Creating Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint

Seclusion/Restraint Prevention Tools

A Core Strategy ©

A Primary Prevention Tool

NASMHPD

ntac

Any work used from this document should be referenced as follows:

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Seclusion/Restraint Prevention Tools

Outline

- Identifying and Managing Risk*
- Developing Crisis Prevention Plans
- Sensory Modulation
- Comfort & Sensory Rooms

*** separate training module**

Module created by Bluebird, Champagne, Huckshorn, LeBel, & Stromberg, 2003

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The next module is on seclusion and restraint prevention tools. This is the second half of the module that in total is called Assessment and Prevention Tools. We did assessment; we split it out because they're both together, kind of a lot of information.

The first part of this particular presentation has to do with the issue about preventing the use of seclusion and restraint versus doing it better; i.e. safer. I want to talk a little bit about the issue of doing it better and I don't want anybody to get the thought, although it may sometimes sound like that because we've had to walk a fine line between the preventing its use in the first place; preventing the lay not of hands of people versus the doing it better which we found as we've gone through the country a lot of people want to continue to focus on. In other words, because of the way CMS and Joint Commission have changed the rules, they still pretty much focus on monitoring, reporting, documentation, how long the person is in there, who's watching or monitoring the person; those kinds of issues and the rules are lagging behind the practice in terms of prevention.

With that said, this entire training is pretty much focused on prevention, that said, while we're still using seclusion and restraint, and I have a feeling especially some facilities will be using it for quite a while for certain folks, especially acute care kind of places. While we're doing that, we do need to learn more about how to do it safer. Part of that was talked about in terms of the assessment that you do for risk for violence and especially also for risk of medical death or serious injury.

Individual Crisis Planning

Module section created by LeBel, Stromberg, 2004

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Individual Crisis Prevention Plans

What are they?

Why are they used?

What elements make up a plan?

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But first, we'll talk about individual crisis plans: what are they; why are they used; what are the elements that make up the plan? I'm glad the slide asks … because I'm now going to tell you.

What is a Crisis Prevention Plan?

A Crisis Prevention Plan is *more than just a plan.*

- Fundamentally it is an *individualized* plan developed in advance to prevent a crisis and avoid the use of restraint or seclusion.

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A crisis prevention plan; it is more than just a plan. This is the beginning of the dialogue. This is the beginning of a therapeutic relationship. This is the time when you start to elicit from the people we are serving -- the things that can lead to a crisis for them, that could potentially lead to restraint or seclusion. So, it's the beginning of a therapeutic process. It's also highly trauma sensitive and individual specific and in trying to obtain this information -- you don't want multiple people trying to have this conversation of developing the plan. You really want to have a good thoughtful conversation with somebody about what works; what helps; and what doesn't when a problem is emerging -- and then begin to craft a plan together. That's what's different about an individual crisis plan. This is not the same old, same old kind of historic, paternalistic approach; we're going to tell you what to do; we're going to do this for you; we will keep you safe; rather – let's figure this out together so you can keep yourself safe.

What is a Crisis Prevention Plan?

- It is also:
  - A therapeutic process
  - A task that is trauma sensitive
  - A plan that is tailored to the needs of each individual
  - A partnership of safety planning
  - A collaboration between consumers and staff to create a crisis strategy together
  - A consumer owned plan written in easy to understand language

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The words of Ben Franklin; very powerful, very helpful and very clear: "… You involve me and I learn". If we involve the people we're serving and work together – we're going to learn together and end up with a plan that is meaningful to the person we want to help.

Other Names for Crisis Prevention Plans

- Safety Tool
- De-escalation Preference Tool
- Advance Crisis Plan
- Individual Crisis Plan
- Personal Safety Plan
- Personal Safety Form
- Safety Zone Tool

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Individual crisis plans are known by many different names and you'll see some of the slides have "Safety Tools," "Safety Plan" "Personal Safety Plan." They're all variation on theme -- the concept is the same; some of the language may change, but the intent does not.

Why Are Safety Tools Used?

