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Eliminating or Decreasing Restraint Use and Seclusion for Adults in an Inpatient Psychiatric Facility

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
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Abstract

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MSN/Ed, Walden University, 2015

ADN, Stark State College of Technology, 2006

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Evidence from research around the world have indicated that the use of restraints and seclusion has become a controversial issue in mental health facilities relating to managing patients' aggressive behaviors. Evidence also shows that the use of restraints and seclusions should be the resort when all other options have failed. The rationale is to bring awareness of all of the alternative interventions that are available, as research has indicated that restraints and seclusions provide no therapeutic value to the patient or mental health staff. The conceptual framework is based on the Tidal model, which empowers the mental health patient with the tools to make a change, addresses their self-behaviors and provides foundation for growth. The conceptual framework also includes the Precede-Proceed model, which focuses on voluntary change and not forced change. It indicates that a voluntary change will last longer and have more positive outcomes than a forced change. The research question is, will the use of therapeutic options decrease or eliminate the use of restraints and seclusions? This was a mixed method design using both quantitative and qualitative data. The qualitative data was based on the options that were used prior to restraint use. The quantitative data was based on a percentage value to all options from 100% for the most used option to 0% to option not used.

The proposed project reflects a need for alternatives for restraints and seclusion use in an inpatient adult psychiatric facility. Options should be provided for patients and health care staff. All stakeholders should be given the tools to eliminate or decrease the use of restraints and afforded opportunity to receive the safest, most respectful, most dignified, most ethical, and most therapeutic environment.

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Dedication

This project is dedicated to my father and grandmother, who have been my constant source of motivation. They have provided me with the tools and discipline to meet any challenge believing that I will be victorious. Also, to a very special person to me, N. Davis, who has been there with me throughout my educational journey. I especially want to thank my professional colleagues who were the inspiration for this effort.

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Section 1: Nature of Project

Introduction/Background/Context

The use of restraints in the treatment of mental illness has long been a controversial practice (Barton, Johnson, & Price, 2009). A call for change has been made by many professional and advocacy groups in mental health to reduce or eliminate the use of restraints and seclusion for mental health patients. The mental health recovery model indicates a change is needed in the culture of mental health units with a focus on patient-centered care by nursing staff that presents a restraint-free environment, and the use of other options and treatment methods instead of restraint use (Barton et al., 2009). Restraints should be used as a last resort when all other options have failed or if a patient presents with suicidal or self-harm behavior. The use of options should be provided for both patients and staff as both are affected negatively, and restraint use can be a traumatic event for both parties. The elimination of restraints and seclusion can be met in many different ways by staff relating to employee safety and the fears of the staff (Barton et al., 2009).

Restraint use for the patient can be traumatic, present physical injury, and even cause death. The use of restraints and seclusion provides no therapeutic value to the treatment methods but may pose an adverse effect on the provider-patient relationship. Many times, the use of restraints by mental health staff is not for the benefit of the patient, but for the interest of the employee based on their fears, not wanting to use methods that are least restrictive, and not wanting to weather the storm. Mental health patients should be provided the best patient-centered care regardless of their behavioral

issues, staff fears, and other mental health challenges other than the use of restraints and seclusion.

Problem Statement

Restraints and seclusion have become a major topic for inpatient psychiatric facilities around the world. Restraints and seclusion are often used when psychiatric patients present aggressive and threatening behaviors and are not redirectable (Ashcraft & Anthony, 2008). Health care officials from around the world have attempted to find options for the use of restraints and seclusion as they have concluded that such use provides no therapeutic value for the patient but can interfere with the nurse-patient relationship relating to trust, therapeutic communication, and overall milieu interaction (Level et al., 2014). Research has indicated that restraint and seclusion can present a danger to both the patient and staff, as staff members attempt to place a violent, uncooperative, and dangerous patient into restraints. Many times, putting a patient into restraints or seclusion can have a lifelong traumatic effect on the patient, but the events can be just as traumatic for staff as it interrupts the therapeutic process and is not conducive to recovery (Huckshorn, 2004).

Some practical options to restraints and seclusion include increased doses of medications, increased staffing, more therapy, better therapeutic communication, use of comfort or quiet rooms, and more family involvement. Providing the patient with options to their negative behavior assists them in identifying triggers to their actions and finding the best solution to address it. Behavioral options for patients not only help them during their inpatient stay but also after they return to society and are exposed to issues in their community. In this doctoral project, I will provide evidence of no therapeutic value in

restraints and seclusion, and I will focus on identifying options for addressing aggressive behaviors.

Purpose Statement and Project Objectives

The purpose of this Doctor of Nursing Practice (DNP) project is to present options for mental health staff when addressing aggressive and threatening behavior from a mental health patient other than the use of restraints and seclusion. My goal in the DNP project is to reduction or eliminate the use of restraints and seclusion to manage behavioral issues. My objective in this project will be to provide options to the patient and mental health staff that provide a therapeutic value to both the patient and employees.

