

Organizational Systems to Minimize Restraint and Maximize Dignity, Effective Treatment and Safety

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Introduction

In October, 1998, a group of journalists working for a Hartford, Connecticut newspaper published a series of articles entitled “Deadly Restraint” that startled the American public. The Hartford Courant articles explored the deaths of one hundred and forty-two children and adults who died in the process of restraint. These deaths occurred in one hundred and twenty-two hospitals and residential facilities over a ten year period. As defined in “Deadly Restraint:”¹

Physical restraint is:

- A broad category of restraints in which a patient’s movements are restricted by the use of physical force.
- This action is usually taken to prevent an upset or agitated person from hurting himself or others.

Mechanical restraint is:

- A broad category of restraints in which a patient is immobilized through external devices such as straps, belts, wrist and ankle cuffs, or restrictive clothing such as straitjackets.

The Hartford Courant journalists conducted research in fifty states and compiled a nationwide database about restraint-related deaths. The process of bringing this information together made visible a nation-wide pattern of that had previously been identified in specific localities. The impact of the report was intense. Knowledge of the pattern of deaths demanded action. It stirred a national dialogue among human service and behavioral healthcare providers, regulators, accreditors, consumers, advocates, legislators and the general public. The Courant articles brought the national dialogue on restraint to a new level.

Restraint is a procedure that has been utilized since the beginning of organized care for individuals with mental illness. Restraint has received a great deal of attention in the professional literature over the years and has been addressed in accreditation standards and in state regulations. Studies on the use of restraint have appeared in the literature as early as the 1700’s. Phillipe Pinel, the noted French physician who brought compassionate innovations to field of psychiatry wrote about the use of restraint in 1794:

“If a madman suddenly experiences an attack and arms himself....., the director-always mindful of his maxim to control the insane without ever permitting that they be hurt-would present himself in the most determined and threatening manner but without carrying any kind of weapon....At the same time the servants converge on him at a given signal, from behind or sideways, each seizing one of the madman’s limbs...The

¹ Hartford Courant, October, 1998

employees are expressly forbidden to retaliate even if they are hit.”² This description is depressingly contemporary in it’s sound.

There have been numerous other studies, task forces, and position papers, many of which were created in response to patient deaths. Here is a small sample:

- During the 1800’s, Benjamin Rush advocated the abolition of instrumental restraint in the service of custodial control.
- In 1844, Issac Ray stated the position of American psychiatry at the founding meeting of the organization that was to become the American Psychiatric Association: “Resolved that it is the unanimous sense of this convention that the attempt to abandon entirely the use of all means of personal restraint is not sanctioned by the true interests of the insane.”
- Preventing Child Abuse and Neglect: A Guide for Staff in Residential Institutions, U.S. Department of Health and Human Services, April, 1980
- Report of the Task Force on Restraint and Seclusion, New York State Office of Mental Health, March 1993.
- Toward a Restraint Free Environment, Braun and Lipson, 1993
- Deadly Restraint, Hartford Courant, October 11, 1998

Everett Rogers wrote about the process of adopting new technology in his book Diffusion of Innovations. He described, for example, the process of change involved in controlling scurvy in the British Navy. Hundreds of men used to die of scurvy during long sea voyages. Of the one hundred and sixty men that sailed with Vasco de Gama around the Cape of Good Hope in 1497, one hundred died of scurvy. The first controlled experiment to evaluate the use of lemon juice to prevent scurvy was conducted in 1601. One hundred and fifty years later, the experiment was replicated. Forty-eight years later, the British Navy eliminated scurvy by using citrus fruits. Seventy years later, in 1865, the British Board of Trade implemented a similar policy and eliminated scurvy in the merchant marines.³ In retrospect, it is incredible that men continued to die when the solution had been identified. In reality, the process of change can be incredibly difficult and apparently irrational.

Rogers studies the way that innovations are diffused into the culture. When you look at it from Rogers’ point of view, the identification of the fact that the use of restraints involves the risk of death is in the first stage of the process.⁴ The innovations that will either prevent the use of restraint, or prevent death from restraint are still being developed. We have accomplished this first step, but the next step is the creation of an innovation that will solve the problem. There may be organizations that have created restraint-free environments, but according to the literature, there is no set of clearly

² Fisher, 1994.

³ Rogers, Diffusion of Innovations

⁴ Rogers, Diffusion of Innovations, page 132

defined, accepted, researched processes that have been demonstrated as successful in eliminating the use of restraint or eliminating death and injury if restraint is used.

People continue to die and experience trauma and injury while they are being restrained. We all find ourselves enmeshed in an undesirable system, how do we change it? There is a great deal of hard work ahead as we study, learn, teach, experiment and develop information about how to create systems of care that are safe, effective and provide for the dignity of the individual.

