

Connecticut Valley Hospital

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Recovery to Wellness



Connecticut Valley Hospital's

**Restraint and Seclusion Prevention
and Reduction Initiative**

Connecticut Valley Hospital

- 615 Bed State Operated Inpatient Psychiatric Hospital
- Provide services to adults
- Treatment of persons with long term psychiatric disabilities, substance abuse disabilities, and those with forensic treatment requirements
- Care and treatment provided within a network of services provided by DMHAS
- Special responsibility to those who are poor or medically indigent

Demographics

- Persons served: 72% Men, 28% Women
- Age: 4% (18-22 yrs), 21% (23-30 yrs), 23% (31-40 yrs), 27% (41-50 yrs), 19% (51-60 yrs), 5% (61-70 yrs), and 1% (71plus years)
- Race: White/Caucasian: 65%; Black/African American: 18%, Other: 16%; Asian: 1%
- Diagnoses: Schizoaffective, Schizophrenia: Paranoid Type, Alcohol and Opioid Dependence, & Schizophrenia: Undifferentiated Type

Connecticut Valley Hospital

- Addiction Services Division (ASD)
 - Total Bed Capacity = 152
 - 2 Detoxification & 4 Rehabilitation Units; 2 Campuses
- General Psychiatry Division (GPD)
 - Total Bed Capacity = 220
 - 11 Units: YAS, TBI, Geriatric, Psychiatric, & Transitional Cottage
- Whiting Forensic Division (WFD)
 - Total Bed Capacity = 232
 - 11 Units: Maximum, Enhanced & Moderate Security

Connecticut Valley Hospital

- Staffing Complement
- Hospital FTE's: 1,632
- Physicians: 67
- Licensed Nurses: 285
- Mental Health Assistants & Forensic Treatment Specialists: 632
- Clinical Staff: 260

Connecticut Valley Hospital

Vision Statement

To promote recovery through collaborative, compassionate, and culturally competent treatment in a safe and caring environment

Mission Statement

At Connecticut Valley Hospital, individuals receive treatment and services that assist them to better manage their illnesses, achieve personal goals, and develop the skills and supports that lead to living the most constructive and satisfying lives possible.

Definitions

- Seclusion is the involuntary confinement of a patient (person) in a room or an area whether alone or with staff supervision where he/she is prevented from leaving.
- Restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body or head freely.

Clinical Indications

- Imminent dangerousness to self, others and the environment
- Seclusion is often used to decrease the stimulation a person receives
- Restraint is used to prevent deliberate acts of self harm or mutilation
- Seclusion or restraint may be used to prevent someone from deliberately harming another or unintentionally endangering them as a result of disorganized /psychotic behavior

Historical & Present R/S Use

- Restraint Hours: CY 2000: 26,290 hours
- Seclusion Hours: CY 2000: 3,125 hours
- Restraint Hours: CY 2012: 529 hours
- Seclusion Hours: CY 2012: 337 hours

Factors Influencing Change

- Connecticut legislature enacted P.A. 99-210, “An Act Concerning Physical Restraint of Persons with Disabilities,” effective October 1, 1999
- Hospitals participating in the Medicare & Medicaid Programs and those accredited by the Joint Commission
- CVH entered into a Settlement Agreement with DOJ on behalf of CRIPA in July 2008.
- Hospital’s Recovery Mission
- NASMHPD Training

R/S Prevention Initiative

- SAMHSA awarded grant to Connecticut, Indiana, New Jersey, New York, Oklahoma, Texas, Vermont, and Virginia in the fall of 2007.
- 6 Senior leaders at CVH participated in, NASMHPD, National Executive Training Institute's 6 Core Strategies for Preventing, Violence, Trauma, and Reducing Restraint and Seclusion in April 2008.
- Hospital targeted the unit with highest R/S Utilization (CY 2006: 50% of total Restraint Hrs and 62% of Seclusion Hrs)

Intensive Treatment Unit (B3N)

- 20 Bed Co-ed Unit on B3 North
- Age Range 18-74, average 41 years
- Diagnoses: Schizophrenia; BPD, sub-group of PDD spectrum and multiple co-morbidities
- Treatment of refractory illnesses, with an emphasis on acute psychotic, suicidal, and assaultive behaviors
- Average LOS: 3.5 years
- Highest Restraint & Seclusion Use in the Hospital for many years

NASMHPD: Six Best Practice Strategies

- Leadership Towards Organizational Change
- Using Data To Inform Practice
- Workforce Development
- Use of Seclusion and Restraint Prevention Tools
- Consumer Roles in Inpatient Settings
- Debriefing Techniques

