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Purpose:
Nebraska Hospital Association
"Quest for Excellence" Award Application - August 26, 2005

Topic:
Use of Therapeutic Milieu Management in Seclusion Reduction
Category of Criteria: Process Management / Organizational Performance Results

Overview

The goal of this initiative was to markedly reduce seclusion rates in the child adolescent population of a behavioral health residential treatment center (RTC), with the long-term aim of creating a seclusion free environment. The seclusion rate, which is calculated as the number of episodes / patient census days, decreased from more than 25% in 1999, to less than 1% in 2001 and sustained through fiscal year end 2005 at .08%. Improved clinical outcomes, patient satisfaction scores and employee satisfaction scores were additional results of this initiative. Implementation of strength-based milieu management protocols was the primary contributor to developing and sustaining this practice improvement. The protocols addressed the environment, staff development and competency, patient care interventions, and use of data to enhance quality of patient care.

The RTC staff and leaders recognized that high seclusion rates were not congruent with the organization's mission. Alegent Health's Mission is "to provide high quality care for the body, mind and spirit of every person. Our commitment to healing calls us to:

- Create caring and compassionate environments
- Respect the dignity of every person
- Care for the resources entrusted to us as responsible stewards
- Collaborate with others to improve the health of our communities
- Attend especially to the needs of those who are poor and disadvantaged
- Act with integrity in all endeavors"

Also in 1999, the new Center for Medicare and Medicaid Services (CMS, formerly known as HCFA) and Joint Commission Accreditation of Hospitals (JCAHO) published new standards regulating the use of restraint and seclusion. These standards reinforced our efforts to create a seclusion free environment. A Steering Committee was formed to compare current practices to

recommended standards. Review of the white paper, "Learning from Each Other, Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health"[1], resulted in recommendations for change. Action plans emerged from this thorough gap analysis. These action plans were developed to map a journey of culture transformation by implementing therapeutic milieu management protocols.

The targeted population was the child adolescent patients, ranging in age from 6-18 years old, in a twenty bed residential treatment center setting located within an acute care hospital within the Alegent Health System. Our hospital-based RTC is one of two in the State of Nebraska. Admission criteria include treatment failure history in intensive behavioral health settings and multiple levels of care. Each patient requires 24-hour supervision in a safe environment with specialized therapies. These youth have histories of serious problem behaviors with symptoms that are persistent, unpredictable, and may jeopardize the health and safety of others. Thus therapeutic milieu management protocols greatly benefits not only our youth, but their families, RTC employees and organizational leaders.

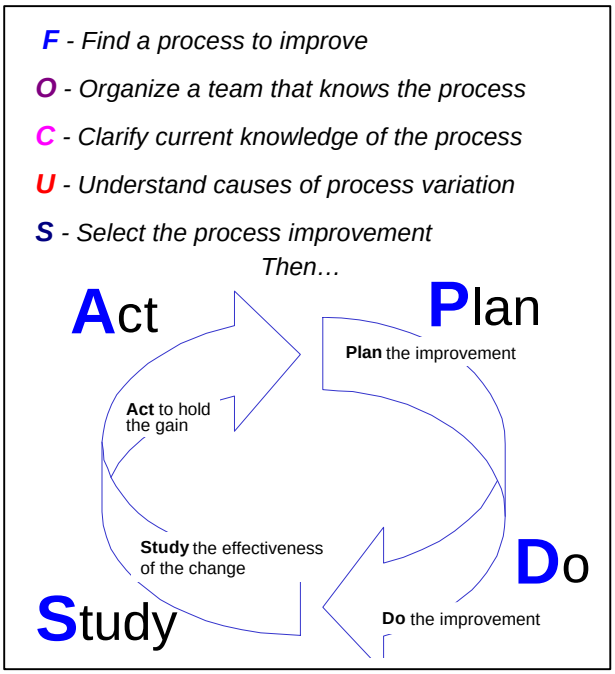
The organization maintains high expectations for departmental implementation of ongoing best practice standards and quality improvement initiatives. The goal of the RTC program is to provide high quality care with positive patient outcomes in a safe, caring, and compassionate environment for patients and staff. Seclusion rate reduction impacts and is impacted by this program goal and thus drives the selection of quality improvement initiatives and the overall quality improvement program. Current initiatives for this department include seclusion rate reduction, as well as behavior modification target skill ratio, use of time outs, patient and employee satisfaction, and functional clinical outcome measurements. In addition, the RTC Quality Core Measure