What do we know about the process of restraint? This article will review some key findings in the literature. It will also include recommendations for a framework of processes that can constitute a well formed approach to restraint reduction, dignity and safety. The statements from the literature in this paper are not intended to represent an accepted standard. Many of the findings were from single organizations and small samples. The findings are often contradictory. This review can be viewed as a statement of themes found in the literature. I hope that this review will stimulate thought, the development of the profession and further study and research.

Components of a Well-Formed Organizational System to Address Restraint

If an organization is to excel in providing a safe environment that respects the dignity of the individual, certain systems must be in place. What are these systems? What structures and processes must an organization have in place in order to minimize the use of restraint and maximize the safety of this process if it is utilized? This article will cover these organizational systems:

1. Leadership
2. Treatment Program
3. Assessment and Treatment Planning
4. Human Resource Issues
5. Accountability and Client Rights
6. Restraint Processes
7. Review of Selected Training Programs
8. Performance Improvement
9. Sentinel Events and Root Cause Analysis
10. Risk Management

1. Leadership

What does the literature tell us about leadership and restraint?

- Organizational culture is a stronger predictor of the use of restraint and seclusion than the clinical picture of the individuals served.
- Restraint is used infrequently in Europe. This poses the question: Are patients in Europe less in need of restraint, or is this an indication that European treatment methods minimize the need for restraint?
- Organizations continue to use procedures despite the fact that they are known to be dangerous and despite the fact that some clinicians do not believe that the procedures are very effective.

Policy

- The rationale for the use of restraint, varies greatly from organization to organization.
- Restraint has been considered as having therapeutic value in some organizations. Other organizations consider the sole purpose of restraint is as a safety intervention.
- Policies generally agree that restraint may be used if the individual is a danger to self or others.
- Restraint is applied for the purposes of behavior management in some organizations.
- In some organizations, the procedure is used as a contingency in a treatment plan developed from an analysis of the individual's behavior.
- Clearly defined procedures are crucial, but there are no widely accepted standards, policies and procedures among treatment facilities.
- Numerous professional organizations, and accreditation and regulatory bodies have developed restraint standards.

- Interview with the Director of Quality Improvement, at a Pennsylvania State Hospital:
 - The primary factor that enabled the State Hospital to reduce restraints was a clear decision by leadership to reduce or eliminate restraint use.
 - The factor that enabled the shift away from restraint was a change in the staff's perception that they had the ability to exert power over the hospital patients.
 - The elimination of restraint as a major approach to behavior management resulted in few significant changes in risk to the clients.
- Experience at KidsPeace:
 - We were able to reduce holds in residential treatment by 64% over a period of six months.
 - The reduction was based on a strong leadership statement that involved: numerous "town hall" meetings on the subject, attention to data and the use of quality improvement teams.

Solutions

- In order to effect improvement in the organization, there must be proactive leadership from the highest level of the organization.
- Demming teaches us that the large majority of what goes on in an organization is the result of the way the leaders have set up the processes that compose the work of the organization.
- That is, the way the leaders define the process (or allow it to be defined) determines 99% of the outcome.
- Leaders are responsible for creating an organizational culture that supports effective treatment, safety and dignity.
- Parallel process: As the leaders treat the staff, so the staff treat the clients. If staff work in an environment empowerment, safety and dignity, they will be more likely to treat the clients in the same way.
- In order for leadership to be effective, there must be effective systems for translating leadership from the top of the organization to the place where client care takes place. If one or more links in the change are not there, or are weakly implemented, leadership impact will be diffused or non-existent at the client care level. Here is a metaphor: With a heavy steel rod used as a lever, the energy exerted at the end is effectively translated to where the work gets done. A leader can move heavy rocks and obstacles. Attempting to exert leadership in the absence of effective organizational systems, however, is like trying to use a slinky for a lever. In absence of effective systems, therefore, you get a lot of movement at the top, a great deal of wavering in the middle, and aimless, ineffective flailing about at the end.
- Leaders must have these systems in place that support the minimal use of restraint:
 - Organizational culture
 - Mission and vision
 - Values
 - Clearly defined treatment philosophy
 - Clear, effective policy
 - Program design
 - Operational guidelines and protocols at the unit level
 - Performance measurement and improvement systems
 - Program evaluation to determine the gap between the formal systems and daily operations.

2. Treatment Program

What have we learned about the use of restraint in treatment programs?

History

- The literature indicates a long history of the use of restraint.
- There have been numerous studies over the years. Many were instituted in response to deaths in restraint.