Strategy One: Leadership

- Nurse Executive & Director of Recovery assigned responsibility for leading charge (6/2008)
- Developed a Strategic Plan (9/2008)
- Patient/Staff Steering Committee formed to direct change process(9/2008)
- Hospital Restraint/Seclusion Prevention Project Team formed (9/2009)

Resident Staff Steering Committee

- Chaired by the Director of Recovery & Consumer Affairs and the Nurse Executive
- Membership consists of people living and working on B3N, and representation from GPD leadership (Senior leadership and PI Manager)
- Group meets weekly for an hour and minutes are taken
- Minutes are discussed in Community Meetings, posted and shared with staff

Partners For Recovery

(B3N) Mission Statement

- The Partners for Recovery Steering Committee is made up of men and women who receive services here and those who provide services here.
- We know that people can and do recover
- We know that taking good care of the people who work here helps them take good care of the people who recover here.
- We know that violence and trauma affects everyone on a unit.
- People working together can choose to get the skills and tools to prevent violence and promote recovery.

Strategy Two: Use of Data

- Seclusion and Restraint Data reviewed weekly in the Partners for Recovery Steering Committee
- R/S events and hours are calculated for the previous week and compared against the prior week and previous year. Day of the week and time of year are also listed.
- The PI Manager provides an analysis or point of emphasis for the week and graphs data over time. This is included in weekly minutes.
- People in recovery and staff analyze patterns and trends and seek alternate strategies.

Strategy 3: Workforce Development

- All clinical staff receive Annual Collaborative Safety Strategies Training
- Staff on the Partners for Recovery unit received education relative to the Preventing Violence, Trauma and Use of S/R Curriculum
- Many staff participated in the Trauma Informed Care and Changing Roles, Changing Lives Curriculums
- Staff receive monthly clinical supervision and every episode of R/S reviewed and feedback given to staff re practice aspects and documentation

Strategy Four: Use of R/S Prevention Tools

- Persons served are asked their personal preferences upon admission in terms of what helps and hurts them
- Conjoint development of Crisis Plans by people in recovery and staff
- Development of and use of a Comfort Room
- Occupational Therapy Use of Both Prescribed Sensory Modulation Techniques and more general use of Sensory Cart
- Weighted Blankets Available

Welcome
To



Partners For Recovery







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Strategy Five: Consumer Roles

- Persons in recovery engaged as partners in change initiative by serving as teaching faculty, and representatives at various hospital workgroups.
- The Voice of Consumers is more broadly recognized and respected as staff are more cognizant that what they say matters and is communicated to leadership at all levels.