Purpose:

- To help consumers during the earliest stages of escalation before a crisis erupts
- To help consumers identify coping strategies before they are needed
- To help staff plan ahead and know what to do with each person if a problem arises
- To help staff use interventions that reduce risk and trauma to individuals

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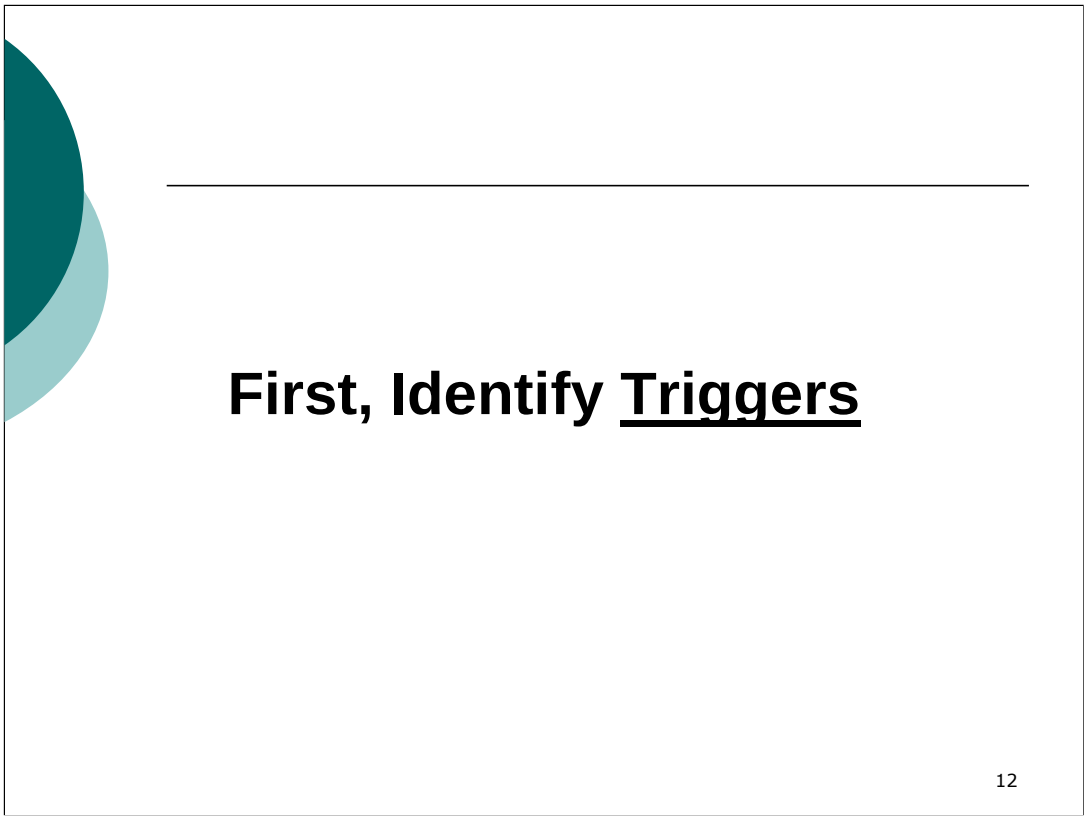
What are they? What's the purpose? Obviously you want to be able to identify at the earliest possible moments those warning signs that something is happening, so you can pay attention to it and respond to it. But if you look at the list, the purpose, the elements here, look at the top two, to help consumers; look at the bottom two, to help staff. These are really tools that are not just to help consumers develop a plan so that they've got a roadmap through the crisis, it's as much to help and inform staff so that staff know what to do in that crisis. Things activate crisis that are different and unique to each and every one of us. So the same old, same old standard crisis approach is not going to work for everybody. So truly this process is what's going to help each individual who's involved in that, whether you're staff or consumer, through that.

What are the components: triggers, early warning signs, strategies. If you're like me, I need little helpful reminders so I can remember these. I think about triggers as the antecedents; that's an "A". I think about early warning signs that's a behavior that then gets elicited, that's a "B." Strategies are the calming interventions that are then used … a "C." So I think about it as the ABC's: a, b, c; triggers, warning signs, strategies, antecedents, behavior and calming interventions



First we're going to start by identifying triggers.