Nature of the Doctoral Project

Current research has identified different approaches to reduce the use of restraint and seclusion in the adult psychiatric population (Cummings, Granfield, & Coldwell, 2010). Many studies in mental health facilities relate to options that can be used first before the use of restraints, but these interventions or options have not been used systematically. Furthermore, The Joint Commission has not presented a standard for restraint-free environment in mental health institutions. The current method of interventions needs to be evaluated in all mental health facilities and the new or updated changes applies in all mental health programs.

Significance

Restraints and seclusion continued to be a primary tool used in managing aggressive and threatening behaviors without the consideration of other options. With the importance of the effects that restraints and seclusion have on both the patient and the mental health staff, there should be a focus on using all options first prior to restraint use,

such as comfort rooms, increased scheduled medications, family involvement, counseling, increased staffing, and more group activities that keep patients from being bored (Cummings et al., 2010). Restraints use has put a dark cloud over the treatment methods used to manage behavioral issues in the mental health setting without looking at the long-term effect it has on patients, staff, and the mental health organizations that provide treatment for psychiatric patients. The culture needs to change in these mental health facilities by the leadership to develop new knowledge and training for staff relating to treatment methods other than restraint use (Chandler, 2012). With a change in culture, nurses and health care staff will be able to provide evidence-based treatment for mental health patients that provide a tool for presenting positive outcomes for both the patient and staff.

Definition of Terms

Aggression: Behavior that attacks, threatens, or intimidates.

Comfort room: A space designed with comfortable furniture, soothing colors, soft lighting, quiet music, and other sensory aids to help reduce unsettled patients' level of stress.

Fear: An unpleasant emotion caused by the belief that someone or something is dangerous, likely to cause pain, or a threat.

Least restrictive measure: Lowest level of interaction to address a behavior (restraint use is the highest measure).

Option: A thing that is or may be chosen. A choice or alternative.

PRN medication: Medications that treat occasional conditions

Restraint: A procedure that limits movement. These are leather or cloth devices, bed rails, or geri-chairs used to modify the behavior of an individual through the limitation of physical movement.

Seclusion room: A place in a hospital for those with mental illness, or a school for children with special needs, where a person can be taken if they need to be kept away from others for a short time.

Self-control: The ability to control oneself, in particular one's emotions and desires, or the expression of them in one's behavior.

Therapeutic value: Having a healing or curative power for a disease or ailment.

Assumptions

I assumed that the nursing population would be honest in their response to the survey and return the survey to me, the DNP student. It was also assumed by the nursing and mental health staff that restraint and seclusion provide a therapeutic value to the patient and provide positive outcomes for both the patient and mental health staff. I also assumed that restraints and seclusion are important tools for managing aggressive behaviors.

Limitations

The first limitation for this project was the size of the sample, which was limited to 100. Another limitation is based on the existing knowledge of the population of nurses on restraints and seclusions, and the facility policy. The method of intervention was based on whether the nurse is novice or an expert, and their understanding of the potential options that are available.

Summary

In Section 1, I identified the problem, purpose, nature of project and the significance of the topic. By addressing the issue of restraints and seclusion reduction or elimination, health care practitioners have to provide a treatment method that provides alternatives to restraint use in the adult mental health population that also provides positive outcomes.

Section 2: Background and Context

Concepts, Models, and Theories

Middle range theories present methods relating to high, middle, and low theoretical concepts. These methods were specific and relate to a limited focus on the real world (McEwen & Wills, 2014). The Tidal model is a middle range nursing theory relating to psychiatric and mental health nursing. This is a psychiatric and mental health nursing, as well as a psychiatric nursing model that has three core concepts: human experience relating to change and unpredictability. Other main concepts relate to world, self, others, risk assessment, and empowerment (McEwen & Wills, 2014).

The Tidal model provides the patient with the skills to control their behaviors and interact with staff, family, and themselves in a way that can prevent the use of restraints and seclusion. This model empowers the patient to look at all options that are available to them to control their behaviors and allow them to have positive outcomes.

The precede-proceed model is a community-oriented model that was developed to assist communities in creating health promotion interventions. The precede aspect of the mode ha four phases relating to social diagnosis epidemiological diagnosis that include environmental and behavioral diagnosis, organizational/educational, and administrative and policy diagnosis. The proceed area of the model has four evaluation phases that include implementation, process, impact, and outcomes. The precede-proceed model presents a sound basis for developing intervention and framework for analysis that the community can play a significant role in (Zaccagnini & White, 2014).

The precede-proceed model allows the community to play a vital role in the behavioral interventions for patients, which may include family members. All

stakeholders have a valuable voice in all aspects of patient care, and many times the stakeholders assist with providing the options that can prevent or eliminate the use of restraints and seclusion.

