The Minimization of Restraint Initiative

GRAFTON

Helping people with disabilities lead better lives.

Grafton—An Overview

For almost half a century, Grafton has been providing 24 hour support to individuals with co-occurring intellectual, developmental and psychiatric disabilities. As a nationally recognized leader in behavioral healthcare, Grafton employs more than 700 employees and supports more than 400 clients per year. Facilities are located in Berryville, Richmond and the Winchester regions of Virginia. A psychiatric residential treatment center supports children and adolescents with mild to moderate developmental and psychiatric disabilities. The psychiatric residential treatment facility is CARF(Commission on Accreditation of Rehabilitation Facilities) accredited and approved by Virginia Medicaid.

Services provided in Richmond and Winchester include special education services, clinical services, case management services, medical and nursing services and residential support for children, adolescents and adults. Grafton is licensed by the Virginia Office of Interdepartmental Regulation of Residential Facilities and accredited by the Virginia Association of Independent Special Education Facilities. Grafton's CEO/President is Jim Gaynor II.

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The Journey Towards Eliminating the Use of Physical Restraints

Summary:

Dignity and respect are at the foundation of good care and effective treatment planning and guiding principles at Grafton. The use of physical restraints is contraindicative to treatment with dignity and respect. Due to the numerous risks to clients and employees associated with the use of physical restraints, an innovative plan was implemented to eliminate the use of physical restraints. During our journey, a number of lessons were learned. Not only did we successfully improve client care and programming, we also drastically reduced physical restraints, staff injuries and created a safer place to work, learn and grow. It made a significant impact on the way Grafton serves those in its care and attracted the attention of other healthcare providers around the country.

Background:

There is numerous literature and research to support the tremendous risks of injury and trauma—to both clients and employees—associated with physical restraints. The need to eliminate restraint is not only identified as a key initiative for Grafton in providing an environment in which treatment can be most effective, but also has been recognized by other respected healthcare and educational organizations. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) issued a *National Call to Action* in 2003 concerning restraint and seclusion. "SAMHSA is committed to work with states, communities, consumers, families, providers, and provider organizations to ultimately eliminate the use of restraint and seclusion. Individuals with mental illness should not be confined, restrained, or retraumatized by the person and resources put in place to help them." http://samhsa.gov/seclusion/SRMay5report 4.ht.m.

This paper will highlight the successes Grafton has experienced in moving towards the elimination of physical restraint at the Winchester facility. Grafton's Winchester facility serves children and adults with Autism, mental retardation who may also have a concurrent psychiatric condition. Clients supported in the twenty-one community-based group homes lack safety awareness and display severe aggressive behaviors and required 24-hour residential support to manage their behaviors. Over the years various de-escalation strategies have been utilized, however, when those failed, physical restraint was used to maintain safety. An example of one of Winchester's highest months of data was in 2003. There were 260 physical restraints for a total duration of 3800 minutes.

Grafton's journey began in the summer of 2004 when Jim Gaynor, Grafton's CEO issued a mandate: eliminate restraint without compromising employee and client safety. This quality improvement initiative was so important that it was tied into a company-wide "gainsharing" bonus program. The "gainsharing" program is a quality-driven revenue sharing program—i.e. when the organization meets financial and quality improvement

targets, revenue is shared with employees. Following the CEO's mandate, each regional facility was challenged with creating an individual, facility-specific plan towards the elimination of restraint. Employees at all levels, direct care staff to top level executive management, embraced the mandate, understood the philosophy and immediately set to work on this defining objective.

Methodology:

A four step process was utilized to meet the initiative of eliminating restraint with many steps occurring simultaneously and some steps being revisited more than once.

Step 1—**Communication**—The first step in the plan was to involve employees in the process. The philosophy of supporting, comforting and managing a client experiencing emotional distress versus "controlling" a client in crisis was communicated to employees. A highly respect supervisor was designating as a "*reporter on the street,*" and charged with soliciting feedback from other employees. This included getting a pulse of employees' feelings about the initiative, what reservations they may have had and what tools and resources they needed to support the initiative.

Step 2—**Training**—It quickly became apparent that eliminating a tool (utilization of restraint) to manage behaviors without replacing it with another was not viable. The training, required for all employees, consisted of sharing philosophical perspectives and various verbal strategies that are useful when a client is in distress or crisis. Employees were asked to consider the following when supporting a client in distress: 1) Does this situation require a hands-on intervention? 2) What choices and alternatives can I offer to this client? 3) Who has a connection with the client? and 4) If I was experiencing emotional distress, how would I want someone to respond to me?

In addition, extensive, mandatory training was provided to all employees on "Extraordinary Blocking" techniques as an alternative to restraint. The training emphasized the use of pillows, cushions, bean bags and other soft objects to support a client in crisis and protect staff so they can take a step back and ask the important questions listed above. Throughout the training, it was stressed that the basic techniques and ideas would be taught, but it was up to each multidisciplinary team to use its creativity to find items that worked best for each individual client. The teams' innovative approaches resulted in numerous requests for alternative protective equipment that they believed would support the clients. The equipment was purchased as requested by employees.