Patient Response

- The use of restraint can result in death, physical and psychological trauma.
- Restraint can result in retraumatization for victims of sexual abuse.
- Some studies have shown that the individuals who experience restraint and seclusion do not feel that the procedures were implemented with safety and dignity.
- Many individuals experiencing restraint believe that the procedures were applied based on a desire to control and gain compliance rather than to maintain safety.
- Individuals who are restrained often retain a negative impression from the use of these procedures. This impression negatively affects their perception of treatment.
- Other individuals have reported that the use of restraint enhanced the therapeutic relationship.
- Individuals appreciate the efforts of staff to minimize the use of these procedures.
- In some locations, patients report feeling safer when these procedures are used with other patients. Also, they report the perception that the other patient “got what he deserved.”
- Client perceptions indicate that they felt they were not a danger to self or other prior to restraint and that restraint was used as punishment.

Cause of death

- Respiratory and cardiac failure account for two thirds of the deaths in the Hartford Courant study.
- Other risks associated with these deaths were: drug or medication-related, cerebral-related causes, blood clotting, and other causes.

Issues associated with the implementation of restraint

- Physical violence is the most common antecedent to restraint.
- Staffing levels can have a significant impact on the use of restraint.
- Escalating patterns of noncompliance leads to verbal threats and physical aggression, which can result in restraint.
- Countertransference issues significantly impact the use of restraint.
- Staff counter-aggression can result in escalating levels of violence.
- The use of restraint is more likely to be related to environmental factors than intrapsychic factors.
- There is little relationship between the use of restraint and client characteristics. Organizational culture and procedures are a higher predictor of the use of restraint.

- The use of restraint has no clear impact on outcomes, though it can reduce dangerousness and injury.
- The incidence of violence in psychiatric facilities is significant and under estimated.
- Although restraint may be moderately successful in managing an immediate crisis, staff are less effective in helping patients manage their own aggressive behaviors.
- From the point of view of learning principles, the use of restraint may be aversive and it may also serve to reinforce aggressive behavior.

Solutions

Program design

- The program must be designed from the ground up to minimize the use of force and maximize effective treatment and client dignity.
- Specify, test and improve treatment protocols. When effective treatment is going on, restraint is less likely.

Systematic approach to behavior management

- Clearly define and train procedures for proactive milieu management, e.g., scanning, tracking, attention to emotional tone, etc.
- Define the theoretical base/treatment philosophy underlying the behavior management approach. Without it, the behavior management system can be fragmented or contradictory.
- Define positive, respectful approaches to issues of discipline with children and youth
- Over-use of power and control approaches can result in a counter power response from the individual. Design approaches to behavior management that minimize unnecessary confrontation.
- Control access to violent media in 24 hour settings

Systematic approach to time-out

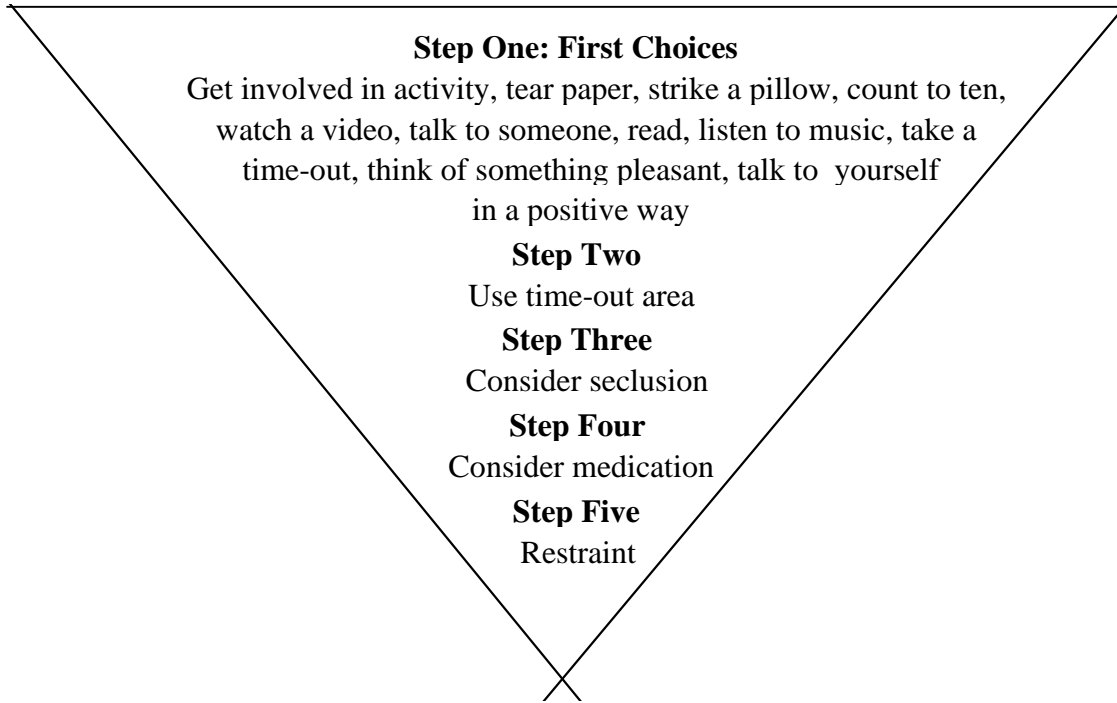
- Encourage client-initiated time-out.
- Define clear approaches to staff-initiated client time-out.
- Create expression spaces for clients to deal with feelings that can be vented physically.
- Address time limits.
- Clearly define release criteria.