[1] American Psychiatric Association, American Psychiatric Nurses Association, National Association of Psychiatric Health Systems, "Learning from Each Other, Success Stories and Ideas for Reducing Restraint/Seclusion", 2003. [1]

Dashboard also consists of patient self-harm incidents, communication with family / guardian / caseworker, length of stay, and staff accidents / injuries.

Methods

The methodology used by Alegent Health to improve processes is FOCUS-PDSA.



Therapeutic milieu management as a treatment modality was the foundation upon which protocols were based. Key activities contributing to seclusion rate reduction in this program are outlined in Appendix I, "Use of Therapeutic Milieu Management to Reduce Seclusion, Grouped by Type of Initiative". Examples include Crisis Prevention Institute (CPI) de-escalation training for all staff, "Planetree"[2] commissioning for creation of a healing environment, strength-based behavioral modification care model approach, shared decision making model implementation, needs based staff training and critical skill competencies with continual process improvement. The staff's dedication and creativity, as well as patient involvement, contributed many of the healing environment initiatives. Fiscal resources were dedicated for training courses and training supplies.

Behavioral organization leaders provided oversight and direction to ensure high quality implementation of standards and action plans developed after gap analysis. The Service Line Vice

[2] Planetree, Inc. 130 Division St. , Derby , CT 06418, planetree@planetree.org

President, Operations Leader, as well as the campus Chief Operating Officer and Chief Nurse Executive, supported this project. This initiative was a top down and bottom up approach, which clearly exemplifies the principles of hardwiring process improvement. The organization's leaders ensure that mission and commitment behaviors are incorporated by monthly communication, award recognition and an annual ceremony to formally recommit to the mission. In addition, the system's strategic priorities aligned all activities and quality initiatives into the categories of relationship, innovation, quality and stewardship.

Our organization's leadership philosophy integrates the JCAHO standards of inclusion of initiative leaders. For this initiative, the following Steering Team members include: Service Line Vice President, Operations Leader, Operation Directors, Managers/Coordinators, Clinical Consultant, Quality Improvement Specialist, and Data Management Staff. Direct clinical care staffs were professionally and passionately engaged in the implementation of this initiative's protocols reducing seclusion.

As listed in Appendix I, staff improved the healing environment, participated in training and competency development, provided a consistent behavioral modification care model, treatment plan development and implementation, and used most facilitative treatment approaches. Evidence of staff involvement and engagement resulted in improved employee opinion scores, decreased staff turnover and improved retention rates. In addition, therapeutic alliance with the patients in relationship building and intervention strategies resulted in positive patient satisfaction and improved clinical outcome scores. This competence and experience of the RTC core staff was inherent in their own professional development, self-knowledge and skill building. Patient care councils and leadership coaching provided team-building and individual skill sets that contribute to staff's adherence to cultural and philosophical change.

The quality measurement tool used in this initiative was the rate-based measure of seclusion episodes per patient census days tracked from 1999 to present. Additional data collection elements included day of the week, time of day, location of behavior, duration of episode, diagnosis, number of seclusion per patient, and others as defined by CMS standards. Clinical change was quantified and benchmarked by repeated measures on the Brief Psychiatric Rating Scale for Children (BPRS-C)[3]. Behavioral modification teaching interactions to patient's referral behaviors, or target skills, were tracked. These target skill-teaching interactions were measured as a quality indicator and link early intervention and youth's skill development to prevent aggressive behaviors leading to seclusion. Time out logs documented least restrictive intervention strategies used. Patient satisfaction scores were tracked upon dismissal. Annually, employee satisfaction surveys are scored. If variation occurred, investigation into the cause was studied. Checks and balances from staff, supervisors, data management specialist, and quality improvement specialist tracked the data to discover if entry errors occurred and investigated the cause. If special cause variation occurred, specific departmental team care conferences were implemented with Steering Team, Quality Council and Management Council oversight.

