NASMHPD

Six Core Strategies for Reducing Seclusion and Restraint Use©

<u>Note:</u> This document contains the following items: (1) a **Snapshot** of the Six Core Strategies©; (2) a **Planning Tool**; and (3) an **Example of Debriefing Policies and Procedures.**

A Snapshot of Six Core Strategies for the Reduction of S/R ©
(Revised 11/20/06 by Kevin Ann Huckshorn)

These strategies were developed through extensive literature reviews (available upon request from joan.gillece@nasmhpd.org) and dialogues with experts who have successfully reduced the use of S/R in a variety of mental health settings for children and adults across the United States and internationally.

1. Leadership toward Organizational Change

This first strategy is considered core to reducing the use of seclusion and restraint (S/R) through the consistent and continuous involvement of senior facility leadership (most specifically the CEO, CNO, and COO). Leadership strategies to be implemented include defining and articulating a vision, values and philosophy that expects S/R reduction; developing and implementing a targeted facility or unit based performance improvement action plan (similar to a facility "treatment plan"); and holding people accountable to that plan. This intervention includes the elevation of oversight of every S/R event by senior management that includes the daily involvement of the CEO or COO in all S/R events (24/7) in order to investigate causality (antecedents), review and revise facility policy and procedures that may instigate conflicts, monitor and improve workforce development issues and involve administration with direct care staff in this important work. The action plan developed needs to be based on a public health prevention approach and follow the principles of continuous quality improvement. The use of a multi-disciplinary performance improvement team or taskforce is recommended.

This is a mandatory core intervention.

2. Use of Data To Inform Practice

This core strategy suggests that successfully reducing the use of S/R requires the collection and use of data by facilities at the individual unit level. This strategy includes the collection of data to identify the facility/units' S/R use baseline; the continuous

gathering of data on facility usage by unit, shift, day; individual staff member's involved in events; involved consumer demographic characteristics; the concurrent use of stat involuntary medications; the tracking of injuries related to S/R events in both consumers and staff and other variables. The facility/unit is encouraged to set improvement goals and comparatively monitor use and changes over time.

3. **Workforce Development**

This strategy suggests the creation of a treatment environment whose policy, procedures, and practices are based on the knowledge and principles of recovery and the characteristics of trauma informed systems of care. The purpose of this strategy is to create a treatment environment that is less likely to be coercive or trigger conflicts and in this sense is a core primary prevention intervention. This strategy is implemented through intensive and ongoing staff training and education and HRD activities. It includes S/R application training and vendor choice, the adequate provision of treatment activities that offer choices to the people we serve and that are designed to teach illness and emotional self-management of symptoms and individual triggers that lead to loss of control. This strategy requires individualized person centered treatment planning activities that include persons served in all planning. This strategy also includes consistent communication, mentoring, supervision and follow-up to assure that staff are provided the required knowledge, skills and abilities, with regards to S/R reduction through training about the prevalence of violence in the population of people that are served in mental health settings; the effects of traumatic life experiences on developmental learning and subsequent emotional development; and the concept of recovery, resiliency and health in general. This work is done through staff development training, new hire applicants interview questions, job descriptions, performance evaluations, new employee orientation, and other similar activities.

4. **Use of S/R Prevention Tools**

This strategy reduces the use of S/R through the use of a variety of tools and assessments that are integrated into facility policy and procedures and each individual consumer's recovery plan. This strategy relies heavily on the concept of individualized treatment It includes the use of assessment tools to identify risk for violence and S/R history; the use of an universal trauma assessment; tools to identify persons with high risk factors for death and injury; the use of de-escalation surveys or safety plans; the use of person-first, non-discriminatory language in speech and written documents; environmental changes to include comfort and sensory rooms; sensory modulation interventions; and other meaningful treatment activities designed to teach people emotional self management skills.