Cognitive/Behavioral System for Clients and Staff

- Define a cognitive/behavioral system common to both staff and clients for identifying and addressing thoughts, feelings and behaviors that signal the potential for injurious behavior.
- Training materials will need to address both developmental and problem-specific approaches (e.g., aggressive acting out and psychotic behavior).
- Define treatment protocols for aggressive behavior.

- The system is addressed as a part of treatment plans, milieu meetings, individual sessions, group sessions

Example of educational materials for staff (adapted from Visalli, et al ⁵)



Crisis Prevention

- Design, train, implement and measure a formal approach to Life Space Counseling
- Create a system for triggering Treatment Team meeting in response to escalating tension.

Medication

- Chemical restraint: according to HCFA, this is the most restrictive form of restraint, more restrictive than mechanical restraint.
- Ensure that systems for appropriate use of medication are well designed.

Appropriate touching

- Develop methods to include legitimate and appropriate physical contact.
- This is particularly important in treating young children.

⁵ Visalli, et al, Reducing High-Risk Interventions for Managing Aggression in Psychiatric Settings

3. Assessment and Treatment Planning

What have we learned about the assessment and treatment planning?

- The concept of the advance directive is recommended by consumer advocacy groups. This consists of discussing the issue with the individual while they are calm and coherent to identify triggers, prevention and methods that will minimize psychological trauma and physical injury.
- A history of sexual trauma places individuals at higher risk for psychological trauma during restraint.

Solutions

Clinical Assessment

- Evaluate the individual's history of physical and sexual abuse to determine whether or not this may affect how the individual responds to restraint
- Develop a system of advance directives. At admission, discuss how to avoid restraint and how to utilize restraint to avoid trauma and injury
- Develop an assessment procedure that identifies the risk for aggressive behavior and restraint. The findings from this assessment should then trigger treatment protocols.
- When there is escalating tension, the ongoing assessment process should trigger a treatment team meetings to address the issue.
- Assign clients to the level of care that maximizes client safety. E.g., avoid mixes in acuity, IQ and diagnosis that will allow/encourage client aggression.

Treatment Planning

- Develop behavioral management plan specific to the individual's needs, with the individual's and family's participation.
- In the treatment plan, address high risk issues identified in the assessment.
- Set a trigger for review of the treatment plan based on the individual's rate of restraint use.
- In cases where restraint is used repeatedly, use the services of a behavioral analyst to assess the contingency and reinforcement patterns that are influencing client and staff behavior. Develop a treatment program based on this analysis.

Clinical review of restraints

- HCFA rules/JCAHO standards require an interview by a Licensed Independent Practitioner after each restraint
- In the absence of HCFA/JCAHO standards, an individual with a masters degree in a clinical discipline should be responsible for clinical review of all restraints, including an interview with the client and the staff involved.

4. Human Resource Issues

What have we learned?

- We have learned that in many organizations staff members do not have levels of competency in the safe and respectful utilization of restraint and seclusion.
- Effective staff training is crucial.
- Staffing ratio is an important variable affecting the use of restraint.
- Staff feel safer when these procedures are utilized.
- Frequent use of restraint is hard on staff and can result in high turnover rates.
- Training in prevention approaches can significantly lower the use of restraint.
- There is little research on staff perceptions of restraint.
- The informal culture of direct care staff can be more powerful than the formal culture defined by the leadership.
- There is a “tradition of toughness” among treatment staff that is contrary to the use of cooperation and persuasion.

Solutions

Training

- Specific set of behavior management protocols supported by specific training procedures and behavioral definitions of competency.
- Clearly defined processes and staff competencies in prevention, de-escalation and response to crisis situations as well as restraint
- Dynamic leadership in training. The training system will succeed to the degree that your trainers believe in the system and dynamically communicate this belief.
- Initial and ongoing training and competency measurement in prevention, de-escalation and response to crisis situations
- Ongoing assessment and improvement of training systems
- Certification and re-certification is crucial for competency as well as risk management
- Train staff on how to recognize respiratory distress.