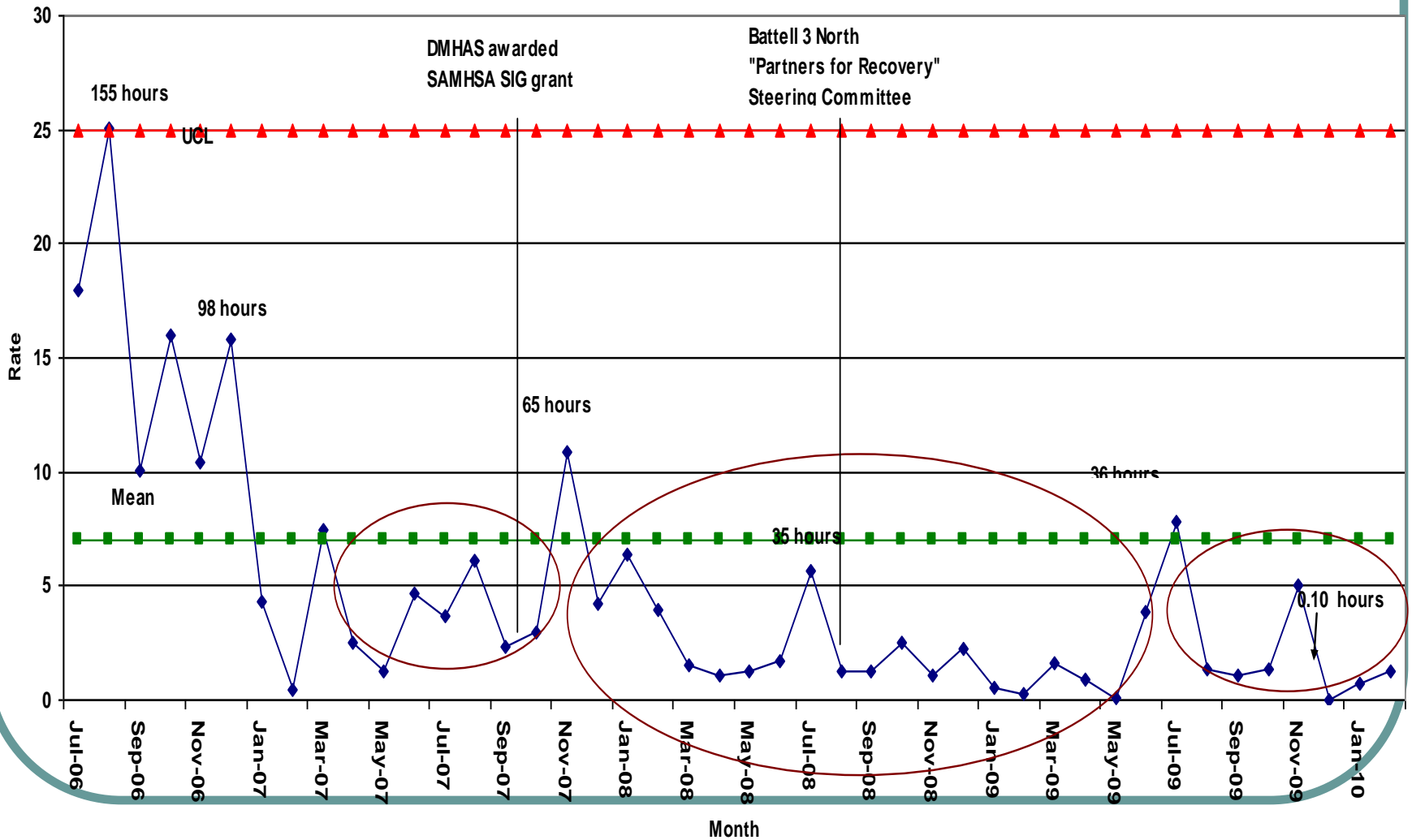
Strategy Six: Debriefing

- Information obtained from Patient Debriefings is more valid and reliable in seeking to understand and address contributory factors that led to R/S
- There is significant efforts to avoid and or minimize the use of R/S on the Partners For Recovery unit.
- There has been a remarkable decrease in the length of time folks use R/S

62% reduction comparing FY'08 to FY'09

84% reduction comparing FY'06 to FY'09

CONNECTICUT VALLEY HOSPITAL General Psychiatry Division - B3N Restraint Hours per 100 Patient Days



Intensive Treatment Unit

Seclusion Events

FY 05: 101

FY 06: 202

FY 07: 91

FY 08: 216

FY 09: 78

FY 10: 100

FY 11: 42

FY 12: 18

Restraint Events

FY 05: 122

FY 06: 190

FY 07: 217

FY 08: 113

FY 09: 82

FY 10: 159

FY 11: 68

FY 12: 30

Additional Actions

- R/S Project Team sets targets for reduction every 6 months
- Model established for working with teams when R/S increases
- Quality, Risk and Safety Committee receives monthly reports
- Risk management thresholds set: anyone in R/S greater than 4 hrs, 2 episodes in 7 days, and 4 episodes in 30 days reviewed & person assessed
- RM protocol developed: includes evaluations by Psychology, Occupational Therapy & Guidelines for Nursing Staff
- Focus on use of brief holds to contain and calm while offering choice in lieu of mechanical restraint use

Additional Actions

- Assisting staff in identifying predisposing, precipitating and perpetuating factors related to aggression
- Development of behavioral support plans and ongoing supervision
- Instituting daily engagement strategies and documentation of effort
- Case Conferences DMHAS Medical Director
- Yoga Training for Staff & Person's Served

Additional Actions

- 22 Comfort Rooms instituted across campus
- Weighted Blanket Training for Clinical Staff
- Face to Face Assessment by RN Supervisor for any person in R/S longer than an hour
- Reduced Duration of MD Orders for R/S from 3hrs to 2 hrs per order implemented (3/12)
- Revision of Special Observation Tool to better capture behaviors of concern and staff interventions
- Using peers to assist with debriefings
- Teaching new staff in orientation about our philosophy in regards to recovery, trauma, and the prevention of restraint/seclusion

Challenges

- Other organizational issues take priority and interfere with plan
- Effective communication as to why prevention and reduction strategies make sense
- Timely analysis of data and disseminating results
- Teaching and providing staff with new skills