5. **Consumer Roles in Inpatient Settings**

This strategy involves the full and formal inclusion of consumers, children, families and external advocates in various roles and at all levels in the organization to assist in the reduction of seclusion and restraint. It includes consumers of services and advocates in

event oversight, monitoring, debriefing interviews, and peer support services as well as mandates significant roles in key facility committees. It also involves the elevation of supervision of these staff members and volunteers to executive staff who recognize the difficulty inherent in these roles and who are poised to support, protect, mediate and advocate for the assimilation of these special staff members and volunteers. ADA issues are paramount here in terms of job descriptions, expectations, work hours, and an ability to communicate to staff the legitimacy of the purpose and function of these important roles.

6. Debriefing Techniques

This core strategy recognizes the usefulness of a thorough analysis of every S/R event. It values the fact that reducing the use of S/R occurs 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 for all witnesses to the event. Recommended debriefing activities include two - an immediate post-event acute analysis and the more formal problem analysis with the treatment team. Using the steps in root cause analysis (RCA) is recommended. (Please see the attached Debriefing Policy and Procedure template.) For facilities that treat kids and who use holds frequently, the use of full debriefing procedures for each event may not be manageable. These facilities need to discriminate their use of holds and target multiple holds on same children, identify same staff member involvement in these events so as to note training needs and explore holds that last longer than usual.

Six Core Strategies for Reducing Seclusion & Restraint Use ℗
Planning Tool
(*Kevin Ann Huckshorn, revised 2008*)

<u>Purpose:</u> The Planning Tool is designed 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, children, and 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 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 individual staff members 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 the event can be carefully analyzed and learning can 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 Human Resources (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 are 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:

A. On-call Executive Role (member of executive team)

   1. 24/7 on call supervision for event analysis
   2. Use knowledge gained by event analysis to identify organizational problems, potential resolutions and ensure timely follow-up
   3. Make S/R a standing agenda item for all meetings at all levels
   4. Ensure that data is collected, used and shared
   5. Ensure staff accountability and performance recognition

B. On-site Supervisor Role

   1. 24 hr on site response, supervision and attendance at all events and near misses when possible (to observe what worked and why)
   2. 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

C. Line Staff (Direct Care)

   1. Understand and be able to describe the organizational approach in reducing S/R
   2. 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

D. Consumer Role

1. Use employed internal consumer staff or external consumer consultants to act as interviewers, gather data, investigate and to provide a critical perspective
2. Representation 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. This includes an understanding of the characteristics and principles of trauma informed care systems. It 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 HR department activities and includes safe S/R application training, choice of vendors and the inclusion of technical and attitudinal competencies in job descriptions and performance evaluations. This 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? (Includes 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. S/R Reduction Core Strategies as appropriate
    h. Risk for Violence
    i. Medical/Physical Risk Factor for Injury or Death
    j. 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 restraint
    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 that assists staff to discriminate between agitated, disruptive, destructive, dangerous and lethal behaviors and decreases the premature use of restraint/seclusion?

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, trauma informed, overall support and behavioral support 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) he 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? 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 or staff, in advocacy roles, also be 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?

Six Core Strategies for Reducing Seclusion and Restraint Use©

Example: Policy and Procedure on Debriefing
for Seclusion and Restraint Reduction Projects
(Kevin Ann Huckshorn, revised 2008)

Policy: The use of seclusion and restraint (S/R) are high risk, problem prone interventions for both consumers and staff and are to be avoided whenever possible. S/R shall only be used in the face of imminent danger and when unavoidable. The use of S/R may cause trauma and re-traumatization in an already vulnerable group of persons and may also cause trauma, stress and injury for staff persons. Preventing the use of S/R is the organizational goal and this includes the mandatory use of debriefing procedures whenever an event of S/R does occur.

Debriefing procedures for the purpose of this policy are defined as three discrete events. The first is titled an "immediate post acute event analysis" and occurs immediately following the S/R episode and with all involved parties including those witnessing the event. The second Debriefing activity is also called "Witnessing or Elevating Oversight" and includes a call from the person in charge of the unit where the event took place to a facility executive staff person to relate what occurred 24 hours/7 days a week. The third Debriefing activity is a formal rigorous event analysis that takes place within 24 to 48 working hours following the S/R event and includes the participation of key professional, administrative and support staff as well as participation by the consumer involved or his or her designee.