Supervision

- Supervisory approaches should encourage personal growth. It is crucial to deal with our own emotional baggage so that we can focus clearly on the client’s needs.
- Assist staff in developing objectivity, that is, focusing on the client’s emotional issues, rather than interpreting behavior as a personal assault.
- Staff responsibility should be assigned based on their competency and maturity level.
- In addition to certification and recertification systems, developing and improving competency on the front line should include these systems:
 - Performance evaluation that addresses crisis management
 - Ongoing work-group review
 - Practice working together as a team
- Consider a system whereby staff members are required “tap out” a colleague that has lost control/objectivity. “Tap out” is a physical and verbal cue that says “I’m

relieving you and taking responsibility for this interaction.” This is helpful when a staff member has lost objectivity.

Staffing

- Hiring and recruitment of competent staff
- Ensure that there are adequate staff/client ratios
- Consider a system for flexing staff ratios based on client level of severity

5. Accountability and Client Rights

What have we learned?

- Many organizations have poor systems to protect client rights
- Systems of external accountability are not effective.
- HCFA, JCAHO and many state regulatory bodies are working to make standards higher and reporting of sentinel events more consistent.

Solutions

- Many organizations have found that using an external group to assist in the assessment of client rights, dignity and safety has been useful. Developing a partnership with an advocacy group should be considered.
- Consider creating an ombudsman position to address client rights issues.
- Many organizations utilize a system of client interviews after restraint events to obtain the client’s point of view and to address any post trauma issues if necessary.
- Consider a client code of behavior developed in partnership with the clients and families that includes:
- Develop a system of advance directives: seek out parent feedback when the client is calm and coherent about how to avoid physical holds
- Client/Family Feedback
 - Create formal client/family advisory groups
 - Regularly interview clients on safety and dignity-related issues
 - Obtain family and client feedback and input on the use of restraint

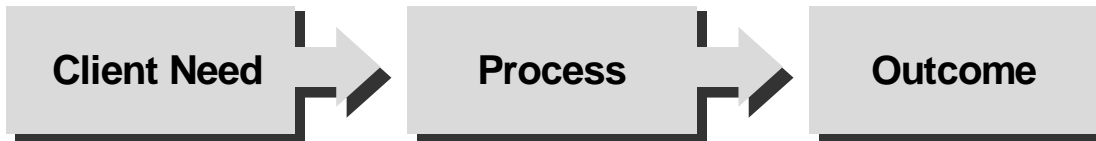
6. Restraint Processes

What does the literature tell us about restraint processes?

- This author has found no research that addresses the specific processes used in restraint.
- There are numerous training systems available with wide variability in content.
- There is no national standard for restraint process.
- Any restraint should be considered to have the potential for serious harm or death.
- The major causes of death in restraint are asphyxiation and cardiac failure.

Solutions

Without a sound process, you can not expect to have a positive outcome. The organization must have a clearly and highly specified defined restraint process. Without a clear process, you can have no control over the outcome. This means the creation of highly specified policies and procedures. For most organizations, this also means purchasing of the services of a training organization. Here is a simple diagram that emphasizes the importance of the process.



Choosing a restraint training system

This author reviewed numerous restraint systems and was certified as a practitioner in several systems. I saw trainings that allowed participants to engage in counter aggressive behavior and I saw a training that encouraged staff to put clients up against the wall as a method of control. I saw training systems that had highly specified training procedures and systems that were less specific. Do not assume that the restraint or prevention system is sound and therapeutic. Evaluate it for yourself.

- I recommend using a professional provider rather than a “home grown system.”
 - Certification by a company that will go to court with you is a benefit from a risk management point of view.
 - It is very difficult and time-consuming to design a safe system. Make use of the experience and expertise of organizations who have tested their procedures.
 - Recognize that this will be an expensive process both in terms of fees and staff time.
- Prior to choosing a training program, clearly and specifically define your criteria.
 - Consistency with organizational culture
 - Appropriateness to the population served
 - Other criteria defined by your organization and regulatory requirements
 - See the appendix for an example of a decision matrix.
- Process of choosing a training system
 - Involve staff who will use the process
 - Define your training needs and the ability of the company to meet these needs
 - Search for candidates that meet your criteria
 - Screen them
 - Have members of your staff, including direct care, take the training prior to making the final choice.

-Talk to customers who have used the system

- Implementing a new system
 - Be prepared for resistance to change
 - Strong leadership commitment and communication is necessary.
 - To a man whose only tool is a hammer, everything looks like a nail.** In the absence of effective treatment systems, the use of restraint can increase.
 - Also be aware that with the implementation of a restraint training system, you will be likely to see an increase in the use of restraint after the training. This should subside, but only if you have strong systems of therapeutic care and only if your staff is competent in basic therapeutic approaches.