Challenges

- Staff empowerment
- Supportive supervision with staff who may be ambivalent and continued monitoring
- Recognition and reward for best practices
- Consumers have real power to influence changes
- Debriefing is meaningful and not a paper exercise or a venting session

Strategies for Sustainability

- Sustained Commitment: Executive Leadership
- Embed in Organizational Goals
- Incorporate as PARS Objectives
- Availability & Support from performance improvement, data management and technology staff

Strategies for Sustainability

- Message branding, using as many opportunities as possible to reinforce purpose, goals, objectives and results
- Analysis, and sharing of data in as many forums as possible, particularly direct care staff
- Developing curriculums to teach new skill sets
- Trying new practices

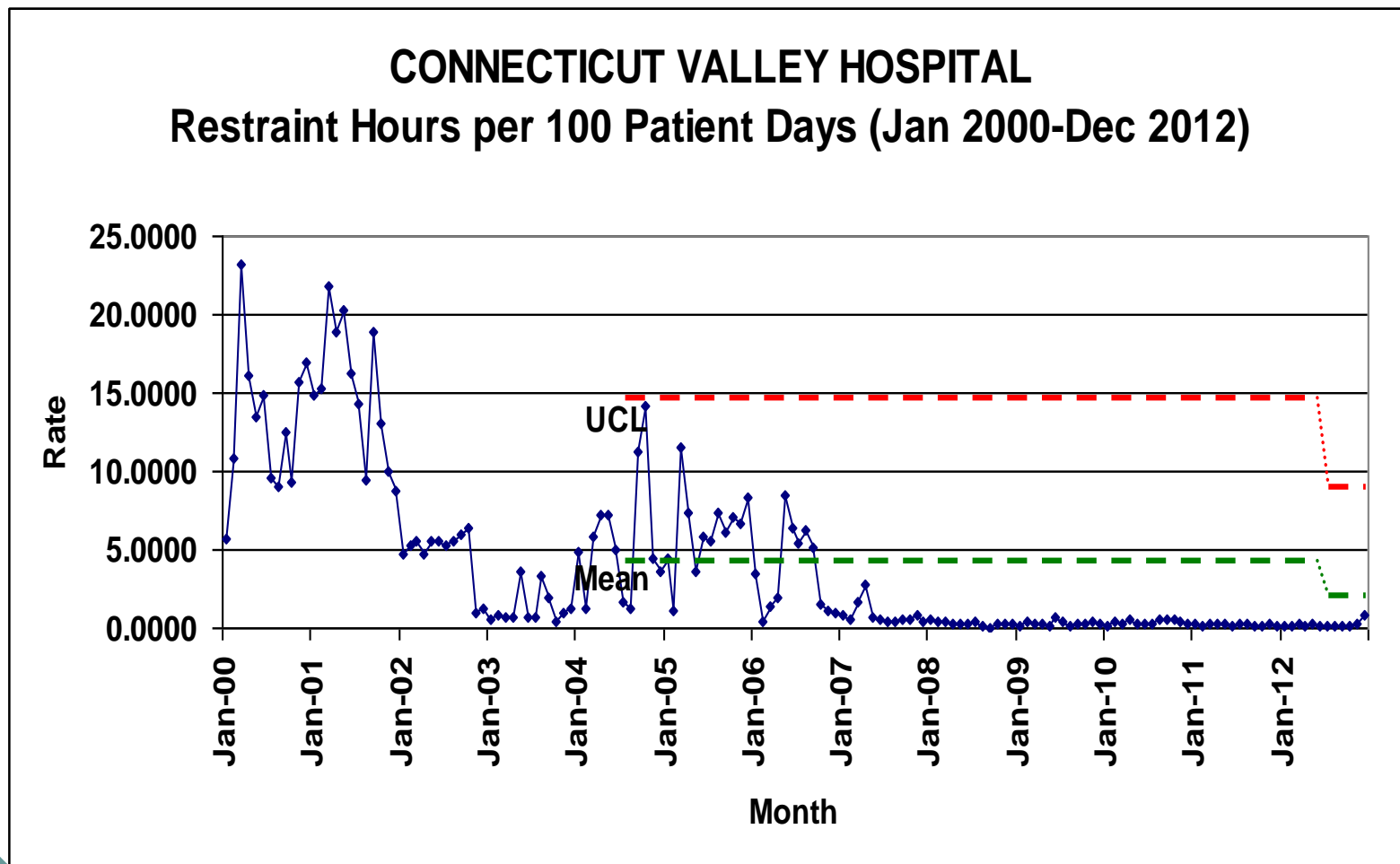
Strategies for Sustainability

- Involve staff in change effort, solicit suggestions for improvement and assign responsibility
- Mentor staff and develop champions
- Recognize and reward staff and the people we serve; awards, announcements in bulletins, newsletters, community meetings, emails from leaders, "I made a difference stickers"
- Paid roles for consumers
- Utilize debriefing findings to make changes in policies/procedures