No, not that Trigger …

Trigger, Roy Rogers' Horse

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Okay, but not that Trigger; wrong Trigger. Sorry, it's a little Western humor; we thought you'd like it.

These Triggers

- A trigger is something that sets off an action, process, or series of events (such as fear, panic, upset, agitation):
  - bedtime
  - room checks
  - large men
  - yelling
  - people too close

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What are the triggers? Triggers can be any number of things. Again, they are individual-specific. One person's trigger is not going to be another person's. Sometimes triggers are very clear; like loud noise & yelling.

More Triggers: What makes you feel scared or upset or angry and could cause you to go into crisis?

- Not being listened to
- Lack of privacy
- Feeling lonely
- Darkness
- Being teased or picked on
- Feeling pressured
- People yelling
- Room checks
- Arguments
- Being isolated
- Being touched
- Loud noises
- Not having control
- Being stared at
- Other (describe)

_____

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Sometimes triggers are not clear at all. People yelling; very overt; we can all hear that. That's very clear what's leading to that activation. But some of these are feeling states; feeling pressured, feeling lonely. You're not going to see that. So it's very important to remember that sometimes the ques will be very obvious and sometimes they won't.

More Triggers:

- Particular time of day/night_____
- Particular time of year_____
- Contact with family _____
- Other* _____

*** Consumers have unique histories with uniquely specific triggers - essential to ask & incorporate**

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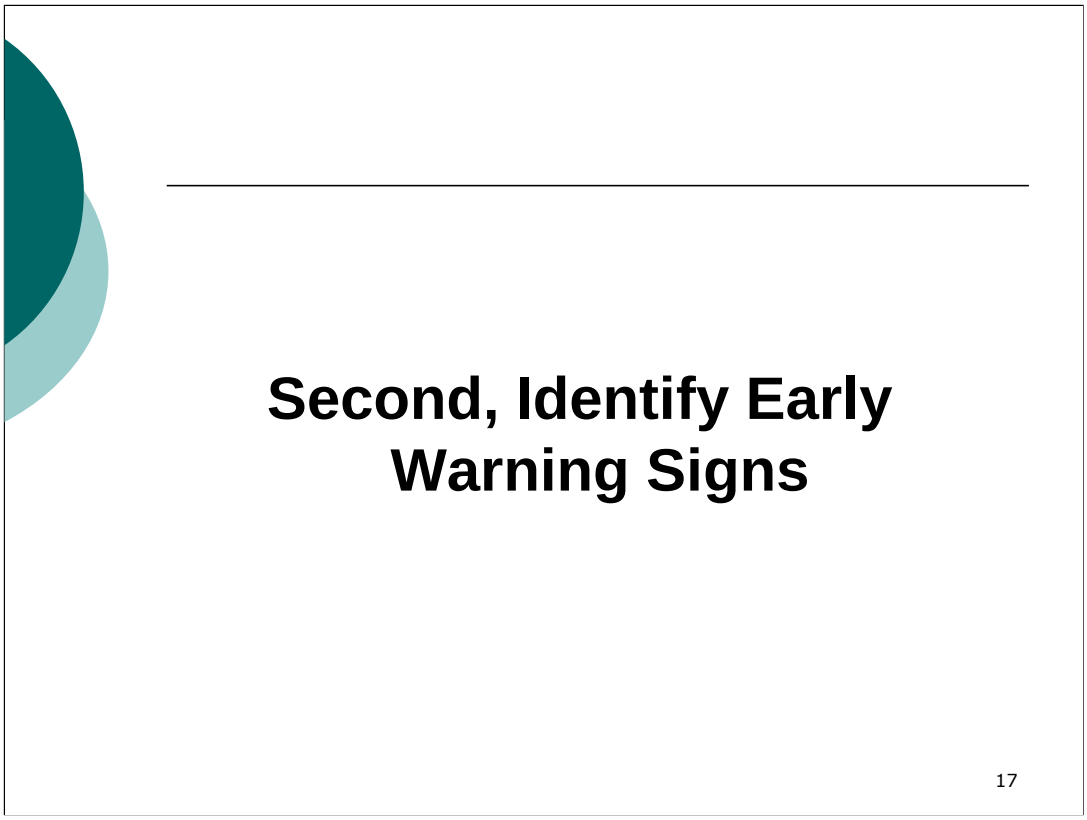
There are other triggers and these are more associational, particularly for folks with histories of trauma. There are lots of associations to the terrible things that happen that remind and activate that anxiety. It can be a time of day; a season; a fragrance, an aroma; language, particular family member; a holiday. So it's important to kind of ask those questions and then listen to the information that you're getting and if you're not sure, clarify it. Sometimes there could be cultural nuances, so it's really important to make sure you understand the information that you're being given.