Relevance to Nursing Practice

The use of restraints in an inpatient psychiatric facility have a direct effect on nursing practice; in most cases, it is the nursing staff who initiates the restraint use (Chandler, 2012). The nursing staff creates the working culture on the unit based on the facility's restraint policy. The nursing policy directs restraint use and the options that are available to be used before initiating the use of restraints. If the facility nursing policy were changed to a no-restraints policy, nursing staff would change how they provide treatment to an aggressive and threatening patient and use all other options that are available, without the use of restraints. Staff training is a key factor in addressing restraint use and in change in the vocabulary relating to a patient issue that negatively presents data and receives a negative response. Furthermore, in a change in the terminology that addresses what is a negative behavior and how staff responds to all levels of behaviors.

Local Background and Context

The use of restraints and seclusion has a long history to manage aggressive behaviors in the inpatient psychiatric setting. *Restraint use* can be defined as the process that limits movement. Many types of restraints exist, including mechanical, physical, chemical, and seclusion (Riahi, Dawe, Stuckey, & Klassen, 2016). Current research has indicated that major safety issues exist for both the patient and staff that could lead to potential injury and death (Chandler, 2012). Many times, the use of restraints is the initial response by mental health staff members to address aggressive behaviors by mental

health patients without thoughts of an alternative approach. Restraints use should be the last resort and should be indicated as a final restrictive measure after all other measures have failed. Restraints use has been a means of punishment for inappropriate behaviors and has presented no therapeutic value to the patient, but restraint use can interfere with patient/staff relationship. Research indicates that the leadership should take an in-depth look at all of the alternatives that are available and ensure that staff is trained in their use and that staff is trained to have an understanding of their fears and lack of knowledge (Riahi et al., 2016).

Role of the DNP Student

My role as the DNP student in this project was to bring about awareness to the use and abuse of using restraints and seclusion. Awareness should be brought to the public, health care leaders, healthcare staff, patients, and all stakeholders. I collected all related data about the options that are available to the health care staff, and the need for education about the dangers and safety issue while using restraints. I also advocated for all mental health patients for the total elimination of restraint use to manage aggressive behaviors. Furthermore, I collected data by survey from two mental health facilities.

Section 3: Collection and Analysis of Evidence

Introduction

A considerable body of evidence demonstrates no therapeutic value in the use of restraints or seclusion in managing aggressive behaviors (Riahi et al., 2016). Many options and alternatives have been developed to provide a better treatment plan for the patient that bring about better patient outcomes. The use of these options and choices provided a safer milieu for both the patient and health care staff.

Practice-Focused Questions

1. Will the use of therapeutic options decrease or eliminate the use of restraints and seclusion?
2. Will eliminating the use of restraints and seclusion for aggressive behaviors provide a safe milieu?
3. Will staff training to identify triggers to behaviors assist with eliminating or decreasing restraint use?
4. If restraint use is discontinued at all mental health facilities, will healthcare staff use all available options to address aggressive and threatening behaviors?

Sources of Evidence

The American Psychiatric Nurses Association (APA) has a sustained commitment to the reduction and ultimate elimination of seclusion and restraints, and advocates for continued research to support evidence-based practice for the prevention and management of behavioral emergencies (APA, 2014). Both patient and staff safety are a primary concern for the association. The organization has indicated that restraints and seclusion should be used only as a last resort when all other interventions have failed

(Zun, 2005). The APA has also indicated that when a potential for injury or death exists, all other options should be attempted first to ensure the safety of patients and staff. The Joint Commission on Accreditation of Healthcare Organization (JCAHO) has standards PC.11.10-11.100 and PC.12.10-12.190 that are requirements and conditions for the use of restraints and seclusion, and also for patients' rights. Using options other than restraints and seclusion allows health care workers to provide the patient with other tools to address negative behaviors and forces the staff to grow beyond restraints use by providing more positive and therapeutic treatment.

The American Nurses Association (ANA) strongly supports the nurse's role in eliminating or decreasing the use of restraints and seclusion in health care settings (ANA, 2012). The ANA has indicated that seclusion and restraints either indirectly or directly have been indicated contrary to the fundamental goals and ethical focus of the nursing profession, which upholds the autonomy and inherent dignity of each patient (ANA, 2012). The Mental Health American Association (MHA) had a policy position that indicates restraints and seclusion cause human suffering, severe emotional and physical harm, provides no therapeutic value, and even death. The MHA indicates the use of restraints and seclusion should be immediately terminated.

I collected evidence by using the Walden University Library and electronic search, and I used the following databases: Medline, Ovid Plus, CINAHL, PubMed, and Nursing Journals. The terms that used for the search included *restraints*, *options*, *elimination of negative effects*, *seclusion*, *patients' rights*, *ethical use*, and *therapeutic value*.

