training program for S/R application techniques and will include HR.)
11. Has leadership reviewed the facility's plan for clinical treatment activities in an effort to assure that active, daily, person centered, effective treatment activities are offered to all persons receiving services; that these services are offered off living units preferably; and that persons attending have some personal choice in what activities they attend. The minimal criteria to meet under this objective is to assure that service recipients are not spending their days in enclosed areas with no active effective psycho-social or psychiatric rehabilitation occurring that is effective in teaching living, learning, recreational and working skills.
12. Has facility leadership ensured oversight accountability by watching and elevating the visibility of every event 24 hours a day/7days per week by assigning specific duties and responsibilities to multiple levels of staff including on-call executives, on-site nursing supervisor, direct care staff, advocates/consumers?

Note "Creating responsibilities for oversight for events" includes the following functions:

1. On-call Executive Role (member of executive team)
 - a. 24/7 on call supervision for event analysis
 - b. Use knowledge gained by event analysis to identify organizational problems, potential resolutions and ensure timely follow-up
 - c. Make S/R a standing agenda item for all meetings at all levels
 - d. Ensure that data is collected, used and shared
 - e. Ensure staff accountability and performance recognition
2. On-site Supervisor Role
 - a. 24 hr on site response, supervision and attendance at all events and near misses when possible (to observe what worked and why)
 - b. Take lead post a S/R event by debriefing all staff involved, the service recipient, all event witnesses, gathering event timelines, reviewing documentation, and providing a report (verbally and written) to oncoming supervisor or administrator
3. Line Staff (Direct Care)
 - a. Understand and be able to describe the organizational approach in reducing S/R

b. Be introduced to project and philosophy, through:

- New hire application and interview
- New staff orientation
- Job description
- Competency review
- Meet performance criteria in evaluations
- Demonstrate positive attitude about the project

4. Consumer Role

- a. Use employed internal consumer staff or external consumer consultants to act as interviewers, gather data, investigate and to provide a critical perspective
- b. Be represented on all S/R related committees and task forces

STRATEGY TWO: USING DATA TO INFORM PRACTICE

GOAL TWO: To reduce the use of S/R by using data in an empirical, non-punitive, manner. Includes using data to analyze characteristics of facility usage by unit, shift day, and staff member; identifying facility baseline; setting improvement goals and comparatively monitoring use over time in all care areas, units and/or state system's like facilities.

1. Has the facility collected and graphed baseline data on S/R events to include at a minimum, incidents, hours, use of involuntary medication and injuries?
2. Has the facility set goals and communicated these to staff, setting realistic data improvement thresholds? Has the facility created non-punitive, healthy competition among units or sister facilities by posting data in general treatment areas and through letters of agreement with external facilities?
3. Has the facility chosen standard core and supplemental measures including seclusion and restraint incidents and hours by shift, day, unit, time; use of involuntary IM medications; consumer and staff related injury rates; type of restraint, consumer involvement in event debriefing activities; grievances, consumer demographics including gender, race; diagnosis insurance type; and other measures as desired?
4. Does leadership have access to data that represents individual staff member involvement in S/R events and is this information kept confidential and used to identify training needs for individual staff members? (for supervisors only)

5. Is the facility able to observe and record “near misses” (and the processes involved in those successful events) to assist in leadership and staff learning of best practices to reduce S/R use?

STRATEGY THREE: WORKFORCE DEVELOPMENT

GOAL THREE: To create a treatment environment whose policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services and the experiences of our staff. Includes an understanding of the characteristics and principles of trauma informed care systems. Also includes the principles of recovery-oriented systems of care such as person-centered care, choice, respect, dignity, partnerships, self-management, and full inclusion. This intervention is designed to create an environment that is less likely to be coercive or conflictual. It is implemented primarily through staff training and education and HRD activities. Includes safe S/R application training, choice of vendors and the inclusion of technical and attitudinal competencies in job descriptions and performance evaluations. Also includes the provision of effective and person centered psychosocial or psychiatric rehabilitation like treatment activities on a daily basis that are designed to teach life skills (See Goal One).