It is noted, that with the Centers for Medicare and Medicaid's issuance of the Final Rule on Patient's Rights in January of 2007, that physical holds are now considered restraint. Physical or manual "holds" are most often (but not always) used in child and adolescent units. These holds can be very brief ; often under 5 minutes. For units who now must count these kinds of brief holds as restraint, it is recommended that supervisory staff determine when these holds reach the level of significance that require that activities described in this policy. For some units this may be for kids that require brief holds over 5 minutes, any holds that were disruptive to the unit, more than three holds in one week on the same child, or any holds that resulted in injuries to staff or the patient. Each unit will need to determine their threshold for a thorough review.

IMMEDIATE POST ACUTE EVENT ANALYSIS

Procedure:

1. When the S/R event code is called the onsite clinical supervisor or administrator/designee will immediately respond to the site. The responder will need to be an objective mid-level or senior level clinical staff member with

training in S/R policy and procedures and should not be someone involved in the S/R event occurring at the time.

2. Upon reaching the unit or site of the occurrence, the clinical supervisor will immediately survey the environment and seek to assure that all persons are safe and that processes are orderly. Unless an emergency occurs that requires direct intervention, the clinical supervisor's role is to document what occurred, who was involved, the antecedents to the event, least restrictive alternatives attempted and the results, specific dangerous behaviors necessitating the use of S/R, and the staff's response. In addition the physical and emotional safety of the consumer and other consumer witnesses to the event will be assessed and responded to.

3. The onsite clinical supervisor will document their findings and report these to the executive on-call (or whomever they are supposed to report to). The onsite clinical supervisor shall assist the unit staff in returning the milieu to a pre-crisis level and assure that all necessary documentation has been completely adequately.

4. When possible, the onsite clinical supervisor will attend the formal debriefing. If that is not possibly, the onsite clinical supervisor (whether charge nurse or another person) will need to communicate what occurred through either written documentation, shift report, or phone in participation in the formal debriefing. The point here is that the post acute event information gets passed on up to the formal debriefing activity so that all information is communicated and shared with the entire team.

5. In facilities where there is no onsite supervisor, the charge nurse on the unit will need to take responsibility for these activities. It is always best to have additional staff respond in these kinds of events but when not possible the senior clinical person on the unit will need to do so.

WITNESSING OR ELEVATING OVERSIGHT

Procedure:

1. This procedure expects the senior clinical person responsible for patient care to communicate information regarding a seclusion or restraint event to a designated agency executive staff member 24 hours/7 days a week (in real time). This procedure assumes that agency leadership have already set up an executive staff, on call process, to receive these communications.

2. The senior, onsite, staff person best able to report key information to the executive staff member on call is the one that is expected to make this call and provide the necessary information. Information communicated is critical and can include, but not be limited to the following:

   A. A description of the event (what happened)

B. What was the result (seclusion, restraint, involuntary medication, any injuries to staff or patients

C. Who was involved in events leading up to the seclusion, restraint or involuntary procedure

D. What were the antecedents (patient history, past events, behavior immediately prior to the event)

E. Was there any warning or change in behavior prior to the event and what did staff do?

F. Did we know that this was a high risk for violence person? If so, what had been done to prevent this event?

G. What was the source of the conflict, if any?

H. What did staff do?

I. When the escalating behavior was noted, were other interventions tried, and if so, what and what was the response?

J. Did the person have a relationship with anyone on staff at this time of the event and did that person try to intervene?

K. Was the person offered alternatives and what was the response?

L. Had the person developed a safety plan and was that used?

M. What staff were directly involved and are they ok?

N. Is the person safe and where are they now?

O. What have staff done to prevent another occurrence?

P. What is the person saying at this point, if anything?

Q. Were the event "observers" debriefed and how are they?

R. Were the staff involved debriefed and how are they?

S. Is there anything, right now, that you can add regarding how this event could have been avoided?

T. Can you attend or "call in" for the formal event debriefing and, if not, how can we get your information to the team members who will debrief this event.