Analysis and Synthesis

The synthesis of literature consisted of systematic reviews and/or research studies that focus on the evidence of the research. The use of restraints and seclusion could be a traumatic event for patients and health care staff; it provides no value to the therapeutic process and has no bearing on recovery. There have been six strategies that have been effective to reduce restraints and seclusion use and have been indicated to be low cost, and easily and publicly available (Huckshorn, 2004). The direction and focus of the leadership is a major component to the reduction and potential elimination of restraints. The leadership developed policies, procedures, and practices that are based on the principles that these elements will provide a more positive intervention when addressing aggressive and threatening behaviors. This is based on education, staff training, and development activities by human resources that include training for restraints and seclusion application (Huckshorn, 2004). A variety of assessments, tools, and strategies can be implemented to adjust the mental health facilities method of addressing aggressive behaviors.

Data have shown that by implementing a variety of core strategies that focus on reducing restraints and seclusion, there can be a major reduction in restraint use. Mental health nurses are in a position to use these tools and to demand the necessary changes that will provide safe and positive outcomes for both patients and mental health staff (Huckshorn, 2004).

A bicultural study conducted between the United States and Norway assessed and monitored 50 patients in Norway and 50 patients in the United States. Chart data were collected from two intensive care units. The collected data indicated that 39 patients of

the 50 that were observed in the United Sates were placed in restraints and none of the 50 patients in Norway were placed in restraints (p = .001) (Martin & Mathisen, 2005). It was concluded that facilities that have similar characteristics of patients and technology vary differently in level of sedation, restraint use, and nurse to patient ration per nation.

The use of physical restraints has become an acceptable standard of practice, but not without scrutiny. Recently, a major focus has been on reducing or eliminating the use of restraints because of patient and staff safety and to present better therapeutic options to the patient, not punitive interventions (Martin & Mathisen, 2005).

Researchers conducted at Yale-New Haven Hospital that has a 15-bed capacity and has an average of 198 admissions per year. Information was collected during a 5-year period. During this 5-year period, a collaborative problem solving (CPS) intervention was used. CPS is a manualized therapeutic program rooted in cognitive behavioral concepts that were developed for patients with aggressive behaviors (Martin et al., 2008). During the 5 years, a total of 998 patients were admitted. Prior to the implementation of the CPS model of care, there were 559 restraints and 1,671 seclusions during the period. After implementation of the CPS model, there was a reduction of restraint use from 263 events to seven events per year, and seclusion from 432 to 133 a year (Martin et al., 2008). During the implementation of the CPS model, there was a moderate increase in staff assaults by the patients. The collected data indicate that options exist to restraints and seclusion that will present with positive outcomes for the patient.

Borchardt et al. (2011) found that a study was conducted at a state psychiatric hospital that was an experimental designed study that examined the outcomes of systematic implementation of behavioral interventions. The study included using a set of

interventions that were preselected on five different units. The participants included both patients and employees during a 3.5-year period. Some of the components for the design were trauma-informed care training, including patients in treatment planning, changes to unit rules and language, and changing the characteristics of the therapeutic milieu. Each unit applies the interventions in different orders. After the data were collected for 3.5 years, the data indicated that substantial decreases in the use of restraints and seclusion are possible based on changes in the milieu and culture of the unit (Borckardt et al., 2011).

Many studies in different countries have been conducted that have recognized the harm in using restraints and seclusion and have made efforts to decrease or eliminate the use of restraints and seclusion (Lebel et al., 2014). The United States has led the way by implementing a national effort to prevent and reduce restraint use. The U.S. government, along with evidence-based practice, federal impetus and funding, and the six core strategies has developed interventions relating to violence and conflict behaviors that has led to being placed in restraints. The model relating to the six core strategies have been successful in many states in the United States and is currently being adopted by the United Kingdom, Finland, Australia, and other countries. Data that have been collected worldwide have indicated that using the six core strategies have led to major decrease in restraint use and have forced health care providers to use all options that are available with restraint use being the final resort. Evidence shows that challenges still must be addressed in the fight to eliminate restraint use (Lebel et al., 2014).

Many times, the milieu plays a major role in patient behaviors. A study was conducted to determine the effects of the milieu and staff on addressing behaviors by

patients who were in a psychiatric setting that could potentially lead to being place in restraints (Sclafani et al, 2008). The study focused on reducing the behaviors that lead to restraints by applying a nontraditional consultation process. The results of this study decreased restraint use from 36 episodes to zero episodes per month (Scalfani et al, 2008). The study also promoted a culture for change in the treatment method and staff interaction with the patients.

Implementation of DNP Project

Data that were collected from this project were shared with local mental health facilities in Los Angeles, California. I also attempted to change the restraints and seclusion policy at my place of employment and ensure that all options are in place to be used by mental health staff. With this DNP project, I attempted to change the culture of facilities regarding restraints and seclusion while assisting them in providing a more therapeutic milieu that benefits both patients and staff. Safety and positive patient outcomes were the priority for all mental health facilities. In this DNP project, I ensured that all options, other than restraints and seclusion, were the key to providing an environment that is therapeutic and safe for all patients and staff while ensuring positive outcomes for all.