Measurement data were objective; the same definitions for measurement were used across the system. 100% of all seclusion episodes were reported. In addition, each seclusion episode was reported within the team, across shifts, and to leadership. Patient responses assured all episodes were evaluated and debriefed. Monitoring of individual staff trends and patterns were used in training and development as indicated. Control charts (Appendixes II & III) were studied to monitor special cause variation. Action plans were developed as needed to use the data to impact program changes at the point of care.

[3] Brief Psychiatric Rating Scale for Children (BPRS-C) developed by Dr. John E. Overall, Department of Psychiatry and Behavioral Sciences, University of Texas Medical School, P.O. Box 20708, Houston, TX. 77025

As depicted in Appendix II, data was first collected in 1999. Comparison data and benchmarks were not available as there are no uniform definitions for restraint / seclusion indicators. However, based on our own internal review the rate seemed high as determined by the number of seclusion episodes. In 1999 Culture changes had not yet evolved around use of best practice recommendations. The beginning of the re-engineering of the seclusion process occurred in May, 1999. In September, 1999 the CMS and JCAHO standard gap analysis action plan implementation began. Then in December, 1999 the unit restructuring occurred to increase space and begin the environmental improvements. In August 2000, "Planetree" commissioning for a healing environment, clinical outcomes tracking, strength-based behavioral modification training and patient care councils began. In January 2001 (Appendix III), mandatory CPI training was required for all staff with nationally certified instructor and coordinator of the training as core staff. The core staff program and patient satisfaction outcome surveys began in April, 2002. These protocols demonstrated special cause variation with positive trending of sustained results. The minor rise in October, 2003 accounts for a special cause variation that was attributed to a single high acuity case and addressed with consultation and special case conferences. In addition, staff training on use of time out and FOCUS-PDSA study methodology resulted in program structure change and sustained positive results. These initiatives reflect interventions used to impact the seclusion rate reduction and relate to the protocols of environmental initiatives, staff training, competency, and team building, patient care intervention, and use of data to improve care

The internal benchmark set by the organization has seen significant change through the years. In 1999, internal program comparative data trends led to a benchmark of 7%, then in 2000 was lowered to 5%, in 2002 to a goal of 2.5%, and year end 2003 at below 1%. This reduction in benchmark shows a significant philosophical and cultural change to move toward seclusion-free environment. Improvement changes were planned and tested as outlined in Appendix I "Use of

Therapeutic Milieu Management to Reduce Seclusion". Identification of changes occurred through consistent therapeutic milieu management, special case conferences and consultation. Patient care councils, an integral part of therapeutic management, is a shared governance process in which direct care staff, leadership, and collaborative health care partners defined and implemented changes to impact the quality of patient care as patient care needs evolved.

The targeted population of 6-18 year olds with histories of treatment failure and explosive acting out behaviors learned positive coping strategies and pro-social skills in the treatment protocols depicted in Appendix IV. This focused behavioral modification intervention plan connects youth behavior and the related staff interventions at each behavioral indicator in the cycle. This process assisted clinical staff's ability to initiate early interventions and de-escalation tools to prevent seclusion. Staff's competence in therapeutic relationships, use of therapeutic modalities such as patient specific debriefings, care conferences with case specific treatment planning also contributed to the success of this initiative.

Sustained reduction in seclusion rates over time demonstrated the short and long term success of the improvement changes. If a special cause variation occurred, use of data to investigate the reasons for the variation and to implement action plans assured continued success. Monitoring all the elements inherent in the process also ensured ability to conduct investigative analysis and cause and effect relationships. Consistency and persistence in maintaining the protocols outlined in this initiative account for the long-term success of the obtained changes.

Results

The relationship between the improvement changes and the measurement data was evident in the relative stability of the process. An example of the use of data to identify a special cause variation occurred in October 2003. Data revealed a significant rise in seclusion exceeding control limits of +3 sigma. FOCUS-PDSA methodology utilization by the RTC patient care council

determined time of day to be significantly related to seclusion episodes. Council discussions determined that early evening scheduling did not provide sufficient program structure. Programmatic changes were made to increase structured activities during this period and the results showed a significant drop to zero seclusion episodes in the months directly following this small test of change.

