Reduce inpatient violence: 6 strategies

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Active, unwavering, and visible commitment of hospital leadership is key to reducing violence and restraints

The least effective, most costly method of reducing patient violence is to attempt to contain it after it has occurred. If containment includes using restraints, staff and patients are at additional risk for injury.

Our facility, a 315-bed, medium-security forensic program and a 75-bed civil program, is in its 16th year of violence and restraint reduction.[1] We have reduced restraint usage by >95%, and our hospital is one of the safest in our state. In March 2010, we were 1 of 10 institutions recognized by the Substance Abuse and Mental Health Services Administration for our efforts in reducing and preventing use of seclusion and restraints. If your facility is interested in such efforts, we recommend becoming familiar with the Six Core Strategies Planning Tool.[2]

Leadership toward organizational change. Any restraint reduction program is likely to encounter resistance. Active and visible presence of hospital leadership is essential to success. According to LeBel,[3] "Advancing seclusion and restraint standards is in the hands of administrators. The knowledge… is available, but it takes leadership, courage, and effort."

Using data to inform practice. Leadership's most effective tool is data. When we began our efforts in 1995 by doing nothing more than telling staff we would be tracking restraint usage, usage decreased by 36%. Next, leadership reduced the maximum time for a restraint order from 4 to 2 hours. Eventually, we reduced the maximum time to 1 hour. Restraint orders seldom required renewal.

One of the most useful pieces of data we developed established that on average, our well-trained staff incurred injuries severe enough to require medical treatment in 1 of every 4 instances of applying mechanical restraints. All staff could appreciate that as restraint usage was reduced, the number of associated staff injuries also would fall.

Workforce development. Leadership's most valuable resource is its workforce. Experience showed that a substantial number of restraint episodes started with rigid enforcement of unit rules. We provide staff with the tools necessary to make clinically based decisions, rather than relying on strict adherence to rules. Staff should never get the impression that patients are being empowered but staff are not.

Initially, we relied on a "champion" or "train the trainer" model. This proved nonproductive because our message often was distorted by the time it reached direct care staff. We developed a half-day training program in which our hospital administrator and medical directors participated. In 16 sessions over 9 months we trained 590 clinical staff, security officers, and other support personnel. Training included interactive education in the public health

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prevention model, principles of recovery, trauma informed care, and conflict resolution. Recovery specialists and patients were among the presenters. We acted out and analyzed conflict scenarios based on actual experiences on the units with varying approaches. We learned that a number of our direct care staff had informally developed various techniques for successfully resolving problematic situations in a noncoercive manner. We celebrated these staff members and incorporated their ideas into our training sessions.

Ongoing efforts include sessions for direct care staff on subjects such as relaxation techniques, verbal de-escalation, and fundamentals of a mental status evaluation. These are conducted primarily by staff psychologists or incorporated into required annual staff training.

Use of seclusion and restraint reduction tools. Our psychiatric evaluation, which included a thorough assessment for violence risk, was revised to include assessment of risk factors for restraint use. Nursing assessments were revised to include history of restraint or seclusion use, options for early intervention, and patient preferences for anger management and interventions. Intake areas and common rooms were repainted and amenities added to create a more pleasant, less institutional atmosphere. For a description of comfort rooms, visit www.power2u.org/downloads/ComfortRooms4-23-09.pdf Where there wasn't space for a comfort room, we created comfort kits, which include items such as stress balls, word games, and soothing pictures. These kits are for patients' benefit and patients should have a role in designing them. Use is voluntary. Comfort kits are not a substitute for therapeutic involvement or necessary seclusion or restraint to prevent imminent injury.

Consumer roles in inpatient settings. Patients are an often-overlooked resource. They too have a vested interest in hospital safety. We involved patients in staff training sessions. Consumer councils were consulted on relevant hospital policy changes and participated in revising the hospital's Patient/Family Handbooks. Patient/staff workgroups were asked to replace ad hoc unit rules with expectations for civil behavior that apply to patients and staff. Patients were trained to co-lead groups dealing with accepting responsibility for their own recovery.

Debriefing techniques. The patient and staff are debriefed after every restraint and seclusion episode. A nurse and psychologist debrief the patient, focusing on what the staff and patient could have done to avoid the incident. A recovery specialist and a medical administrator attend each debriefing. The focus initially was to justify restraint and seclusion use, but quickly broadened to include exploring early signs that if recognized and addressed could prevent a repeat incidence.

Different hospitals may place different emphasis on each core strategy. In our experience, the 2 strategies most important to positive results were:

• active, unwavering, and visible commitment of hospital leadership to reducing violence and restraints, and

• timely analysis of relevant data, and the determination to address the results of such analysis in a coherent and collegial manner.

References
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3. LeBel J. Regulatory change: a pathway to eliminating seclusion and restraint or "regulatory scotoma?" Psychiatr Serv. 2008;59:194-196.