Step 3—**Schedule of Support**—Increased physical presence and support was provided by the management team to help the employees. This included having management support in addition to the normal, rotating on-call schedule. Plans were developed for employees to call for assistance when clients were experiencing the early stages of difficulties. Imminent restraints could then be avoided with the additional support to assist in deescalating the

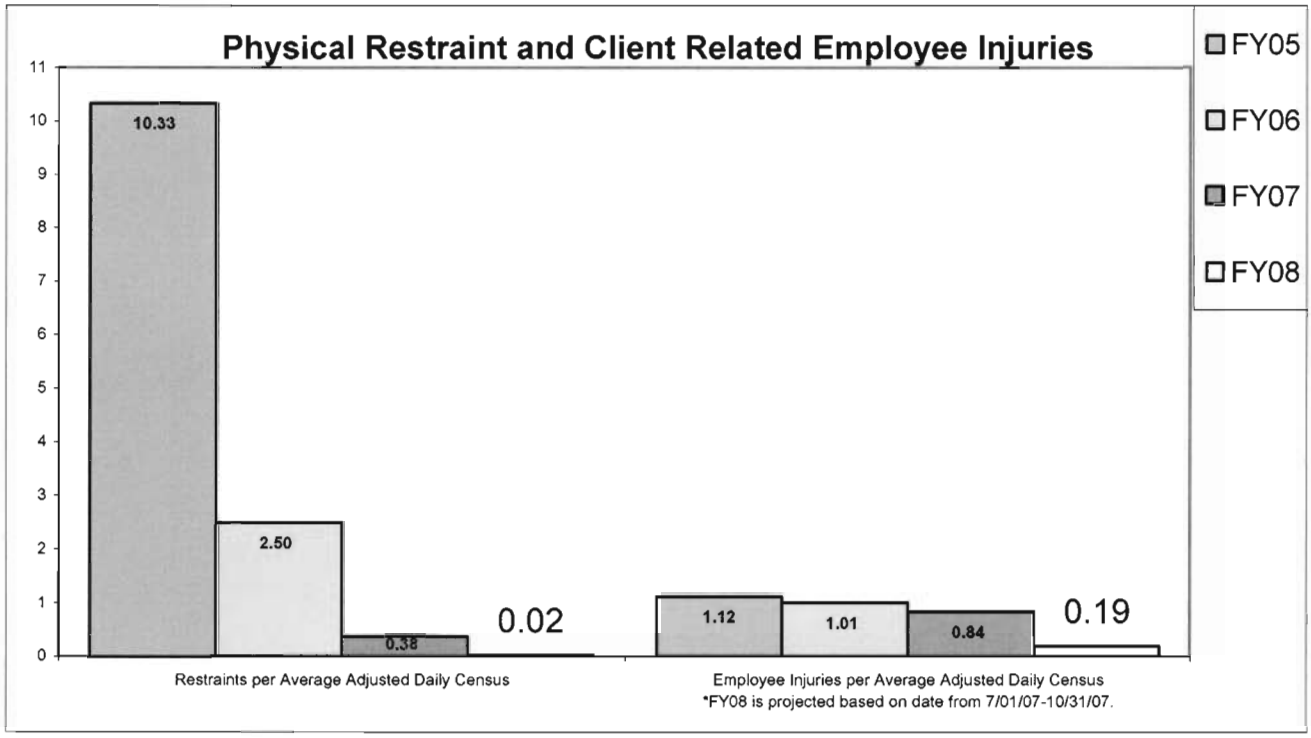
situation. Managers actively modeled responses to challenging situations in ways that did not include the use of physical restraints. This schedule of additional support was provided 24 hours a day and seven days a week. At any given moment, a direct care employee could look at the on-call schedule and contact a manager on call for support. Support was literally a phone call away.

Step 4—**System of Processing each Restraint/Seclusion**—As part of a larger effort to reduce the use of restraints, each and every physical restraint was subjected to an immediate system of processing. The purpose of this processing system was to debrief with the individuals involved. Clients were involved whenever possible, to learn lessons from each incident. Questions like the following were asked during the initial debriefing: 1) Was anyone hurt during the incident? 2) How did you de-escalate the client? 3) Is there any employee who might have had a better chance of de-escalating the client? 4) Was extraordinary blocking used? 5) What would you need next time to be able to effectively use the extraordinary blocking instead of a restraint? 6) Is there a plan in place for the client that offers alternative strategies to restraint? If yes, were those strategies used? 7) How might a similar situation be avoided in the future? 8) What is not in place that should be?

