



CHOC Children's Hospital *Best Evidence and Recommendations*

Strategies to Reduce Seclusion & Restraints on a Pediatric Mental Health Unit

Jamie Calderwood, BSN, RN, CPN & Dawn Hughes BSN, RN-BC, CPN

jcalderwood@choc.org, dhughes@choc.org

PICO: On a pediatric mental health unit, what are best practices to promote a restraint free environment that is safe, calming, and supportive of patient and family needs?

P (Population/problem): On a pediatric mental health care unit,

I (Intervention/issue): what are best practices to promote a restraint free environment

C (Comparison): (compared to current practice)

O (Outcome): that is safe, calming, and supportive of patient and family needs?

Background

Restraints and seclusions are physical interventions used to contain patient's aggressive behavior in inpatient settings. Such procedures have been considered by patients and their families as aversive and traumatizing, and in the worst-case scenarios, deaths have been reported. According to the CMS and Joint Commission, these interventions are only to be used when there is an imminent risk to the patient or others. More recently a lot of concern about the negative impact has been raised but evidence-based studies of various proposed methods to reduce restraints and seclusions has been limited (Gaskin, Elsom, & Happell, 2007). In the past few years, various regulatory agencies and professional groups such as the Association of Child and Adolescent Psychiatric Nurses, American Academy of Child and Adolescent Psychiatry (AACAP), American Psychiatric Association (APA), Centers for Medicare and Medicaid Services (CMS), and National Association of State Mental Health Program Directors (NASMHPD) have provided specific guidelines to reduce the use of restraints and seclusions (Azeem, et al., 2011). These organizations have emphasized that restrictive interventions should be used in only the most extreme circumstances when patients pose imminent risk of harm to themselves or others (Azeem, et al., 2011).

Apart from physical injury and medical complications, recurring concerns include the psychological impact of restraint and seclusion, both on the children and on the nursing staff and other direct care staff involved in the children's care. Moreover, there is no clear evidence supporting the efficacy of these interventions (Martin, et al., 2015)

Each inpatient unit is unique, with diverse patient populations and staff with varying levels of education and experiences who are working with unit philosophies and practices that have evolved over the years. One major problem is that some of the restraint and seclusion practices that have developed over time, do not support newer evidence-based practices related to "trauma-informed care" or the intentional reduction of restraints and seclusion (Chandler, 2012). For example, current mental health care practices understand that trauma-informed care begins with the recognition that 85% of the patients admitted to inpatient units have experienced serious maltreatment from physical abuse, sexual abuse, or physical neglect (Chandler, 2012). A *traumatic event* is defined as when an individual has experienced, witnessed, or is confronted with an event that involved actual or threatened death, serious injury, or threat that causes intense distress (American Psychiatric Association, 2013). Trauma that results in mental health problems is often



repeated, prolonged, and severe, extending over time. Restraint and seclusion practices may re-traumatize individuals and those witnessing the experience (Chandler, 2012).

Researchers have consistently reported a number of best practices based on analysis of successful seclusion and restraint minimization efforts (O'Hagan, Divis & Long 2008). Best practices that contribute to seclusion and restraint reduction include: a national direction that supports seclusion and restraint reduction and elimination efforts, active, committed and high profile organizational leadership and oversight, and an organizational culture that embodies recovery oriented approaches to trauma informed care (O'Hagan, et al., 2008). Workforce development is another crucial aspect of successful reduction efforts and includes recruitment, education, supervision and staff involvement initiatives (O'Hagan, et al., 2008).

Beginning in February 2018, CHOC Children's Mental Health Inpatient Center provided standardized education and training to all unit staff, including trauma informed care, motivational interviewing, comprehensive crisis management, and therapeutic communication. These align with the recommendations supported in the literature. Since opening in April 2018, 95% of patients who have been admitted, have received care free of restraints or seclusion. The purpose of this evidence-based practice project was to conduct a comprehensive literature review to identify best practices that will continue to support a restraint free environment that is perceived by patients and families as safe, calming, and supportive of their care needs.