The improvement accomplished in this initiative was to reduce seclusion rates. The impact of the interventions used over time and outlined herein resulted in the qualitative objectives of quality patient care as evidenced in improved patient satisfaction, clinical outcome scores, and employee opinion scores. Patient satisfaction scores were ranked first among in the ten RTC national comparative sample with a score of 85.7% in comparison to the national mean score of 75.0%. Clinical outcome scores, reported as change scores from admission to dismissal, were 19.00 with a national comparative of ten like hospital programs with a mean score of 17.13. Our employee turnover rates decreased from 11.54% in 2001, to a new department low of 4.17% in 2005. Overall employee opinion scores for this program were 74% positive with a national mean comparative of 68%. The RTC staff responded to the following questions, the results of which indicate job satisfaction and commitment to high quality patient care:

- Do you like your job? 98% Yes
- Do you like working here? 98% Yes
- Do patients treated at this organization receive good care? 95% Yes
- Does your day to day work reflect the organization's mission? 93% Yes

The above qualitative and quantitative findings reflected excellent results in clinical outcomes, patient satisfaction, employee turnover and employee satisfaction. Sustainable improvements over time as evidenced in the graph outlined in the appendix have shown trends downward with some

variation that has been addressed systemically through scientific approach. Since February 2001, Seclusion Rates have been sustained at less than 1%, except for a brief special cause variation that occurred in October 2003. Focused study and plan implementation sustained the seclusion rate at zero for several months and at less than 1% since this one-month anomaly. These initiatives cluster in categories analogous to the "Six Core Strategies" identified as best practice in the recent "Creating Violence Free and Coercion Free Mental Health Treatment Environments"[4] which is research by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center (NTAC). This research has reinforced this initiative's protocols as best practice standards. Six core seclusion reduction strategies are defined as follows: organizational philosophy, use of data to inform practice, workforce development, use of seclusion/restraint reduction tools, consumer roles in inpatient settings, debriefing techniques

Appendix V entitled "Therapeutic Milieu Initiatives for Seclusion Reduction Compared with Six Core Strategies" depicts a pyramid schematic that correlates these national six core strategies on the far right with this initiative's protocols in the pyramid.

Lessons Learned

Realization of this program's quality initiative results exemplified best practice standards that were identified national, but were being implemented locally over time. In addition, since this behavioral program is part of an acute care hospital setting, of a larger organization, and within a behavioral health service line, the lessons learned are applicable to all levels of care treating aggressive behaviors in youth. This information will be shared nationally at the American Association of Children's Residential Centers in October.

[4] Training Curriculum for the Reduction of Seclusion and Restraint, *Creating Violence Free and Coercion Free Mental Health Treatment Environments*, National Association of State Mental Health Program Directors (NASMHPD) and National Technical Assistance Center (NTAC), Alexandria, VA. 2004

Obstacles to overcome were related to culture change, lack of clear clinical practice protocols, followed by inconsistencies of protocol implementation. Challenges included establishing and sustaining the protocols that led to the best practice initiatives. Organizational philosophy with an integrated approach brought best practice to not only policies and procedures, but to attitudes and actions of milieu staff. A multi-modal approach that hardwires process improvement must have a top down and bottom up integration. Therapeutic milieu management was the foundation upon which all components of this initiative were built. The national "six core strategies" are recommended as a template for designing a seclusion reduction plan that uses a prevention approach and establishes a monitoring tool for seclusion data supervision. The above-mentioned national guidelines link to this initiative and provide evidence of replication potential by other behavioral health care settings serving youth.

Our experience has been that isolated pockets of change in systems of care cannot sustain positive re-engineered improvements. However, a high performance therapeutic system with minimized use of seclusion will result from therapeutic milieu enhancement, behavioral modification protocols, collaborative therapeutic alliances, and best practice-based staff competencies. The results of this initiative have improved the health and skill level of the patient population, enhanced patient outcomes, and raised employee satisfaction. The strength-focused milieu management protocols led to significant and sustained seclusion rate reduction approaching a seclusion free environment.

