


Reducing the need for seclusion and restraint on an inpatient neurobehavioral unit: Changing the treatment culture

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Objectives




- Project had 3 goal areas for patient, organization, and staff
- Move to a “Zero Restraint” culture
- Enhance patients’ rights
- Decrease workplace injuries
- Comply with regulatory standards

**The project initiative:** To reduce the number and duration of events requiring physical restraint by staff members and placement in a locked seclusion room

**Persons served:** Adults, male and female with Traumatic or Acquired Brain Injury and a co-occurring psychiatric diagnosis

**Demographics:** Male 63% ; Female 37%  
Average Age 41  
Average Age at onset of injury 27




**Problem:**

Patient population with a high rate of events posing potential harm to self or others and high rate of response using seclusion and restraint

**The setting:**  
A 28-bed inpatient neurobehavioral rehabilitation unit with a secure environment

**The baseline period:** Prior to initiating the project the average number of seclusion and restraint events per month were 45-50

- Evaluating the treatment culture:
- Examined the historical response of staff members to verbal aggression and physical violence
  - Observed attempts to attain external control and impose limits on behavioral events
  - Identification of patients who were “high consumers” of seclusion and restraint



**Stratifying Behaviors:**

- Two ways to act out
  - Verbal
  - Physical

- Methodologies
- Resetting the “Go or No Go Response”
    - Assisting staff with identifying if physical response is needed
  - Reframing aggressive behavior
    - Understanding how response may sustain or foster aggression
  - Providing alternative tools and strategies
    - Restructuring Crisis Prevention Institute (CPI) training
    - Identify teams of highly trained staff to respond to Seclusion/Restraint events
    - Assist individual in identifying alternatives
  - Revise restraint training curriculum to better address brain injury issues
    - Establish consistency among all trainers
    - Diversified training between response team members and general staff
  - Provide intensive training and ongoing incident debriefings to reinforce strategies and access to alternatives for individuals and Response Team members to focus the team on effective resolutions of events
  - Use paging system to activate team to location of possible event
    - Provide individual with opportunity to alter their behavior

- Response Team Strategies
- Diminish the emotional response of the involved staff
  - By reducing the number of responders in a behavioral event, we “remove the audience” to reduce external stimuli
  - Create response teams made up of highly trained responders to reduce the number of individuals participating in an event
  - Each seclusion or restraint event requires a staff debriefing (required by JC, CMS standards of care)
  - Conduct staff debriefings on ALL events to maximize learning from events that do not end in seclusion or restraint