1. Has the staff development department introduced recovery/resiliency, prevention, and performance improvement theory and rational to staff?
2. Has the facility revised the organizational mission, philosophy, and policies and procedures to address the above theory and principles?
3. Has the facility appointed a committee and chair to address workforce development agenda and lead this organizational change? (Include HR)
4. Has the facility assured for education/training for staff at all levels in theory and approaches including:
 - a. Experiences of consumers and staff?
 - b. Common assumptions and myths?
 - c. Trauma Informed Care?
 - d. Neurobiological Effects of Trauma?
 - e. Public Health Prevention Model?
 - f. Performance Improvement Principles?
 - g. The S/R Reduction Core Strategies as appropriate?
 - h. Risk for Violence?
 - i. Medical/Physical Risk Factor for Injury or Death?
 - j. The use of Safety Planning Tools or Advance Directives?

- k. Core Skills in Building Therapeutic and Person Based Relationships?
 - l. Safe Restraint application procedures including continuous face-to-face monitoring while a person is in person?
 - m. Non-confrontational limit setting?
5. Has the facility encourage staff to explore unit “rules” with an eye to analyzing these for logic and necessity? (Most inpatient facilities have historical rules that are habits or patterns of behavior that are not congruent with a non-coercive, recovery facilitating environment, for instance rules such as putting people who self abuse in non lethal ways in restraint, or putting people who are intrusive only in restraint.)
 6. Has the facility addressed staff empowerment issues? (For example do staff have input into rules and regulations?) Does the facility allow staff to suspend “rules” within defined limits to avoid incidents?
 7. Does the facility empower staff? (e.g. self-schedule, flex schedules, and switch assignments)
 8. Does the facility assume that all staff at all levels are responsible, capable adults, albeit perhaps injured by trauma, and communicated this value to all? How?
 9. Has the facility included HR in the planning and implementation efforts to include the development and insertion of knowledge, skills and abilities considered mandatory in job descriptions and competencies for all staff at every level of the organization? Does this include both technical competence and attitudinal competence and how these are demonstrated?

STRATEGY FOUR: USE OF S/R REDUCTION TOOLS

GOAL FOUR: To reduce the use of S/R through the use of a variety of tools and assessments that are integrated into each individual consumer’s treatment stay. Includes the use of assessment tools to identify risk factors for violence and seclusion and restraint history; use of a trauma assessment; tools to identify persons with risk factors for death and injury; the use of de-escalation or safety surveys and contracts; and environmental changes to include comfort and sensory rooms and other meaningful clinical interventions that assist people in emotional self management.

1. Has the facility implemented assessment tools to identify risk factors for inpatient incidents of aggression and violence? (Research shows best predictor is past violent behavior in inpatient settings and past involvement with S/R use.) (Examples of tools are available)

2. Has the facility implemented assessment tools on the most common risk factors for death or serious injury caused by restraint use? (These include obesity, history of respiratory problems including asthma, recent ingestion of food, certain medications, polypharmacy, history of cardiac problems, history of acute stress disorder or PTSD.)
3. Has the facility implemented the use of a trauma history assessment that identifies persons at risk for re-traumatization and addresses signs and symptoms related to untreated trauma sequelae? (Examples of tools are available)
4. Has the facility implemented a de-escalation tool or safety planning assessment that includes the identification of individual triggers and personally chosen and effective emotional self management interventions? (Examples of tools are available)
5. Has the facility:
 - a. Implemented communication techniques/conflict mediation procedures?
 - b. Reduced environmental signs of overt/covert coercion?
 - c. Made environment of care changes (use of comfort rooms & sensory rooms)?
6. Has the facility utilized an aggression control behavior scale such as the Lalemond Behavior Scale that assists staff to discriminate between agitated, disruptive, destructive, dangerous and lethal behaviors and decreases the premature use of restraint/seclusion? (Lalemond Scale is proprietary at this point but we can probably get approval to use or adopt principles.)
7. Has the facility written policies and procedures for use of the above interventions and disseminated these to all staff?
8. Has the facility created a way that individual safety planning or de-escalation information is readily available in a crisis and is integrated in the treatment plan?
9. Has the facility made available expert and timely consultation with appropriately trained staff or consultants to assist in developing individualized behavioral interventions for service recipients who demonstrate consistently challenging behaviors?