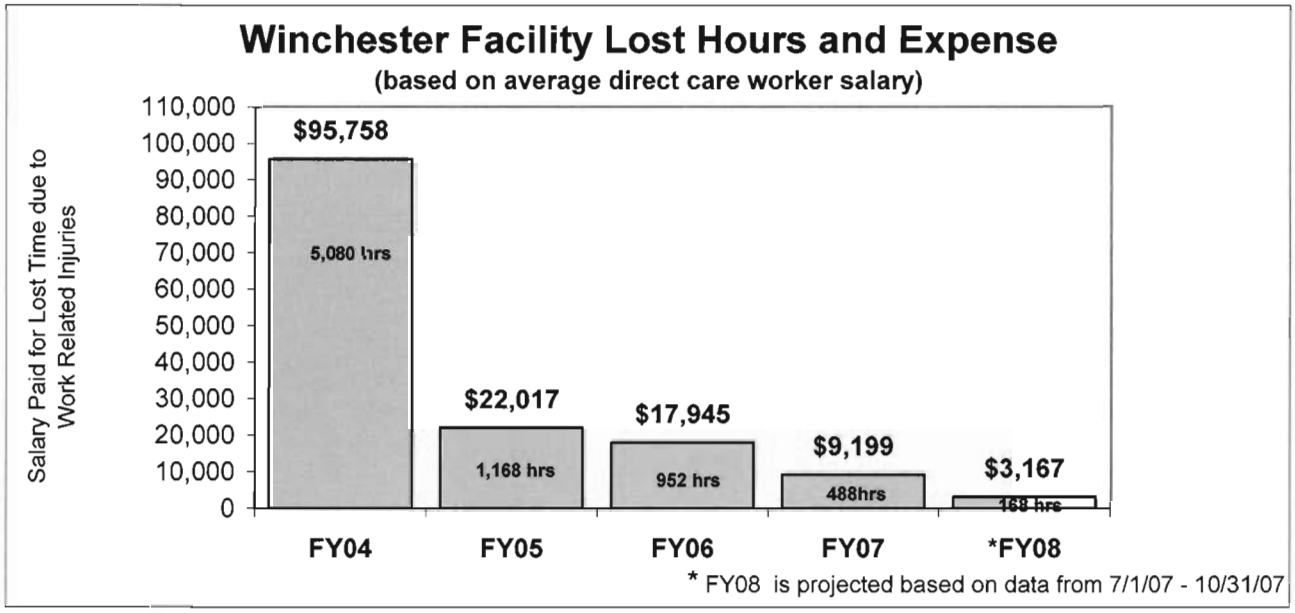
An organization-wide processing of each incident of restraint/seclusion also was put in place. It involved forming two organization-wide review executive committees to examine each incident of restraint/seclusion. The first group is the Restraint and Seclusion Review Committee which is made up of the three Executive Directors, the Director of Clinical Services, and the Chief Operating Officer. This committee meets at least once per month with the Executive Directors presenting to review, in detail, any restraint/seclusion that occurred in their respective region. The committee then makes a determination if the technique was warranted or unwarranted. The other committee is the Executive Review Committee, comprised of the members of the Restraint and Seclusion Review Committee plus the Chief Executive Officer, Director of Quality Assurance, Director of Training and Development and a Board of Directors representative. The purpose of these reviews is not only to ensure that the restraint was necessary and appropriate, but also to examine organizational trends and make adjustments as necessary.

Results:

Since the initiative was implemented, there has been a 99.8% reduction in physical restraints. Employee injuries from clients have reduced by 83%. *(See graphs below.)*



As a result of this initiative, employees report feeling safer and more supported. In addition to an enhanced quality of work environment and increased safety, there has been a 97% reduction in employee lost time and lost time expenses from client induced employee injuries.



Lessons learned:

Grafton is proud to serve as a best practice healthcare organization and feels strongly that factors that led to the success of our program could be easily replicated in other behavioral healthcare organizations. First and foremost, ensuring that there was buy-in from top level management and every employee within the organization is paramount. Second, correlating the elimination of restraint with the quality-driven revenue sharing program reinforced the organization's commitment to the initiative. Communicating the plan to all employees and providing alternative treatment strategies and training to support clients and employees is vital. Lastly, collecting and reviewing progress made on the initiative and sharing and celebrating successes with others for learning and inspiration are integral factors that contributed to the program's success.

Recognition of accomplishments:

Recently, a paper on Grafton's journey to eliminate restraint and seclusion was presented at the National Autism Society of America conference held in Scottsdale, Arizona in July 2007. The positive feedback obtained during the conference was remarkable. Licensing personnel as well as representatives from the Virginia Department of Education have praised Grafton's efforts in embracing the initiative to reduce and eliminate the use of physical restraints. The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services also praised the dedication of Grafton employees to the goal of reducing and eliminating physical restraints. Lastly, the paper depicting highlights of the Winchester facility's success was presented to the International Initiative of Mental Health Leadership (IIMHL). This group chose Grafton as one of the four best practice providers in the United States.