Appendix I

USE OF THERAPEUTIC MILIEU MANAGEMENT TO REDUCE SECLUSION, GROUPED BY TYPE OF INITIATIVE:

ENVIRONMENTAL INITIATIVES:

- Planetree Commissioning – national research based healing environment initiative
- Unit Painting- colors and patterns according to "Planetree" principles and patient and staff decision-making
- Furniture updating to create a more warm and caring environment
- New curtains to promote privacy and a warm environment
- New bed comforters in warm patterns and colors
- Improved office space for individual and family therapy sessions
- Obtained transportation for outings and to increase motivation

STAFF TRAINING, COMPETENCY, TEAM BUILDING

- Staff training on Therapeutic use of time out
- Began mandatory CPI training – with instructor as core staff
- Inservices by the Medical Director on patient care approaches
- Site for medical and nursing students training
- Annual Re-commitment to System Mission and Values Ceremony
- "Celebrating the Harvest" –celebration of patient and staff success stories
- Development of Core Staff program
- Pharmaceutical Medication Inservices
- Addition of Clinical Consultant with inservices developed from Needs Assessments
- Behavior Modification Training- annual competencies and program improvements

PATIENT CARE INTERVENTION

- Debriefing of seclusion episodes by Crisis Prevention Institute (CPI) COPING model
- Patient Care Councils- Shared Governance format for team decisions on programmatic changes and enhancements
- Individual Care Conferences with patient, family, caseworker, staff collaboration
- Clinical Consultant care conferences on approaches of difficult patients
- Use of the YMCA facilities for Recreational Therapy
- Pet therapy
- Participation of patients in the hospital craft fair
- Corps of Engineers Annual Christmas Party
- Volunteer Program- creates healthy relationships
- Reading program in the classroom-promotes a more "normal" environment and improves skill sets
- Planting and harvesting of a garden to promote therapeutic life skills
- Voluntary attendance at church
- Established overhead security assistance to obtain support
- Orientation packets for youth and families to include welcome bags
- Weekly team level meetings-full team discussion on patient progress
- Formal spirituality and bible study groups with daily communion to address spiritual needs