Most Important Lesson Learned

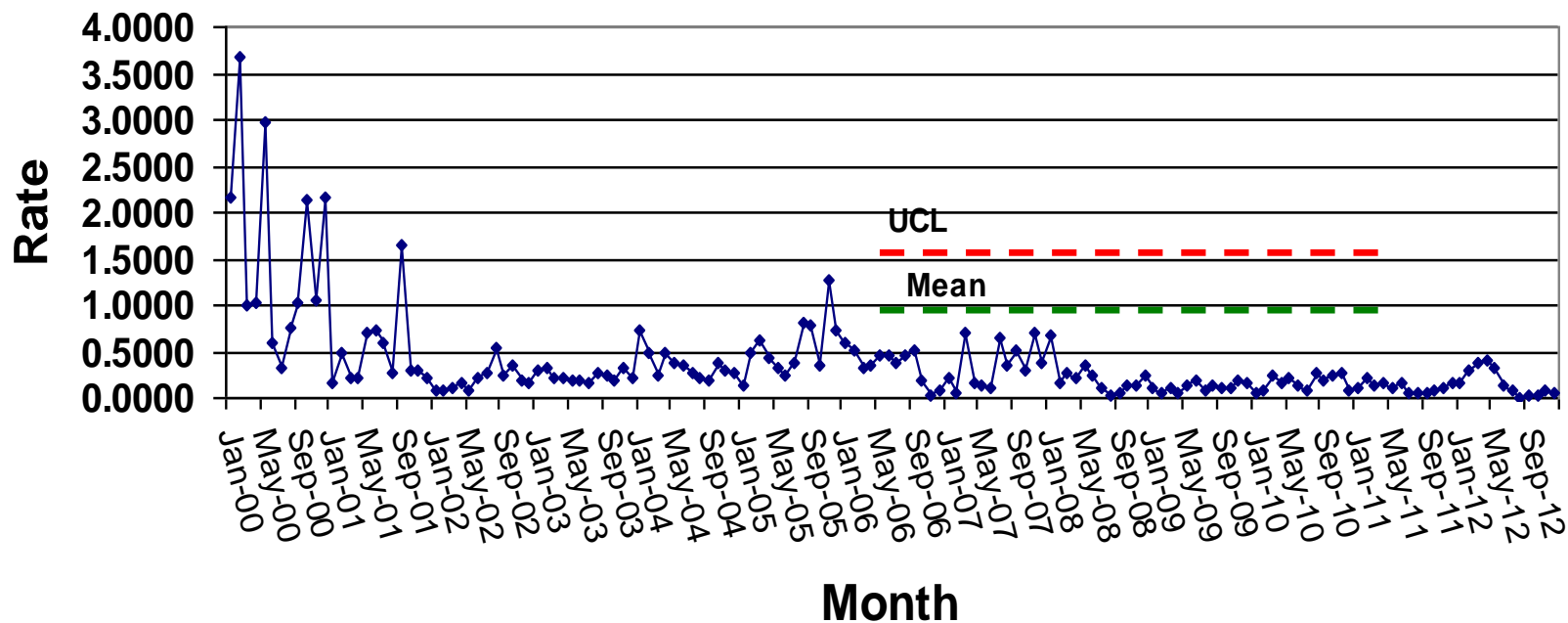
- We engaged the people we serve and staff together in our Restraint and Seclusion Prevention and Reduction Effort
- This leveled the playing field, as both had expertise to contribute and both stakeholders together learned new skills!
- Everyone felt and was **EMPOWERED!**

Restraint Hours per 100 Pt Days January 2000 – December 2012



Seclusion Hours per 100 Pt Days January 2000 – December 2012

CONNECTICUT VALLEY HOSPITAL
Seclusion Hours per 100 Patient Days (Jan 2000 - Dec 2012)



Results

- 98% Reduction in restraint hours
CY 2000 to CY 2012
- 89% Reduction in seclusion hours
CY 2000 to CY 2012
- The rate of both Restraint & Seclusion for the hospital has consistently remained below the NASMHPD Research National Mean for several years.
- The percentage rate of persons restrained or secluded has also remained below the national mean for the same time periods

Contact Information

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