STRATEGY FIVE: CONSUMER ROLES IN INPATIENT SETTINGS

GOAL FIVE: To assure for the full and formal inclusion of consumers or people in recovery in a variety of roles in the organization to assist in the reduction of S/R.

1. Has the facility integrated consumer choices at every opportunity? For children's treatment programs this also focuses on family member choices.
2. Has the facility used vacant FTE's to create full or part-time roles for older adolescent/adult consumers such as:
 - a. Director of Advocacy Services?
 - b. Peer Specialists?
 - c. Drop-In Center Director?
 - d. Community Consumers?
3. Has the facility educated staff as to the importance and need to involve consumers at all operational levels, both through respectful inclusion in operations decisions as appropriate and in the consistent attention to the provision of choices?
4. Has the facility included consumer representation in key committees and workgroups throughout organization?
5. Has the facility empowered consumers to do their facility related jobs and support this work (new roles for consumers) at the highest level by setting up appropriate supervision systems?
6. Has the facility implemented consumer satisfaction surveys, discussed results with staff and used results to direct revisions in service provision? In children's programs satisfaction surveys would also be geared to families.
7. Has the facility invited external advocates to provide suggestions and be involved in operations?

STRATEGY SIX: DEBRIEFING TECHNIQUES

GOAL SIX: To reduce the use of S/R through knowledge gained from a rigorous analysis of S/R events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate to the extent possible the adverse and potentially traumatizing effects of a S/R event for involved staff and consumers and all witnesses to the event. It is imperative that senior clinical and medical staff, including the medical director, participate in these events.

1. Has the facility revised policy and procedures to include two debriefing activities for each event as follows:
 - a. An immediate "post-event" debriefing that is done onsite after each event, is led by the senior on-site supervisor who immediately responds to that unit or area? (The goals of this post-acute event debriefing is to assure that

everyone is safe, that documentation is sufficient to be helpful in later analysis, to briefly check in with involved staff, consumers and witnesses to the event to gather information, to try and return the milieu to pre-event status, to identify potential needs for policy and procedure revisions, and to assure that the consumer in restraint is safe and being monitored appropriately. If the facility has implemented “witnessing” (see Goal One) the on-site supervisor calls in the information gathered in this post-acute debriefing event to the off site executive staff person who is on call or report to administration if during weekday hours.)

- b. A formal debriefing that includes a rigorous analysis that occurs one to several days following the event and includes attendance by the involved staff, the treatment team including the attending physician, and a representative administration. (It is recommended that this formal debriefing follow the steps in a root cause analysis [RCA] or a similar rigorous problem solving procedure to identify what went wrong, what knowledge was unknown or missed, what could have been done differently, and how to avoid in the future. It is also recommended that RCA be used in situations where individuals are injured; where S/R has been used more than twice in a month and at any time where S/R event lasts more than eight hours.)
 - c. Has the facility assured the involvement of the consumer in all debriefing activities either in person or by proxy? (It is extremely important to include the consumers experience or voice in this activity and if the consumer cannot or will not participate it is recommended that another consumer or staff person act as that person’s advocate at the meeting. It is also recommended that the consumer, in staff, or advocacy roles, also be
 - d. involved and that the person running the meeting is well versed in objective problem solving and was not involved in the triggering event.)
2. Do the debriefing policies and procedures specify: (see S/R Debriefing P & P)
 - a. Goals of debriefing?
 - b. Who is present?
 - c. Responsibilities/roles?
 - d. Process?
 - e. Documentation?
 - f. Follow-up?
 3. Has the facility implemented debriefing policies and procedure that address staff responses to the event, consumer responses and issues, and “observer” response and issues?

4. Has the facility provided training on how debriefing will revise treatment planning?
5. Has the facility made an attempt to assist staff in their individual responses to S/R events, up to and including the use of EAP (Employee Assistance Program) services or other supportive resources?