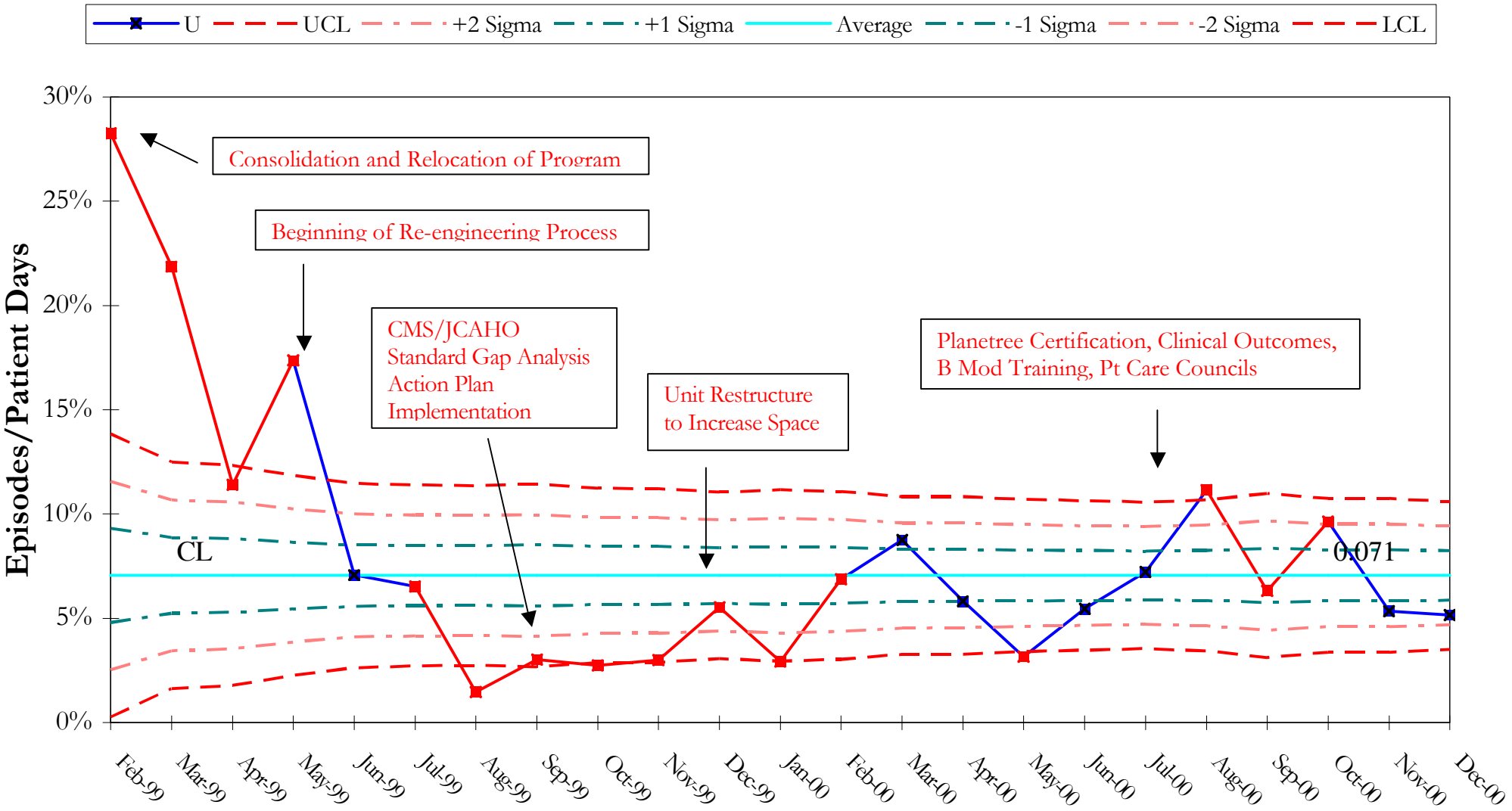
USE OF DATA TO IMPROVE CARE

- Implementation of Mental Health Outcomes- identifies individual functional outcomes and program areas in aggregation
- Improved tracking tools for Restraint and Seclusion to include new standards CMS / JCAHO
- Improved Behavioral Modification tracking of Target Skills

Changed Program Structure as results of increase in episodes on evening shift

Appendix II

RTC Seclusion Episodes as a Percentage of Patient Days
February 1999 - December 2000 U Chart