Next, we move to the early warning signs and remember these are the behavioral cues that something else is happening.

Early Warning Signs

- A signal of distress is a physical precursor and manifestation of upset or possible crisis. Some signals are not observable, but some are, such as:
  - restlessness
  - agitation
  - pacing
  - shortness of breath
  - sensation of a tightness in the chest
  - sweating

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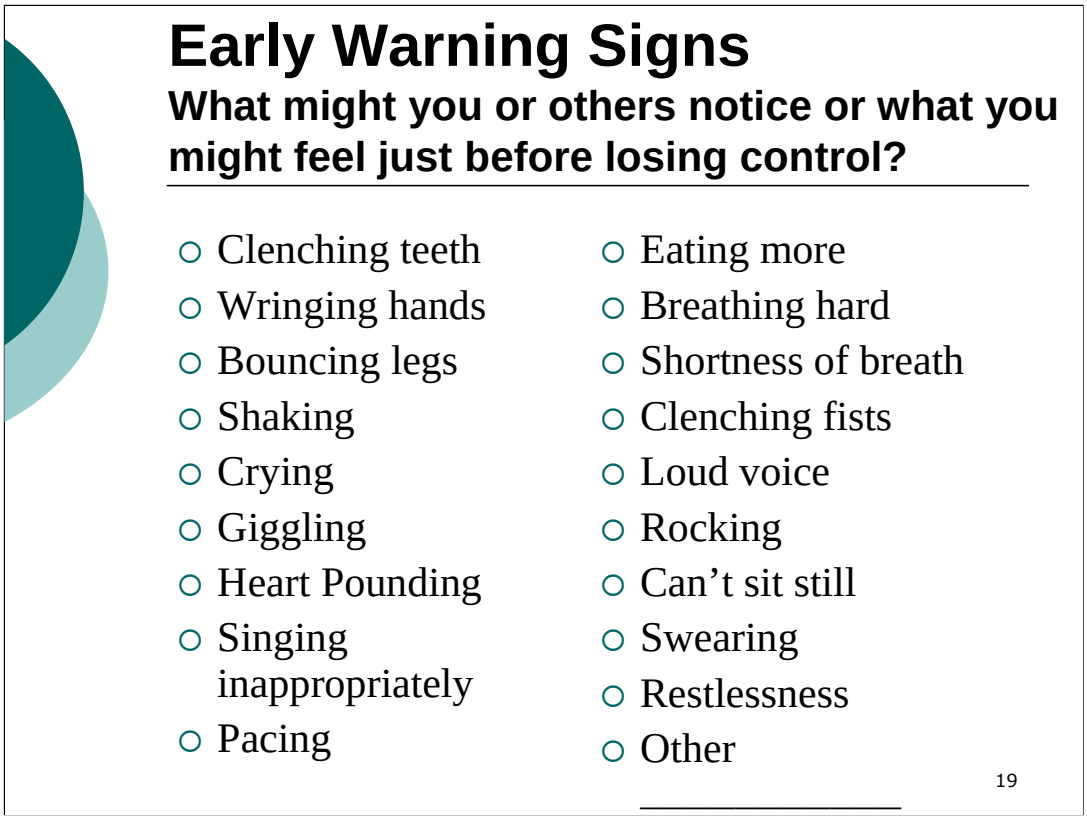
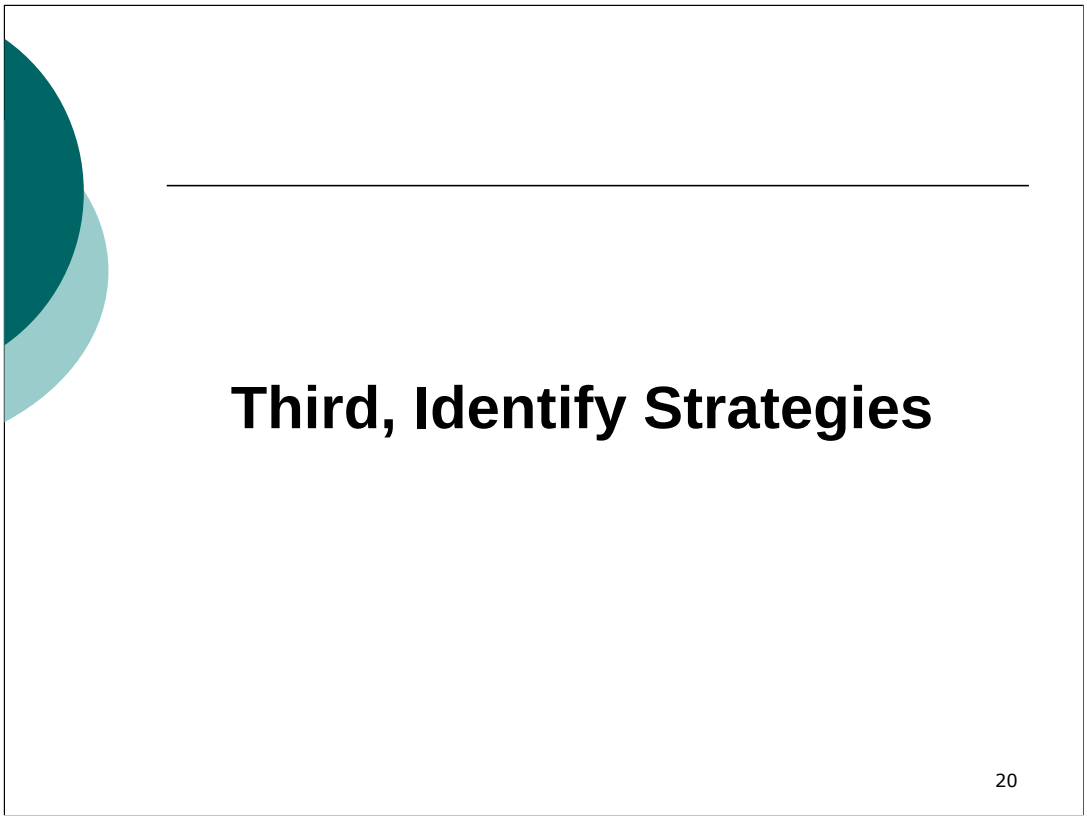
And again, sometimes they're very overt; very easy to understand. You can see it -- like pacing. I can see "pacing." I can recognize that something is happening. But you can't see a "sensation of tightness" unless somebody's got the understanding, language and capacity to express the problem. As we learned in the Neurobiology presentation – the Broca's area of the brain is impacted in times of crisis and people don't always have access to language when they are in crisis. Language may not be readily available to the person we're working with who is upset.



And a whole host of other warning signs. Interesting things are starting to happen here. Some people's warning signs are another person's strategy to weather a behavioral storm. So it's important to know the difference and appreciate the individualized nature of the people we are serving and their unique plans and intervention needs. When we were going through these slides with our Head of Consumer Affairs, he made an important point to us. He said, staff need a strategy for themselves when they're helping consumers develop these plans. Staff needs help in learning how to tolerate the symptoms that we display when we're upset. We may want to yell if we're upset. Yelling is distressing; it's hard to hear. It can activate anyone. He said it's really important that we actively try to not suppress people's symptoms but that we have our own internal strategies to help understand and cope.