Method of Data Collection

Surveys were the primary method of collecting data from nursing staff at both of the potential mental health facilities. I surveyed nursing staff about the use of restraints and seclusion, what treatment methods were attempted before the use of restraints, and whether those methods were successful. The survey did not include any patient data or personal information but focused on the number of times restraints were used per month

and what options were used before and after. The survey also addressed the therapeutic effects restraints use had on the patient and staff. Last, the survey evaluated employees' beliefs about discontinuing the use of restraints and seclusion and changing the unit culture when addressing aggressive and threatening behaviors. Along with each survey staff received a list of options they can use prior to the use of restraints, such as comfort room, medications, increased staffing, behavioral counseling, family interventions, patient venting and understanding their fears, and staff education and understanding their own fears.

There were no patient subjects involved or any patient data used. The collected data indicated only a mixed-methods approach about restraint use and a mixed-methods approach relating to the use of options before and after restraints used. I collected on individual workers or their interaction with patients relating to patient behaviors or patients being placed in restraints or seclusion. I used a quantitative method of evaluation to determine which method of intervention provided the best results and which intervention was used the most.

Project Evaluation Plan

The method of data collection was by both qualitative and quantitative methods (mixed method), using a convenience sampling method. I collected data by surveys using a population of 100 nurses from two different mental health facilities. Survey questions focused only on the use of restraints and seclusion, and the options that were available or used. Because there were no patient or staff data used, there were no ethical issues involved. The data addressed the issue how many times did the nurse use restraints and whether any options were presented prior to restraint use and if there were any

therapeutic value that was gained by the patient. The collected data from the surveys determined which intervention was used most, and to evaluate which intervention provided the best results.

The Iowa model of evidence-based to promote quality care through research. This model was developed to guide nursing staff in making decisions that affect patient outcomes. The precede-proceed model was a community-oriented model that was developed to assist communities in creating health promotion interventions. The precede aspect of the mode has four phases relating to social diagnosis, epidemiological diagnosis that include environmental and behavioral diagnosis, organizational/educational, administrative and policy diagnosis. The proceed area of the model has four evaluation phases that include implementation, process, impact, and outcomes. The precede-proceed model presented a sound basis for developing intervention and framework for analysis in which the community can play a significant role.

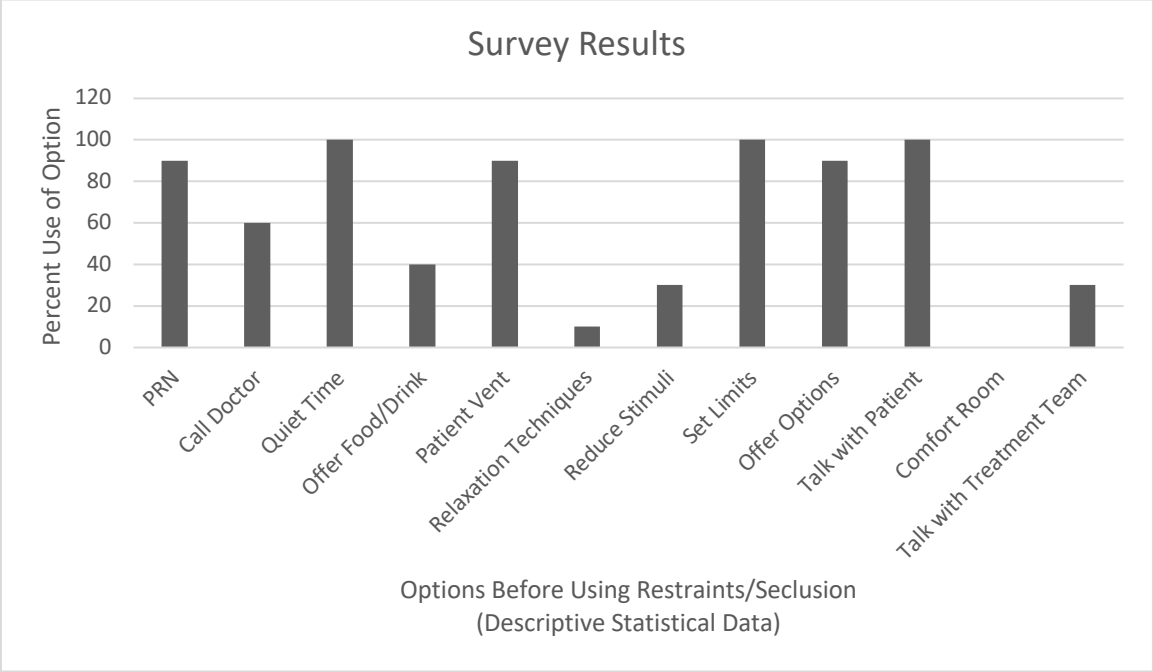

Figure 1. Presentation of results.