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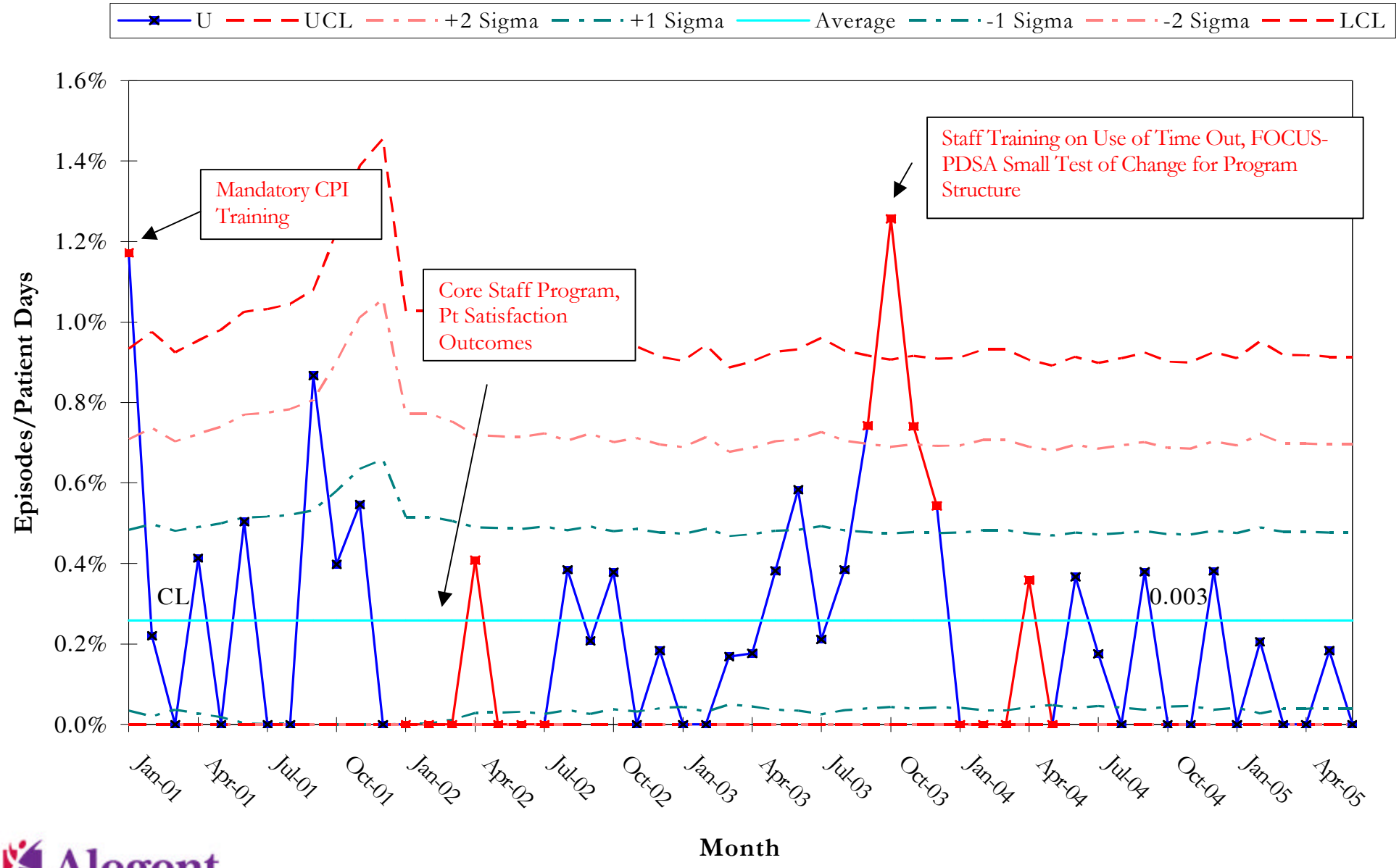
Appendix III

RTC Seclusion Episodes as a Percentage of Patient Days
January 2001 - November 2004 U Chart



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Appendix IV

RTC Behavior Modification Intervention Plan

Staff Intervention

*Assess Antecedents of Behavior

Effective Praise

Corrective Teaching

Use of Four De-escalation Tools
Empathy Statements
Praise Approximations
Consequences
Reality Statements / Rationales

Escalation / De-escalation Process

Deliver 2 I's for Initial Behavior

4 Tools Repeated

Offer Self-Control Strategy (SCS)

Staff Chooses SCS When Youth Unable

SCS
Take Space
Count
Deep Breaths
Journal
Talk to Staff
Draw

Least Restrictive Setting

Observe Youth For Self Control

Use of Self Control / Coping Strategy

Call Team of Support as Needed

Continue to Instruct Youth on Self Control

Open Seclusion Room if Dangerous to Self or Others, then locked if unable to maintain control in Open Seclusion Room

Still Refuses to Make Good Choices

Refuses to Take SCS or Allow SCS to Work

Refuses to Accept Redirections

Argues, Yells, Behavior Escalates

Unable to Accept Consequence of Behavior

Unable to appropriately Demonstrate Social Skill or Deal with Feelings

Youth's Behavior

Apologizes and Returns to Class or Group

Monitors apology

Assesses Pt's Ability to Demonstrate Self Control

Teach Alternative Behaviors SCS, SC, Original Issue

Assess For Self Control

Allow Time to Calm Down

Does Behavioral Assignment Able To Role Play Appropriately

Time Out in Unlocked Seclusion Room

Con'ts to Argue, Yell, Disrupts Therapeutic Milieu, Threatens Harm to Self or Others