U. Is there anything that can be done now to prevent this from happening again?

3. The Executive staff member on call is expected to take this call or call back in a timely manner. It is recommended that this staff person "on call" make informal notes regarding what happened along with any notes that indicate a need to follow-up the next day. These "called-in" occurrences need to be discussed with other senior clinical staff the next working day and all issues requiring follow-up passed on to the appropriate person.

4. In general, this procedure is meant to provide three outcomes. First, to make the executive team well-acquainted with what occurs on units in a timely manner as well as to orient executive staff to the working conditions that direct care staff are facing. Second, this procedure is done to try and make direct care staff aware that the agency leadership is also affected by these events, is supportive, and is available. Third, this activity is designed to make executive staff, with formal power, aware of policy, procedures, and operational issues that could be creating

conflict on units, as well as to help gather information that could be helpful to cover in staff training activities.

5. It is critically important, that unless egregious behavior occurs during an event, that no blaming occurs and that the overall response is not punitive in nature.

6. Finally, it is recommended that the "on-call" responsibilities of executive staff be shared among several of the executive team members. This on-call responsibility can be disruptive at times and more than one person needs to share this load.

FORMAL RIGOROUS EVENT ANALYSIS

Procedure:

1. A formal rigorous event analysis will follow every incident of seclusion and restraint and will occur within the first 24 to 48 working hours post event.

2. The treatment team leader or designee will schedule the formal debriefing and notify all invited participants to include the treatment team, the consumer and/or proxy, surrogate or advocate representative, all other involved parties and other agency staff as appropriate. All care and attention shall be paid to the comfort and safety of the consumer involved and their informed consent and ability to participate without being overly stressed, coerced, or overwhelmed by this activity.

   In certain situations, where the consumer does not want or cannot participate, all efforts will be made to debrief the consumer ahead of time and to gather their input into what occurred and what could have prevented the event. This additional interview will be documented and brought to the formal debriefing by a formal representative and presented as such. Peer staff, if available, should be used to gather this kind of information.

3. The formal event debriefing will begin the process of PDCA (Plan, Do, Check, Act). PDCA is a continuous quality improvement process that provides a stepwise map with which to rigorously analyze a problem and implement effective solutions. "Plan is focused on defining the problem (the event); analyzing the problem for underlying issues and root causes; brainstorming potential solutions based on underlying issues and root causes; deciding on solutions from the bank of potential solutions and creating a plan to implement the solution. "Do" is focused on implementing efforts based on the plan. "Check" is focused on checking the overall process by evaluating what worked or did not work through measurable indicators, making mid-course adjustments or going back to the idea bank if solution fails in the future and revisiting the planning stages if plans did not work or only partially worked. "Act" is establishing a new system, policies, procedures or programs based on positive outcomes and determining how to

sustain and maintain improvement over time. The formal event debriefing activity supports the PDCA process and provides a feedback loop between Act and Plan.

4. Debriefing includes an analysis of: 1) triggers, 2) antecedent behaviors, 3) alternative behaviors, 4) least restrictive or alternative interventions attempted, 5) de-escalation preferences or safety planning measures identified and 6) treatment plan strategies.

5. The facilitator leading the debriefing needs to be clinically skilled in root cause analysis and not directly involved in the event. Questions formulated by the facilitator are directed by the individual characteristics inherent in the event but also share the common characteristic of drilling down to core activities and processes by asking why to the lowest common denominator. The facilitator needs to be skilled and knowledgeable about the common steps in the process of a behavioral escalation that leads to the use of S/R and opportunities for effective staff interventions to avoid, de-escalate or as last resort if S/R is necessary, to avoid injury and minimize trauma. Debriefing processes lead to recommendations for both senior administrative and clinical staff; staff development and direct care staff. These steps are outlined here and include examples of questions that can stimulate thinking and discussion.