7. Review of selected training systems

These systems are primarily focused on prevention:

Crisis Prevention Institute provides nationally recognized training. Their approach stops short of a well defined physical approach, but their verbal approach is very good. They can be reached at www.crisisprevention.com.

Nicholas Long leads the **Life Space Crisis Intervention Institute**. They teach a system designed for schools that is based on getting the child involved in thinking and talking about the issues. It is a counseling approach that is designed to decrease the occurrence of escalation in the first place. Dr. Long can be reached at, 301-733-2751.

These include both prevention and hands-on approaches:

Safe Physical Management by JKM Training is highly regarded by the Department of Public Welfare in Pennsylvania. It is a very good system, with very good training materials. I took the training. It was professionally done. It was designed for children and youth.

JKM Training, Inc.
RR#1 Box 771, Polecat Road
Landisburg, PA 17040
Phone 717-789-9339
jkm@pa.net

Professional Crisis Management Association is very professionally designed. The system is under continual improvement. I believe it came out of adult settings, but it is appropriate for children and youth. The physical part of the system is based on non-verbal feedback from the individual. This program has superior training and criteria for release from restraint.

The Professional Crisis Management Association, Inc.
4321 NW 93 Way
Sunrise, FL 33351
800-341-4699

pcma@msn.com

Physical Management of Aggressive Behavior grew out of psychiatric services in Texas. It is widely used in the state of Texas and is also being applied in other states. The system involves a “floor hold” in which the individual is on his or her side. It thus minimizes or eliminates pressure on the respiratory system. A “life-space” counseling approach is integrated into the system.

Satori Learning Designs, Inc.

P.O. Box 6295

San Antonio, TX 78209

210-828-3563

8. Performance Improvement

What have we learned?

- Processes inevitably move toward chaos in the absence of a systematic measurement and improvement process.
- A rigorous measurement and improvement process is particularly important in the case of such a high risk, problem prone procedure.
- The literature of quality improvement indicates that system variables account for 99%⁶ of the cause associated with process outcomes.
- There is a lack of a systematic method across organizations for the measurement and improvement of these processes.
- Process behavior charts (control charts) are used in many locations to great advantage and is an analysis standard for JCAHO.

Solutions

Leadership

- Strong organizational leadership is necessary for the creation of a well formed performance improvement system.
- A clearly defined approach to measurement, analysis and improvement are necessary.
- Clearly defined staff roles and competencies in performance measurement and improvement.

Resources

- Clearly defined organizational structures are necessary to support continual performance improvement. This may be assigned to dedicated staff, committees or work groups.
- Human resources sufficient to support these structures

Data collection systems

- Create a formal method for collecting data
- Options for data collection: paper form, scan, fax, direct computer entry
- Collect data on 100% of events
- Provide training for data collection to prevent the garbage in garbage out scenario.
- Continually monitor data collection to ensure that data is being collected according to the design.
- Consider the creation of a multi-disciplinary clinical review team. The function of this team is to review a random sample of restraints to determine whether a given restraint was needed, whether the restraint procedures were followed, and whether the documentation of the event met standards.

Measurement principles

⁶ Wheeler, Donald M, Understanding Variation, the Key to Managing Chaos

- Use a rate based measure to understand the process within the context of changing census and across sites.
- Use control chart methodology to understand when to respond to changes in the data
- The control chart or process behavior chart is the voice of the process.
- Create a risk adjustment system to account for different levels of severity
- Smaller units will have a higher event rate. Risk adjust for this.
- Communicate these measurements to staff and hold sites accountable for improving their outcomes (hold and injury rate, e.g.)
- Obtain external comparison data
- Create measurement systems that address both processes and outcomes
- Define the process using a flow chart. This will help create clarity about the process and will identify key points for measurement.

Key aspects of the system to measure

- Event rate
- Staff and client injury rate
- Length of time in restraint
- Percentage of clients restrained
- Clinical profile of frequently held clients
- Correlation with Length of Stay (Do hold rates decrease with LOS? If not does this demonstrate inadequate care?)
- Measure individual hold events over the course of treatment.
- Compare data across sites
- Qualitative analysis of post restraint client comments

Data Analysis

- Process Behavior Charts (control charts) are a highly useful method of determining when to take action based on the data.
- See Don Wheeler's book: Understanding Variation, the Key to Managing Chaos

Performance Improvement Teams

- Consider a standing performance improvement team during at least the initial phase of training and implementation
- Consider defining performance improvement teams composed of the work group
- A simple, teachable method for determining the causes of an outcome and deciding what action to take:
 - Conduct a brainstorm
 - Consider all relevant systems
 - Put the results of the brainstorm into a fishbone chart
 - Conduct a pareto analysis of the causation in the fishbone chart
 - Set priorities for action
 - Collect additional data if you need it
 - Take action on high priority causal factor that are supported by data
- See appendix for team guidelines.