Instruct Youth on Self Control Expectations

Initiate Seclusion Room Monitoring Form

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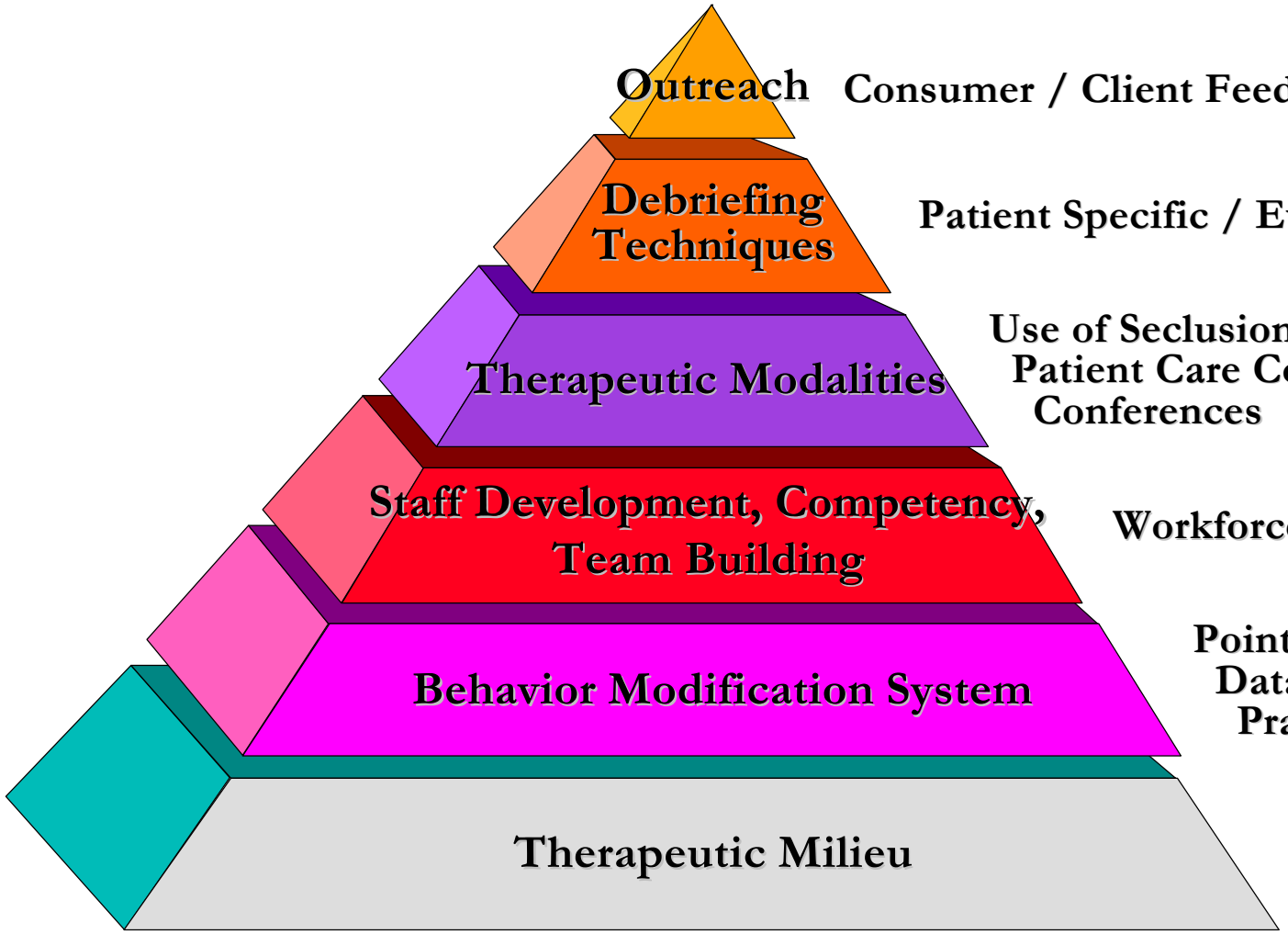
Appendix V

Therapeutic Milieu Initiatives for Seclusion Reduction
Comparison to Best Practice "Six Core Strategies"*



* NASMHPD / NTAC

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