Next, the strategies. This is what are we going to do when things are brewing; things are getting activated.

Strategies

- Strategies are individual-specific calming mechanisms to manage and minimize stress, such as:
  - time away from a stressful situation
  - going for a walk
  - talking to someone who will listen
  - working out
  - lying down
  - listening to peaceful music

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These are some of the strategies, the specific mechanisms to try to intervene early and bring the situation back into some form of control. But look at the strategies: time away from a stressful situation; going for a walk; talking with someone who will listen. These are important to recognize 1) they're a process. They're not brief, discreet tasks and 5 minutes later it's over; I feel better, end of crisis. It doesn't happen that way. The interventions take time. It requires us to be flexible and realize all of a sudden I have to step out of the schedule, attend to what's happening; pay attention to this person in crisis and be able to adapt to their need, not the needs of the facility, not the group schedule, but what is happening for that individual in distress. That times time and flexibility.

Strategies:

What are some things that help you calm down when you start to get upset?

- Time alone
- Reading a book
- Pacing
- Coloring
- Hugging a stuffed animal
- Taking a hot shower
- Deep breathing
- Being left alone
- Talking to peers
- Therapeutic Touch, describe _____
- Exercising
- Eating
- Writing in a journal
- Taking a cold shower
- Listening to music
- Talking with staff
- Molding clay
- Calling friends or family (who?) _____

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A whole host of other strategies and again, some of them are very activating, some are very calming. Some are done with the support of another, some are them are time away from others. Again, the strategies meet the needs of the individual so the plans and interventions to not all look alike.

More Strategies

- Blanket wraps
- Lying down
- Using cold face cloth
- Deep breathing exercises
- Getting a hug
- Running cold water on hands
- Ripping paper
- Using ice
- Having your hand held
- Going for a walk
- Snapping bubble wrap
- Bouncing ball in quiet room
- Using the gym

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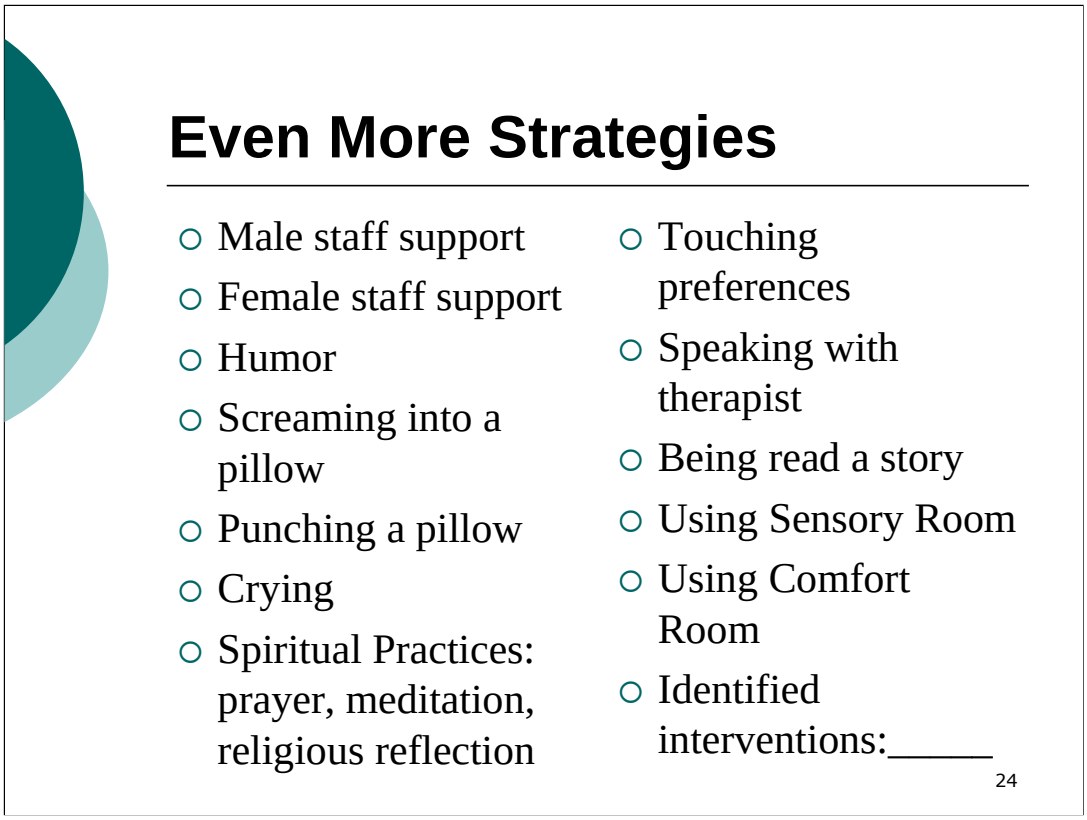
More strategies.