- Consider the use of external comparison to help you determine how your process compares to other organizations. Participation in such systems cost money both in terms of a fee to participate and in terms of the staff time that it takes to collect and organize the data. One of the difficulties with such systems is that your methodology for collecting data may need to be adjusted in order to participate in the system and to compare data.

CAREeval
 Monique ter Haar
 Lehr Management Corporation
 3893 Adler Place
 Bethlehem, PA 18017
 610-974-9490 x1847
 monique.terhaar@hslehr.com

CAREeval is a database developed by Boys Town. Consider this if you do not have a very high level of severity.

Maryland Hospital Association
 Quality Indicator Project
 1301 York Road, Suite 800
 Lutherville, MD 21093-6087
 410-321-828-5718
 www.qiproject.org

This is a long-standing, multi-state data system for hospitals. There are psychiatric hospital measures of restraint, patient injury, re-admission within thirty days and other measures.

Jeanne Negley, Program Manager
 CHARRP (Child and Adolescent Residential Psychiatric Programs)
 4455 N.E. Highway 20
 Corvallis, OR 97330
 888-523-5225
 negleyj@cfh.org

CHAARRP is a group of children's providers in the northwest. About seventy organizations participate. The members provide services along the continuum including residential treatment and in home services.

9. Sentinel Events and Root Cause Analysis

Preparation

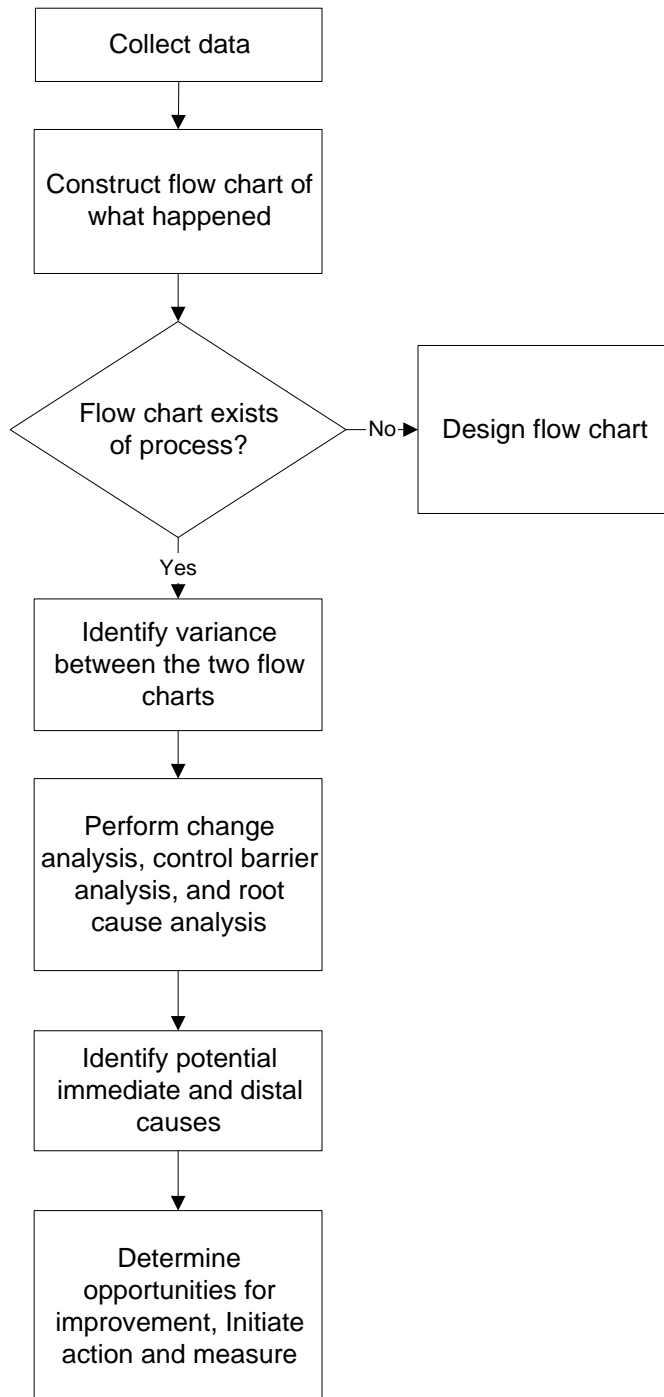
- Define an approach to root cause analysis and training your staff prior to an event

- Define an approach to legal protection of root cause information. Some states have a peer review protection act that might afford some degree of protection.
- Define an organizational approach to managing communications after an event.
- See the bibliography for reference on the Florida Power and Light root cause analysis approach. The Joint Commission also has a useful framework and useful educational materials.