Summary

The project reflected a need for options and alternatives for restraints and seclusion use in an inpatient adult psychiatric facility. Both choices and options should be provided for both patients and health care staff. All stakeholders should be provided the tools to eliminate or decrease the use of restraints and afforded the opportunity to receive the safest, most respectful, most dignified, most ethical, and most therapeutic environment.

The options are directed to both patients and staff. Because nursing staff initiated the restraint use, they should be presented with the tool to provide the least restrictive measure and given the insight to see beyond the behavior and focus on the triggers. I had to address not only the fear that the patient feels when being placed in restraints, but also the fear of the mental health staff. It was based on fear of the patient, but also the fear of

being hurt. I had to provide a safe environment for all and ensure that patients were discharged without injury and distress. In addition, that all staff were able to return to their family without injury or distress.

Section 4: Findings and Recommendations

Introduction

For many years, the use of restraints and seclusion has been a controversial topic for many inpatient psychiatric facilities around the world. Research has indicated that restraints and seclusion should be the last resort and the last intervention after all other options have failed. Many options are available such as PRNs (this is a Latin word that means "as the thing is needed"), increased staffing, quiet time, comfort rooms, talking with the patient, letting patient vent, and many more that can prevent the use of restraints.

Many times, staff members do not use all the resources and options that are available before restraint use and present a dangerous situation for both the patient and staff.

There were four practice-focused questions in this project:

1. Will the use of therapeutic options decrease or eliminate the use of restraints and seclusion?
2. Will eliminating the use of restraints and seclusion for aggressive behavior provide a safe milieu?
3. Will staff training to identify triggers to behaviors assist with eliminating or decrease restraint use?
4. If restraint use is discontinued at all mental health facilities, will healthcare staff use all available options to address aggressive and threatening behaviors?

My purpose in this doctoral project was to validate that restraints and seclusion have no therapeutic value and that the use of alternative interventions other than restraints provide positive outcomes for both the patient and the mental health employees.

I obtained the evidence using a 10-question survey that I passed out and collected. I provided the survey to 100 nurses at two different mental health facilities from two different shifts, with a response from all 100 nurses. The strategy of the survey was to collect data relating to the use of options or alternative interventions other than restraints and to document these options and present a numerical value to the option to verify which was used the most to which was applied the least.

Findings and Implications

I obtained the evidence using a 10-question survey that I passed out and collected. I provided the survey to 100 nurses at two different mental health facilities from two different shifts, with a response from all 100 nurses. The strategy of the survey was to collect data relating to the use of options or alternative interventions other than restraints and to document these options and present a numerical value to the option to verify which was used the most to which was applied the least.

Qualitative Data

1. Limit setting.
2. Talk with patient.
3. PRN.
4. Let patient vent.
5. Quiet time.
6. Reduce stimuli.
7. Offer food.
8. Offer something to drink.
9. Deck break.

10. Relaxation techniques.
11. Exercise.
12. Counseling.
13. Talk to doctor.
14. Talk to treatment team.
15. Offer options.
16. Provide room monitor.
17. Contact family.
18. Comfort Room (neither facility had a comfort room).

The qualitative data were based on a collection of options or alternative interventions that are available prior to implementing restraint use. These options were indicated by the survey participants as a method of preventing the use of restraints and seclusion, and that they provided a therapeutic value that assisted the patient in regaining control over their behavior. Some of the options were used in one facility, but not the other based on hospital policy. The comfort room was not available in either inpatient facility but has been discussed by management in both facilities to possibly implement based upon budget and locating an available room. The qualitative data indicated that alternative methods may be used to address aggressive behaviors other than restraints and these are options that the research participants attempt to use as a first resort to addressing patient behaviors. The research participants believe that restraints should be used as a last resort after all other alternative interventions have failed. Many times, the option or alternative intervention that the survey participants used was based on the behavior and level of aggression.

The Quantitative Data

This data indicated the percentage factor that each option was used. The percentage factor indicated the highest percentage used (100%) to the lowest percent 0%.