S/R Prevention Tree, Staff Intervention Opportunities and Debriefing Questions

Step 1: *Has a treatment environment been created where conflict is minimized (or not)?*

This intervention opportunity asks staff to consider whether the agency has done everything possible to create a treatment setting that prevents conflict and aggression. Potential preventative interventions include the use of person-first language; adopting a trauma informed, recovery focused philosophy of care; comparing actual operational practice, policy and procedures against recovery and trauma informed values; assuring the staff have the knowledge, skill and ability in building therapeutic relationships immediately on admission; making the treatment environment welcoming and non-stressful; using prevention tools such as admission based trauma assessments, risk assessments, safety planning, comfort and sensory rooms and avoiding overt and covert coercion.

Questions to think about or explore:
1) Was the environment calm and welcoming?
2) Was the environment personalized and normalizing or institutional?
3) Was the milieu calm and mostly quiet?
4) Had any staff developed a relationship with the individual?
5) Were there signs about rules, warnings or other indications that might cause a feeling of oppression?

6) Did the individual witness a S/R or other upsetting event?
7) What were the trigger(s) to the aggressive or dangerous behavior?
8) Did we know the individual well enough to know their personal triggers?
9) Was the individual a trauma survivor and if so, did something in the environment create a traumatic re-enaction?
10) What set the individual off?
11) Did anyone on shift talk to the individual or "check in" before the event?

12) Was the individual's behavior a change during the shift or earlier?
13) Did the individual want something before the event occurred?

Step 2: *Could the trigger for conflict (disease, personal, environmental) have been avoided (or not)?*

This intervention opportunity addresses the adequacy of the screening and admission process and the skilled gathering of information, specifically risk factors for conflict and violence that can alert staff to the needs for immediate, preventative interventions. For instance, are staff aware that the individual has not been taking his or her medications for some time and has this issue been addressed immediately on admission? Is information gathered in the pre-screening or admission process relating to the individuals past history of aggression or violence on inpatient units and past experiences of being in restraint or seclusion? Do staff know or try and discover, during admission, each person's individual triggers for conflict, anxiety, fear, discomfort, "fight, flight, freeze" and document these so that they can be communicated? Are advance directives/safety plans developed and used? Does the facility understand the importance of minimizing a rule-based culture of care; minimizing wait times, avoiding shaming or humiliation (intentional and unintentional) of people in daily operations and other institutional issues?

Questions to ask?

1) Did the individual participate in the admission process and treatment planning process?
2) Was a trauma assessment done?
3) Was a safety plan done?
4) Did we know if the person had ever been in S/R before?
5) Did the individual receive a phone call or a visit (or lack thereof) that might have caused escalation?
6) Was the individual worried about anything?
7) Did the individual have to wait an inordinate time for something he or she wanted?
8) Did the individual indicate they needed help, attention or assistance beforehand?

9) Was the individual ignored, treated rudely, shamed, humiliated or consequenced for some behavior?
10) Was the individual taking medication and if so, did they have a therapeutic level? Were they experiencing side effects?
11) Was the individual experiencing signs and symptom of mental illness?
12) Was the individual oriented to the unit and the rules?
13) Is this first admission?

Step 3: *Did staff notice and respond to events timely (or not)?*

This intervention opportunity addresses the staff culture and knowledge base regarding immediate and direct person-to-person responses to changes in individual adult or child behaviors in the milieu. In many facilities staff do not respond immediately due to lack of knowledge regarding types of behavioral escalation that can include both obvious agitation as well as isolative behaviors. In other facilities, staff sometimes have been taught to ignore disruptive or different behavioral changes in the belief that this is attention-seeking behavior and that ignoring it may make it "go away." However, in recovery-oriented facilities, behavioral changes are seen as "attempts at communication" albeit perhaps not clear or direct, that require an immediate and respectful response. Unit staff need to be trained to observe for, detect and respond to changes in the individual behavior or the milieu in general as part of their job and as an important skill in refining the "therapeutic use of self" that is part of being a mental health professional or paraprofessional.

Questions to ask?
1) Who responded and when?
2) Was there any warning that the individual was upset?
3) What were the first signs and who noted them?
4) If no one noticed, why?
5) Should the person have been on precautions?