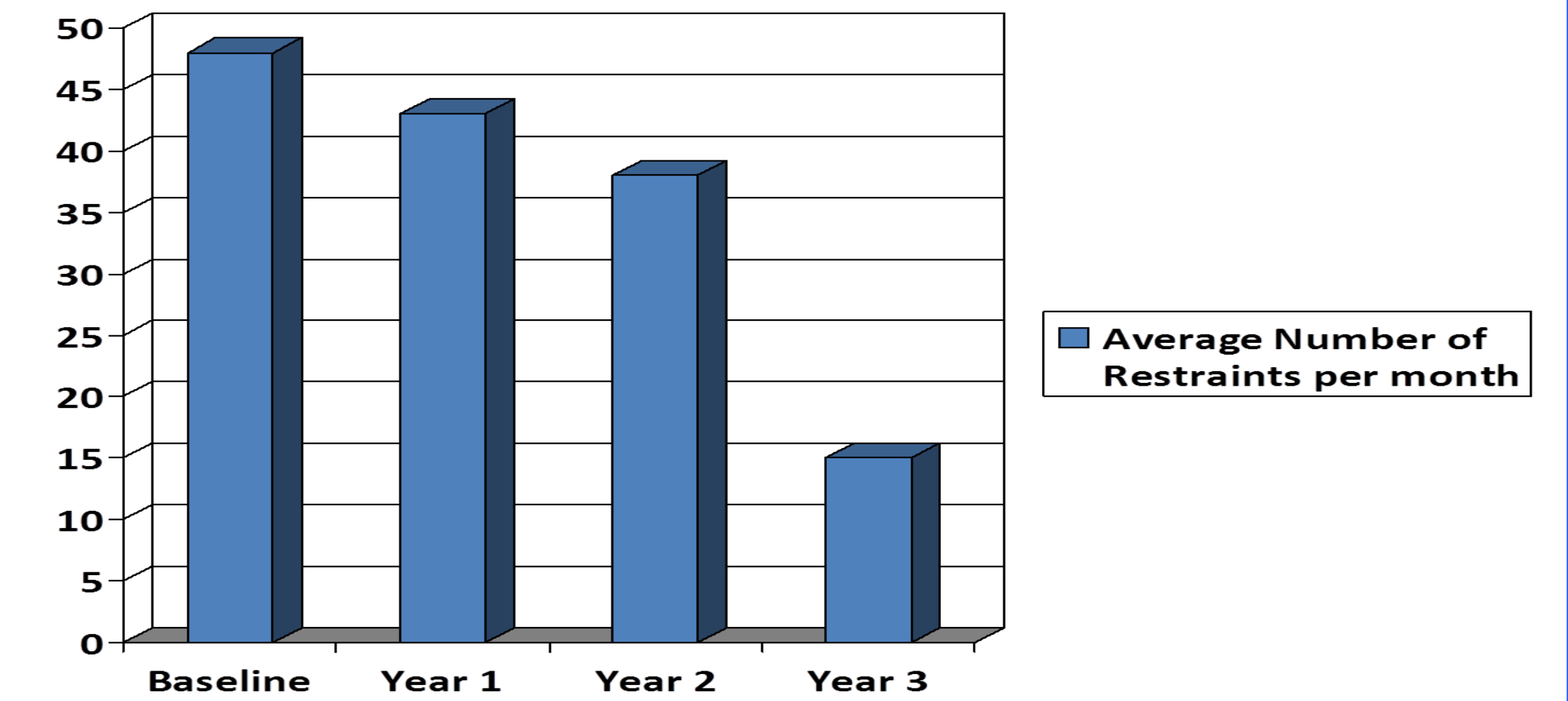
- General Concepts of Training
- Escalation of verbal behavior does not necessarily require restraint
  - The highest level of energy exerted is not sustainable by patient or staff
  - Allow the individual the chance to de-escalate without bringing physical force into the equation
  - What goes up, must come down

- Rule of 2’s
- Behavior = Verbal or Physical
  - Verbal acting out = No restraint
    - “What goes up, must come down”
    - Verbal can escalate into physical
  - Physical acting out = Possible Restraint
    - Establish likelihood of harm to self or others

- Methods of Measurement
- Identified “high consumers” of frequent events
  - Identified staff members involved with “high consumers”
  - Identified other trends such as time of day and types of behavior
  - Implemented logging of all events that required an intervention by our response team, regardless of outcome
  - Evaluated event log each month for events resolved without seclusion or restraint

Results

- 68.09% reduction in Seclusion/Restraint events
- Decreased injuries for both patients and staff



Year	Average Number of Restraints per month
Baseline	48
Year 1	44
Year 2	39
Year 3	16

Summary

- Our Goal: To Reduce Seclusion/Restrains
- Our Plan: Implement Change Agents
  - Create a consistent response mode
  - Improve CPI training
  - Use post-event reviews to analyze success
  - Restore locus of control to the individual to choose alternatives

- Discussion and Future Implications
- Considering the reduction of seclusion and restraint events as causing behavior change for: patients, staff and the organization
  - Humanizing responses to behavior of people with brain injury
  - Generalizing new behavioral responses throughout the organization
  - Maintaining forward momentum through staff recognition of successful resolution without Seclusion/Restraint
  - Attaining durable results by conducting event reviews and incorporating examples of success in future training
  - Establish leadership for change and create “buy in” from staff at all levels to maintain new culture
  - This methodology could potentially be applied to other populations

Standards of Care

- CMS issued regulations on restraints in 2006: Face to face evaluations by an LIP during a restraint became a requirement
- JC issued standards on restraints in 2009: Standards regarding the appropriate use of restraints and seclusions, as well as conducting debriefings
- ANA issued a position statement in 2012: Reduction of patient restraint and seclusions in healthcare settings

Resources

- American Congress of Rehabilitation Medicine, Archives of Physical Medicine and Rehabilitation. (2013). Article 8 Reducing the need for seclusion and restraint in an inpatient neurobehavioral Unit.
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- To view this presentation in slides: [www.traumaticbraininjury.net](http://www.traumaticbraininjury.net)

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- Rolf B. Gainer, PhD has a business relationship with Brookhaven Hospital through Rehabilitation Institutes of America.
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