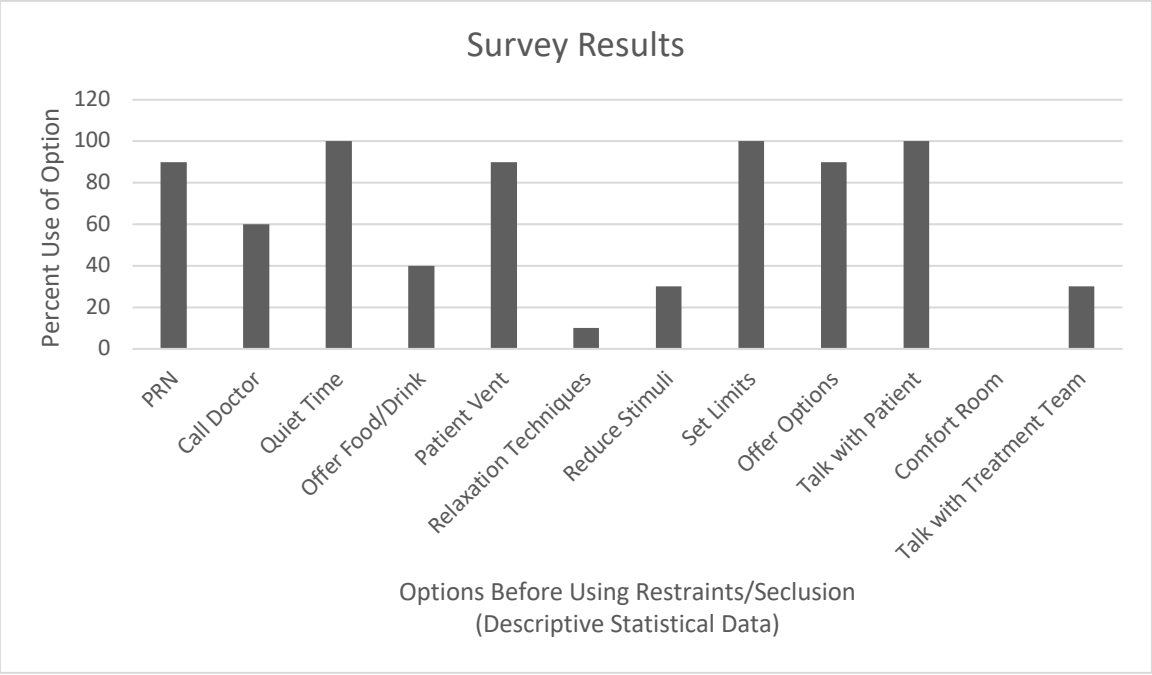

Figure 2. Survey results.

The surveys indicated descriptive statistical data that staff used quiet time, limit setting, and talking to the patient 100% of the time instead of restraint use. These were followed at 90% of interventions that included PRN, patient venting, and offer options. All of the other options vary from 10% to 60%. The comfort room was the only intervention that was 0% because there was no intervention room at either facility.

For the collected quantitative data, the dependent variable indicates that the survey participants were compliant in using alternative interventions to address aggressive behaviors. Figure 2 also indicates descriptive statistics that give a percentage

value to each option based on how often they were used. The percentage value indicated how often an alternative intervention was used to prevent restraint use, many times the option that was used and how often had a direct correlation with the behavior. With the higher percentage options (80% to 100%), restraint use might have a higher priority because the highest percentage option, 0% to 80%, has no positive effects the survey participants indicated that they would try other options that had not been used before they would resort to restraint use.

The collected data from the surveys indicate that mental health staff has attempted to use a variety of options before restraint use. The received data from the participants in the survey suggest that it was not therapeutic for staff because restraints interfere with the nurse/patient relationship. They could not determine whether a patient felt traumatized by being placed in restraints, but they did believe that it presented to be traumatic based on their observation.

Based on the collected data from the surveys, the null hypothesis is rejected. H_0 was rejected because there is a statistical significance between using alternative interventions (options) to eliminate or decrease the use of restraints.

The alternative hypothesis is accepted. H_1 was accepted because there is statistical significance that the use of alternative interventions has a direct effect on eliminating or decreasing the use of restraints and seclusion. The survey participants indicated that they attempt to use every alternative intervention to address aggressive behaviors in the adult population ages 18 to 55 years. The surveys indicate that all available interventions were used prior to placing a patient in restraints. The alternative hypotheses indicate that there

is a direct correlation between the dependent variables (options) with independent variable (restraints use).

The findings do not include suicidal or self-harm behavior where the safety of the patient is at risk and must be protected at all times to prevent harm to themselves. The findings also indicate that staff members prefer a one to one or a two to one observation (one staff to one patient or two staff to one patient) instead of placing the patient in restraints. This data does not affect the overall findings because this was not a part of the survey or collected data.

The use of options or alternative interventions will allow the individual (patient) an opportunity to seek out and request the different options to assist them in returning to a positive state of mental health. It will also help them in accepting help or assistance from their mental health employees who may observe a decompensating behavior. In addition, the data will have an effect on local mental health facilities that can implement the various options and validate that restraints and seclusion should only be used as a last resort and attempt to ensure the safety of the patient and staff at all times. This may also indicate a need for a change in policy and restraint use protocol.

Mental health patients come to mental health facilities for help. This means assisting and providing treatment to the patient regardless of whatever type of behavior they present with. These facilities are not jails or prisons, and mental health patients should be treated with dignity and respect at all times regardless of their behavior, also while providing the best possible care that presents positive outcomes that benefit all stakeholders.

