Systems change for quality improvement of patient safety

Law, Security

Use of restraint in the treatment of mental illness has long been a controversial subject. Regulatory agencies, licensing organizations, and professional and advocacy groups have called for a reduction of restraint use (Barton, Johnson, & Price, 2009). The Hartford Courant cited multiple adverse events and outcomes involving patients who had been placed in restraints in various behavioral health facilities, which brought about immediate changes related to the restraint guidelines (Nadler-Moodie, 2009). The three most prevalent dangers for death while in restraint are asphyxia, agitated delirium, and cardiac complications. According to the Joint Commission (TJC) report of 2005, restraint interventions are estimated to result up to 1240 deaths or severe injuries to patients each year in the United States (Huckshorn, LeBel, & Jacobs, 2014).

The National Association of State Mental Health Program Directors (NASMHPD) unanimously passed a policy statement regarding the reduction and eventual elimination of the use of restraints and its policy position reinforced that the seclusion and restraint should not be used for punishment, discipline, or staff convenience including situations of staff shortage (Huckshorn, LeBel, & Jacobs, 2014). Healthcare organizations must follow clinical practice guidelines and policies and procedures following regulatory agencies to ensure the safety of the patients in restraints. As DNP-prepared nurses, we play an essential role in designing healthcare delivery system change through evidence-based practice (EBP). To reduce the use of restraints in our behavioral health settings, the time frame for restraint was reduced from two hours for adults to one hour and one hour for children less than seventeen years of age to thirty minutes. The purpose of

this project is to introduce a selected advanced practice patient safety concern and system change in restraint reduction from the current two hours to one hour for adults and one hour to thirty minutes for children.

Description of change model

Restraint and seclusion practices in behavioral health settings have received an increased level of interest, oversight, and regulation by legislators and policymakers over the last 20 years (Huckshorn, LeBel, & Jacobs, 2014). According to Sweeney-Calciano, Solimene, and Forrester, (2003), restraint use is potentially dangerous and demeaning for patients and healthcare organizations and providers should strive to promote restraint-free care while maintaining patient safety; use physical restraints only as a last resort when all positive interventions have failed to produce the desired behavioral change, and remove restraints as soon as possible. Reports of patient death and injury while in restraints and studies of patients' experiences in restraint and seclusion have prompted psychiatric-mental health nurses to question the benefit of secluding and restraining psychiatric patients (Huckshorn, LeBel, & Jacobs, 2014). Restraints must only be used as the last resort for patients who are in imminent danger to ensure the safety of the patients and the staff. TJC has challenged the routine use of physical restraints and sustained reduction in the use of restraints in the hospitals (Park & Tang, 2007).

The system change model for the quality improvement for patient safety was the implementation of the reduction in the time frame for restraint from two hours to one hour for adults and one hour to 30 minutes for children. Another

added change is that a face-to-face assessment has to be done by the Assistant Director of Nursing (ADN) covering the area to evaluate the continued need for the restraint in 30 minutes for adults and 15 minutes for children. Also, the ADN must do an audit of documentation after every restraint and manual hold (maximum of 10 minutes). Although the patient is automatically placed on a one-to-one observation at the initiation of the restraint, the nurse must assess the patient every 15 minutes and document per policy including vital signs.

Implementing changes in clinical practice is a significant challenge, and potential barriers at various levels need to be addressed (Grol & Wensing, 2004). Recognizing the barriers to implementation and incentives for achieving change in practice is very important. As with any changes, this change was also met with resistance from staff, especially in the emergency room. Leadership worked relentlessly to empower our staff to see the vision for the change and to implement the change using Kotter’s eight stages of change, which include (a) establishing urgency for change, (b) forming a guiding coalition for change, (c) creating a vision for change, (d) communicating a vision for change, (e) empowering others to change, (f) planning for short-term wins, (g) consolidating improvements, and (h) institutionalizing new approaches (Chamberlain College of Nursing (CCN), 2015).

Before implementing any new policy or change in the existing policy, it is necessary to identify barriers and gaps between recommended practice and current practice. In the implementation of this system change, the first step

was to educate staff about our vision for restraint reduction leading to eliminating restraints. Seclusion room is not used in our facility currently. We went through the same process when we eliminated seclusion rooms. A literature review revealed that successful restraint reduction program is based on strong leadership direction, policy and procedural change, staff training, patient debriefing, and regular feedback (Nadler-Moodie, 2009). Our focus was to train staff towards preventing or de-escalating a crisis situation so that we don't have to use restraints or emergency medicine. Trauma-informed care principles and person-centered care were included in the training increasing the staff's awareness. According to Huckshorn, LeBel, and Jacobs (2014), re-traumatization of people who have a history of traumatic life experience by the use of restraint causes a significant loss of dignity and control over one's own body and potential interruption of the therapeutic relationship, which is the foundation for successful treatment. Awareness and knowledge of what needs to change and why it needs to change are essential steps in enabling to change. We held multiple interdisciplinary focus groups to discuss the change and to share ideas and perspectives.