Step 4: *Did staff choose an effective intervention (or not)?*

This response addresses the knowledge, skills, abilities and personal empowerment of agency staff in identifying an appropriate and least restrictive approach to escalating behavior and then implementing that approach directly and immediately. The ability to formulate an immediate response to an escalating behavioral or emotional problem is not innate and usually requires training and role modeling by clinical supervisors. In addition, the agency culture needs to empower staff to be creative and to, at times, break unit rules to avoid the need for S/R when it is safe to do so. Examples of the latter might include allowing someone to leave group or take personal time in their bedroom during group hours; taking a smoke break to talk to a staff member between smoke break hours; having a snack between meals, being allowed to make a phone call or have a visitor. Unit rules can be interpreted by staff as sacrosanct and this will discourage the use of least

restrictive measures and lead to unnecessary S/R. In addition, fears by staff that "rule breaking will lead to chaos" have not generally been a reality. Individuals who may seem to learn how to get staff to bend rules by acting out will require evaluation by clinical treatment team staff. In general, in our rule based environments, it is fairly easy to label people as manipulative who seek to bend rules but it is important to remember that these rules are institutional in nature and not ones that we apply to ourselves or the client in their natural community.

Staff's ability to be creative and to take the time to try and get to know the individual and his or her needs in crisis is immeasurably helpful and needs to be a part of the expectations for staff knowledge, skills and abilities in the agency job descriptions and performance evaluation process.

Questions to ask?
1) What intervention was tried first and by whom?
2) Why was that technique chosen?
3) Did anything get in the way of the intervention?
4) Did anyone get in the way of the intervention?
5) Was the intervention delayed for any reason?
6) How did the person respond to it?
7) What was the individual's emotional state at the time?
8) What was the staff's emotional state at the time?
9) What else could have been tried but was not?
10) Why not?

Step 5: *If the Intervention was unsuccessful was another chosen (or not)?*

Same as above. Staff need to continue to try alternatives until an intervention works or behavior escalates to the danger level. In the latter situation this is known as "treatment failure" not because the staff person(s) personally failed in their attempt but because the agency did not know enough about the person or had not yet had an opportunity to build a relationship where an intervention could be chosen that was effective.

Questions to ask?
1) Same as above

Step 6: *Did staff order S/R only in response to imminent danger (or not)?*

This step addresses the premature use of S/R for behavior that is only agitated, disruptive or, at times, destructive but where the individual still has control and can be engaged. This step also addresses S/R patterns of use where individuals are restrained or secluded "every time they hit someone or throw something but then stop" or other usually unwritten but common patterned practices. Patterned staff responses for behavioral "categories" such as throwing something, hitting inanimate objects, refusing to get up off the floor, constant pacing, kicking or hitting in one time only "strikes" need to be

discussed and re-framed. At times these patterns are due to staff not understanding common signs and symptoms of mental illness or trauma response histories, leading to individual being blamed for intentionally "acting out" requiring consequences. However, care must be taken to assure that staff need to be free to respond if they feel they are in danger and that unnecessarily restrictive responses will be addressed through training and supervision first.

Questions to ask?
1) What was the exact behavior that warranted S/R?
2) Did it meet the threshold of imminent danger (what would have happened if S/R was not used)?
3) Who made the decision and why?
4) Did the staff member making the decision have good rationale based on training and experience and knowledge of the individual?

Step 7: *Was S/R is applied safely (or not)?*

For every instance of the use of S/R an objective senior clinical staff needs to assess whether staff followed the agencies policy and procedure for application. In addition, for some agencies, policies may need to be revisited for safety in terms of medical/physical risk factors and the use of prone restraint.

Questions to ask?
1) How was S/R applied and did it follow policy and safety precautions?
2) Were enough staff available to assist?
3) Did a professional nurse provide oversight of the event?