Recommendations

A policy change is the primary recommendation to address the use of restraints at the local, state, and national levels. This will set the standard and guidelines that all inpatient psychiatric facilities must follow. Change in the current policy is needed to allow nurses to document on a special behavioral sheet to indicate all the options or alternative interventions that are used or offered prior to placing the patient in restraints, and allowing the doctor to assist with determining the best options to address the aggressive and maladaptive behaviors that will provide positive outcomes for the patient. Nurses currently make the decision and contact the doctor after the patient has been placed in restraints. Change the variety of options that are available, especially if the old options have not been productive. That includes staff training, specifically de-escalation techniques, and therapeutic communication.

Change is the primary tool that allows for a new vision and mission for all mental health facilities that will provide a safe and therapeutic milieu for all patients regardless of their behavior.

Strength and Limitations of the Project

The strength of the project is that it brings insight to an issue that has become a problem at many mental health facilities around the country. In this project, I address the need for change and to take a more in-depth look at the use of restraints and seclusion as an intervention that addresses aggressive behaviors. In this project, I also shed light on the many different options that are available and the ones that are not, such as the comfort room.

The limitation of the project is that I surveyed only 100 nurses at two mental health facilities in Los Angeles, California. The problem goes beyond these facilities, as it is a local, state, and national issue. Future projects should involve a broader geographical area and possibly mental health facilities in different states. The sample population could also be increased depending on the geographic areas that are being assessed.

Section 5: Dissemination Plan

Because of the widespread use of restraints and the difficulty in sharing this data with individual institutions, I will be sharing this data with significant mental health organizations, such as the National Alliance for Mental Illness (NAMI), the APA, the *Journal of Psychiatric Nursing*, the ANA, and state and national representatives to present a problem that needs to be addressed to ensure mental health patients' safety and the safety of mental health staff. This project is appropriate for all mental health facility employees that have the potential to initiate restraints and to assist with placing a patient into restraints. This involves all stakeholders, including the patient, their families, facility management, nurses, doctors, residents, and care partners, not only relating to eliminating or decreasing restraint use, but also to being supportive in providing all options that are available that could bring about positive and safe outcomes for the patient and mental health staff.

Analysis of Self

As an advance practice nurse, scholar, and project manager, I have gained a broader insight on a national issue. This project has given me the tools to advocate for change that will ensure a safe milieu for the patient and mental health staff. I can see a bigger picture now that shows me all the resources and alternative interventions that are available for me to use. I have also gained a better understanding of the best therapeutic treatment that will assist with giving the patient a better understanding of behaviors and actions that are appropriate for the hospital and in the community.

I am currently a nurse educator and plan on spending many years teaching and educating our future nurses. I am not sure what I will become involved with in the future,

but my horizons have broadened, and I am ready to take on any challenge. I love to advocate for patients' rights, so that may be a path that I may follow.

With the completion of my project, I can finally breathe. This has been a long journey but a journey that I have genuinely enjoyed. My dream has finally come true; I am Dr. Charles A. Banks. There have been a few challenges that I have been able to overcome, but nothing was ever a significant issue. I have learned a lot about myself and what I am capable of doing. I have also learned that dreams do come true if you have the heart and desire to pursue them.

Summary

The use of restraints and seclusion is a major topic being discussed by many mental health facilities around the country about the benefits of its use. There have been many problems associated with restraint use and its therapeutic value. Many of these problems are related to the lack of using available options or alternative interventions. The data that I collected from the surveys show the attempt of many facilities to present these options to decrease the use of restraints. Restraints use can be a traumatic event for both patient and staff, in some cases leading to patient's death. Restraints should be used only as a last resort and only when all other options have failed. Patients come to mental health facilities to seek help and assistance because of their mental health problem and should be provided the care and treatment that will bring about positive outcomes that will allow them to function in a manner that is acceptable to society.

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Appendix A: Survey

1. Have you ever initiated an adult psychiatric patient to be placed in restraints and seclusion? Yes No
2. Have you ever participated in placing an adult psychiatric patient in restraints and seclusion? Yes No
3. Was placing the patient in restraints or seclusion your first choice as a behavioral intervention? Yes No
4. Was placing the patient in restraints of seclusion a traumatic event for you? Yes No
5. Do you feel that placing the patient in restraints or seclusion is a traumatic event for the patient? Yes No I Don't Know
6. What options would you attempt to use prior to restraint use?

prn	offer food	relaxation techniques
counseling	talk to treatment team	exercise
contact family	offer something to drinkoffer options	
call doctor	let patient vent	reduce unit stimuli
deck break	provide room monitor	limit setting
quiet time	comfort room	talk with patient

7. Place a numerical value to the options starting with number 1 as the most used option up to number 10 being the least used.

Most Used 1.

2.

3.

4.

5.

6.

7.

8.

9.

Least Used 10.

8. Do you feel the restraints and seclusion were effective and had therapeutic value for the patient? Yes No
9. Do you feel that restraints use should be eliminated or decreased?

   Yes No
10. Would you want to be placed in restraints or seclusion if you had a behavioral issue?

    Yes No