According to Chism (2013), DNP graduates are expert clinicians, who have the knowledge and skills to educate other healthcare professionals to facilitate changes within the organization. DNP graduates, as a leader in healthcare delivery system change, can provide much-needed direction for the future of adequate healthcare, using their knowledge, skills, and integrative abilities associated with such organizational theories as complexity, chaos, change, and innovation (Chism, 2013). As an advanced

practice nurse, my role was to train the staff on increasing their awareness of factors that lead to agitation and violence, teaching less restrictive interventions, verbal de-escalation techniques, ensuring annual mandatory attendance of all staff in crisis intervention training (PMCS- Prevention and Management of Crisis Situation) and restraint application training. Marshall (2011) stated that as the health-care system evolves, DNP-prepared advanced practice nurses are expected to assume the role of transformational leaders and change agents positively influencing the organizational change.

Presentation of the change model

TJC and the Centers for Medicare & Medicaid Services (CMS) now require that the healthcare providers minimize the use of restraints since the restraints are demeaning and potentially dangerous. CMS published its final rule clarifying its original rule expanding some definitions; identifying specificities for manual, mechanical and chemical restraints; issues related to restraint orders; documentation and reporting requirements; and training and education recommendations (Sweeney-Calciano, Solimene, & Forrester, 2003). TJC also aligned its regulations with those of CMS to lead to safer outcomes. The American Psychiatric Nurses Association (APNA) published a position statement and a standard of practice in 2000 related to restraint and seclusion to guide the nursing profession toward a positive culture change (Park & Tang, 2007). Current TJC and CMS guideline for restraint use is two hours for adults and one hour for children from nine to seventeen years of age and 30 minutes for children under nine years of age. The system change model for the quality improvement for patient safety was the

implementation of a reduction in the time frame for restraint from two hours to one hour for adults and one hour to 30 minutes for children.

After months of the implementation process, and pilot study in the inpatient adult psychiatric units, the system change has been adopted into our Comprehensive Psychiatric Emergency Program (CPEP) and Child & Adolescent Psychiatric Inpatient Service (CAPIS) units. Culture change focused on the Mental Health Recovery Model and principles of trauma-informed care with an emphasis on person-centered care. With rigorous screening on admission regarding their triggers for agitation, what helps them to calm down, etc. had helped the team to intervene early with the use of individualized behavioral plans (IBP), sensory modulation rooms, and music therapy without escalating to restraints or unnecessary medications. Seclusion rooms are not in use in our facility, and we had converted our seclusion room into sensory modulation rooms with soothing music, aromatherapy, etc. We have had multiple restraint-free units for the past few months. When restraint was necessary for imminent danger situations, especially in CPEP, then the treatment was directed toward minimizing the time in restraint (as soon as the patient regained control). Also, the use of a wedge pillow as soon as the patient is placed in restraint is in practice at our facility to prevent any respiratory issues/distress.

As a leader in healthcare delivery system change, the DNP-prepared nurse can provide much-needed direction for the future of effective healthcare. According to Essential III of the Essentials of Doctoral Education for Advanced Practice (AACN, 2006), DNP graduates must be equipped with

skills to design and implement processes to evaluate outcomes of practice; assess practice patterns against national benchmarks to determine variances in clinical outcomes and population needs (Tymkow, 2013).

Conclusion

Restraint use has been a controversial subject in the treatment of mental illness.

Restraint use is potentially dangerous and demeaning for patients and healthcare organizations, and providers should strive to promote restraint-free care while maintaining patient safety; use physical restraints only as a last resort when all positive interventions have failed to produce the desired behavioral change; and remove restraints as soon as possible (Sweeney-Calciano, Solimene, & Forrester, 2003). Many reports of patient death and injury while in restraints have been documented and there is no evidence reported in the benefits of seclusion or restraints (Huckshorn, LeBel, & Jacobs, 2014). TJC have challenged the routine use of physical restraints and sustained reduction in the use of restraints in the hospitals (Park & Tang, 2007). My system change model for the quality improvement for patient safety was the implementation of a reduction in the time frame for restraint from two hours to one hour for adults and one hour to 30 minutes for children.

One of the main benefits of the implementation of the new policy is that although some patients felt angry and upset about being in restraint, others verbalized during the debriefing that they didn’t consider this as a punishment because they were released as soon as they were in control.

Another patient had verbalized that he felt punished under the old restraint policy since he was kept in restraint for an entire two hours even after he was calm. On another occasion, a patient reported that she felt better having a choice of taking either oral (PO) medication or IM medications even when she was agitated and had refused PO meds earlier stating, “ not like in the old days, if I had refused PO medications, I had no choice but to take IM medication”. Regulatory requirements and healthcare associations’ position statements and standard of practice grounded in EBP related to restraints and seclusions help guide the nursing profession toward a positive culture change.

The new culture change focused on the Mental Health Recovery Model and principles of trauma-informed care with an emphasis on person-centered care. Seclusion rooms are not in use in our facility, and we had converted our seclusion rooms into sensory modulation rooms with soothing music, aromatherapy, etc. We have had multiple restraint-free units for the past few months. When restraint was necessary for imminent danger situations, especially in CPEP, then the treatment was directed toward minimizing the time in restraint (as soon as the patient regained control). Although there are many barriers to achieving restraint-free, person-centered care, our organization is striving towards a restraint-free facility by working together, pursuing excellence and keeping our patients first.