Step 8: *Was the individual monitored safely (or not)?*

One to one, face to face monitoring of individuals in seclusion or restraint is the safest way to monitor use. This does not include the use of cameras or only 10 or 15 minute checks. Constant monitoring of the individual where the individual's face is visible at all times is the expected standard in order to observe distress or problems. One to one, face to face monitoring is fast becoming standard practice. This also includes following CMS and JCAHO guidelines as to bathroom breaks, food and fluids, range of motion and extremity checks.

Questions to ask?
1) How often was the individual monitored?
2) Was the individual restrained in a prone or supine position and why?
3) Was agency policy followed and documented?
4) Was the hospital's policy and procedure followed?

Step 9: *Was the individual released ASAP (or not)?*

Decisions on when to release a person from seclusion or restraint often requires the judgment of an experienced staff person who is well trained in the physical and emotional risks inherent in S/R use on human beings, has a thorough knowledge of human behavior, and good clinical judgment. In general, individuals (adults or children) who are currently in seclusion or restraint should not have to "jump through hoops to prove" they can be released. Release criteria should mostly be the responsibility of staff and their assessment of regained control. Usually simple questions such as "How are you doing?" "Do you think you can come out yet?", "Are you able to be released and not hurt yourself or anyone?" are sufficient to assess readiness. Again, for individuals who are unknown or who have histories of intentional violence need to be carefully assessed. For persons who fall asleep, best practice calls for restraints to be released or seclusion doors to be opened but with continued face-to-face observation until person awakes and can be assessed. Hospital policy that expects release in 2-4 hours or less can help staff facilitate release in a timely manner.

Questions to ask?
1) When was the individual released?
2) Who made the decision and what was it based on?
3) Was policy followed?
4) Could the individual have been released earlier?
5) Was release too soon and why?
6) What were the documented release criteria were they used and were they appropriate?

Step 10: *Did Post-event activities occur (or not)?*

This step relates to the agencies debriefing processes. The first, described above, is the immediate acute event response by a supervisor or senior clinical staff member. Goals for the post acute (immediate) response include assuring;
- the safety of the individual, the staff and the witnesses to the event;
- that the documentation is accurate and meets the agency standard;
- that information required to inform a formal debriefing is gathered in real time by a person uninvolved in the incident;
- that the milieu is returned to pre-crisis levels

Also included here is the occurrence of a formal debriefing in a timely, rigorous, problem solving, and stepwise process designed to elicit performance improvement ideas and activities. The formal acute and formal debrief activities need to be documented and filed.

Questions to ask?
1) Did the acute response to the event and formal debriefing occur and what were the timelines?
2) Who led the acute response and were they uninvolved in the event?
3) Was this documented and what happened to the findings?
4) Did the findings inform the formal debriefing or practices in general?

5) Is the formal debriefing documented as to processes and results and where does that go?
6) Were consumer staff or advocates involved in the debriefing process?
7) Did the person attend the formal debriefing or did the person agree to be interviewed by a peer staff person?

Step 11: *Did learning occur and was it integrated into the treatment plan and practice (or not)?*

The integrity of the debriefing process can be measured by the learning that occurs and the changes, revisions, additions, deletions that can be tracked in operational procedures. This debriefing process is a continuous quality improvement process that results in learning from mistakes and crafting new responses including policy and procedure changes, individual treatment plan and de-escalation plan revisions, training and education, individual staff counseling, values clarification, operational rule evaluation and other like events.

Questions to ask?
1) What was learned about the S/R event in the debriefing process?
2) Did this learning inform policy, practices, procedures, rules, the treatment plan, staff training and education, unit rules?
3) Did staff receive training and education or counseling?

Note: This debriefing policy and procedure is to be used as a guide. Toward that end it is probably longer and includes more detail than most policy and procedures. Hospitals and facilities will need to adapt their individual procedure to meet their needs and capabilities. For facilities that are using frequent holds and cannot perform this level of debriefing on every incident, it is recommended that the S/R reduction team determine what frequency or individual characteristics will be put into policy to trigger this level of review. For instance, any child who receives more than three holds a week, any event that results in an injury or a pattern of outlier use by a unit, individual staff member that may indicate additional training needs.