Responding to an event

- Determine the degree to which the individuals directly involved in the event are going to participate in the root cause analysis. Should they run the process or just participate?
- Be aware of the emotional impact of conducting a root cause analysis. Address the emotional needs of your staff during the process.
- Be brutally honest in the analysis and evaluate all systems associated with the event.
- Below is a flow chart based on the Florida Power and Light Root Cause Analysis model.

Data Collection and Analysis of Sentinel Event



10. Risk Management

Solutions

The Keys to Risk Management

- Clearly defined process
- Certified competent staff
- Adherence to the procedure
- Accurate, well formed documentation

Progress Notes

- Staff should be competent to write progress notes that meet standards
- Poorly written progress notes are a significant risk

Policy Issues

- Policy is a protection during a crisis: If you have a well-formed policy and follow it, it can provide some measure of protection for the organization and staff members.
 - If your staff injure a client and they are following a sound, clearly defined policy and procedure the staff will be protected from criminal prosecution and the organization will also have significant legal protection.
 - The down side of policy: If you say it, you better do it. Be careful not to specify requirements that you are not able or willing to support.
 - Ongoing assessment and improvement of adherence to policies
 - Ongoing assessment and improvement of policies
-
- Develop systems that can minimize the discoverability of performance assessment information.

Appendix

Recommended Guidelines for Quality Improvement Teams

1. Develop a work plan that defines tasks and time frames. Limit the length of your work plan to sixteen weeks or less. Projects beyond this time frame tend to lose focus and effectiveness.
2. Brainstorm with the team to identify potential improvement priorities.
3. Include all key aspects of the systems that relate to restraint.
4. Create a fishbone chart of the results of the brainstorm.
5. Seek out facts/data that can indicate whether or not the cause identified in the brainstorm is indeed a cause.
6. Identify priorities among the causes that are factually supported.
7. Display the data in graph or table form.
8. Develop action plans for the causes that are supported by fact and that offer the greatest potential for improvement.
9. Recommend action that is within departmental control. With the approval of the department head, implement solutions.
10. For issues that are beyond the scope of departmental control, recommend solutions to the departmental Performance Improvement Committee. These recommendations can then be passed up to the QA Committee.
11. Define a method for measuring the process on which you are focusing, so that you can determine whether or not the project was a success.
12. Create a system for follow-up on the work you did to measure success and monitor implementation.
13. Summarize your work in writing. Develop a storyboard if that would be useful for communication purposes.

Appendix

Training Program Prioritization Matrix

Company being rated: _____

Rating Scale: 1= Not acceptable 2= Acceptable 3= Good 4= Very Good 5= Excellent

Weight: 1= Can do without 2= Very Good to have 3= Important 4= Very Important 5= Crucial

The content of the program addresses these issues:	Weight	1	2	3	4	5
De-escalation Techniques:						
• Verbal techniques						
• Alternatives						
• Voice tone, volume						
• Options for Staff						
• Body language						
• Attitude (win/win not win/lose)						
• Linked to Model of Care Values						
• Counter Aggression						
• Life Space Intervention						
Addresses Specific Situations:						
• Assaultive behavior on staff/other clients						
• Unusual circumstances, e.g., on a van (scenarios)						
• Dealing with client's clinical situation, e.g., history of sexual assault						
• Dealing with special medical problems. Alternatives provided.						
• Size of client vs. staff members						
Specific Techniques:						
• Transports						
• Modified for all Sizes						
• Escorts						
• "Take downs"						
• Escapes/releases						
• Responsibility of each staff member involved						
• How to do holds						
• Transition to mechanical restraints						
»Single staff member						
»Multiple staff members						
»Standing						
»Prone						
Qualitative						
Medical Assessment						
Company is recognized, preferably nationally						
Company will provide support in legal situation						
Program lends to monitoring e.g., holds can be numbered						
Company capable of meeting training needs within a short time frame						
System is practical within our context of care						
Training Materials/Approach						
Clear/detailed						
Visual training materials- (overheads, handouts, video)						
Hands on training (practice time allotted)						
Role play used (verbal and physical portions)						
Specific actions recommended for specific situations						
Training for trainers focuses on how to train, not only physical portion.						

Other information

Cost for trainers: _____

Cost for certification by trainers: _____

Amount of time required for training trainers: _____

Location of training: _____

How often is retraining required?: _____

Time Frame for initial class: _____

Rectification: _____

References:

Restraint Process & Measurement Flowchart

