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

**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

**Summary**

- Our Goal: To Reduce Seclusion/Restraints
- Our Plan: Implement Change Agents
  - Create a consistent response mode
  - Improve CPI training
  - Use post-event reviews to analyze success
  - Restore loci 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 behavioral problems
- 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 become 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 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.
- www.crisisprevention.com

**Disclaimer:**
- To view this presentation in slides: www.traumaticbraininjury.net
- Rolf B. Gainer, PhD has a business relationship with Brookhaven Hospital through Rehabilitation Institute of America
- Matt Maxey, BSN, RN, CBIS is employed by Brookhaven Hospital.
- The authors receive payment from the organization an affiliated organization. The project to reduce seclusion and restraint on the neurobehavioral unit of Brookhaven Hospital is part of ongoing Performance Improvement activities conducted at the hospital. No grant monies or support for the project has been received from any external sources.