Search Strategies and Databases Reviewed:

- Databases searched for this review included CINAHL, Medline, Pub Med and Google Scholar. Key search words: restraints, seclusion, pediatric mental health, adolescent psychiatric units, best practice for restraint free environment, and trauma informed care. This search yielded 11 articles that were relevant to our topic which described preventative measures used to reduce restraints and seclusion on inpatient mental health units.
- Patient restraint and seclusion data obtained from CHOC Cerner database.

Synthesis of Evidence:

- Several studies from 1989-2017 provided evidence that the use of restraints and seclusion in child, adolescent, and adult inpatient settings can be reduced through a systematic approach.
- Cumulative findings of the 11 studies support strategies based on trauma informed and strength based care, with a focus on primary prevention principles to create a culture of safety. Strength based care includes an affirming culture, a focus on the child/adolescent's positive behavior, support for his or her participation, and an emphasis on de-escalation strategies (LeBel, et al., 2004).
- Implementation of (NASMHPD) National Association of State Mental Health Program Directors 6 core strategies shows a downward trend in seclusion and restraints among hospitalized youths. These strategies included (a) leadership towards organizational change, (b) use of data to inform practice, (c) workforce development, (d) use of restraint and seclusion reduction tools, including identifying patient triggers and calming techniques, utilizing comfort room and sensory rooms, providing recreational activities, and employ therapeutic communication such as motivational interviewing, (e) improve consumers role in inpatient setting, and (f) vigorous debriefing techniques (Azeem, et al., 2011).
- A common theme among all articles was the need for healthcare providers to work with the patient/family to identify triggers and calming techniques upon admission to create an individualized plan of care.
- Post restraint or seclusion episode, effective debriefing with staff and the patient is essential to evaluate for seclusion and restraint reduction (Azeem, et al., 2011).



- Limited evidence is available regarding implantation of a family centered care approach during inpatient hospitalization and its effect on decreasing restraints and seclusion.
- Though milieu and direct peer observations were identified as effective strategies to reduce restraint use, limited to no evidence was identified regarding manipulating the use of the milieu to deescalate patients in crisis.

Practice Recommendations:

After thorough review of the literature, it was determined that our organization's current practice for a restraint free environment on a mental health inpatient unit is consistent with the best practice recommendations described in the literature. However, we identified an opportunity to develop strategic initiatives to implement trauma informed and strength based care to reduce restraints and seclusion.

- Collaborate with key stakeholders to create an evidence-based strategic approach to restraint reduction for patients admitted to the mental health unit at CHOC Children's.
- Collaborate with multidisciplinary team to monitor and evaluate effectiveness of practice and make changes as new evidence becomes available.
- Formulate a "restraint and seclusion reduction committee" to monitor, compare and track patient data including:
 - Number of patients requiring seclusion
 - Number of patients requiring restraints
 - Time spent in restraint/seclusion
 - Time of day restraint/seclusion occurred
 - What restraint/seclusion reduction techniques were utilized (if any)
 - What triggers were identified prior to restraint/seclusion
- Provide initial and quarterly education to mental health staff and providers regarding trauma informed care and reduction techniques.
- Develop and initiate individualized plan of care based:
 - A comprehensive list of physical, emotional, and cognitive responses to stress
 - Triggers that create stress
 - Activities that are calming
 - Experience with restraints and seclusion (Chandler, 2012).
- Post crisis, evaluate with staff and patient, effective strategies utilized to deescalate situation thus avoiding restraint or seclusion. Assess non-successful strategies and revise as needed (Azeem, et al., 2011).
- Collaborate with informatics department to implement an individualized plan of care in the electronic medical record.
- Implement the use of debriefing tools after each restraint and seclusion event, with both patient and staff, and perform face-to-face assessment with patient within one-hour post restrain/seclusion (Kalogjera, et al., 1989).
- Create standard reporting following a restraint and review of the circumstances that led to the incident to increase supports or accommodations as ways to prevent future restraint use.
- Institute procedures for notification of parents or guardians regarding restraint or seclusion episode.
- Provide quarterly updates to healthcare staff at Grand Rounds and staff meetings to ensure transparency of ongoing quality improvement project (LeBel, et al., 2004)
- Celebrate success by posting on the Safety Board in the staff breezeway the "number of days since last restraint or seclusion" (Chandler, 2012).



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