And even more strategies. An important strategy to recognize here, spiritual practices. This is very important. In Lowell, Massachusetts, we have the second largest Southeast Asian community in the US. We have a lot of Southeast Asian folks who come into our hospitals who do not believe in mental illness. They believe its spiritual possession. When that happens, an important member of our treatment team is a Buddhist monk. Sometimes our Southeast Asian consumers want a "coining ceremony" – this is far more meaningful to them and their families than a "Treatment Team Meeting." It's a very important component to their care. We integrate their spiritual beliefs into their crisis plan. So understanding the spiritual need and someone's belief and relationship with God or where they find their meaning; is an important component to acknowledge and incorporate. If you have clergy on staff or volunteer Clergy who want to be a support resource, by all means use them, if the people we serve identify the need.

What Does Not Help When you are Upset?

- Being alone
- Not being listened to
- Being told to stay in my room
- Loud tone of voice
- Peers teasing
- Humor
- Being ignored
- Having many people around me
- Having space invaded
- Staff not taking me seriously

"If I'm told in a mean way that I can't do something … I lose it."

-- Natasha, 18 years old

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Equally important, what does not help. It's the flip side, but absolutely key to understanding. Some things help and some things can in and of themselves are highly activating and agitating. Particularly this, and this is a quote from a young lady in Massachusetts: "If I'm told in a mean way that I can't do something, I lose it".

"Every restraint I've reviewed, started with a staff member enforcing a rule."

Ross Greene, Ph.D.
RRI Grand Rounds ~ Cambridge Hospital
January 20, 2004

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Preferences in Extreme Emergencies

(to minimize trauma & re-traumatization)

- ***"This facility is trying to eliminate the use of seclusion and restraint and we want to avoid these interventions at all costs" – Gayle Bluebird***
- If a more restrictive measure is necessary despite all efforts, please identify the following preferences:
  - Time Out

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Moving slightly further into crisis planning. The intent of the plan is to avoid a crisis. Now we're going to shift. If that crisis has started to take place, and it's magnified, and it's well underway, now we're going to think more in a mode of advanced directive; what to do if that's happening. This is Gayle Bluebird's work. What that facility tries to do is ask the questions, pull for the information about how and what to do in the event that restraint and seclusion has to be used.

They try to elicit how the person would like their medication administered. They ask if there a gender the person-served would prefer to have someone work with them. Do they want their hands held? That's a provocative question, but it's an important one. Also they ask about racial, cultural and religious preferences.

Preferences in Extreme Emergencies
(to minimize trauma & re-traumatization)

Preference list continued…

- Medication
  - by mouth
  - by injection
- Preferred medication _____
- Prefer women/men
- Hold my hands, do not restrain my body
- Consider racial, cultural, and religious factors

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More preferences; in an extreme emergency again, this has gone beyond the crisis management. Something else is happening but it's trying to get those preferences identified before the fact.

Preferences in Extreme Emergencies
(to minimize trauma & re-traumatization)

- Pre-existing medical conditions that place you at risk
- Physical disabilities/limitations that place you at risk
- Are you able to communicate with staff when you are having a hard time?
- If not, what can staff do at these moments to help?

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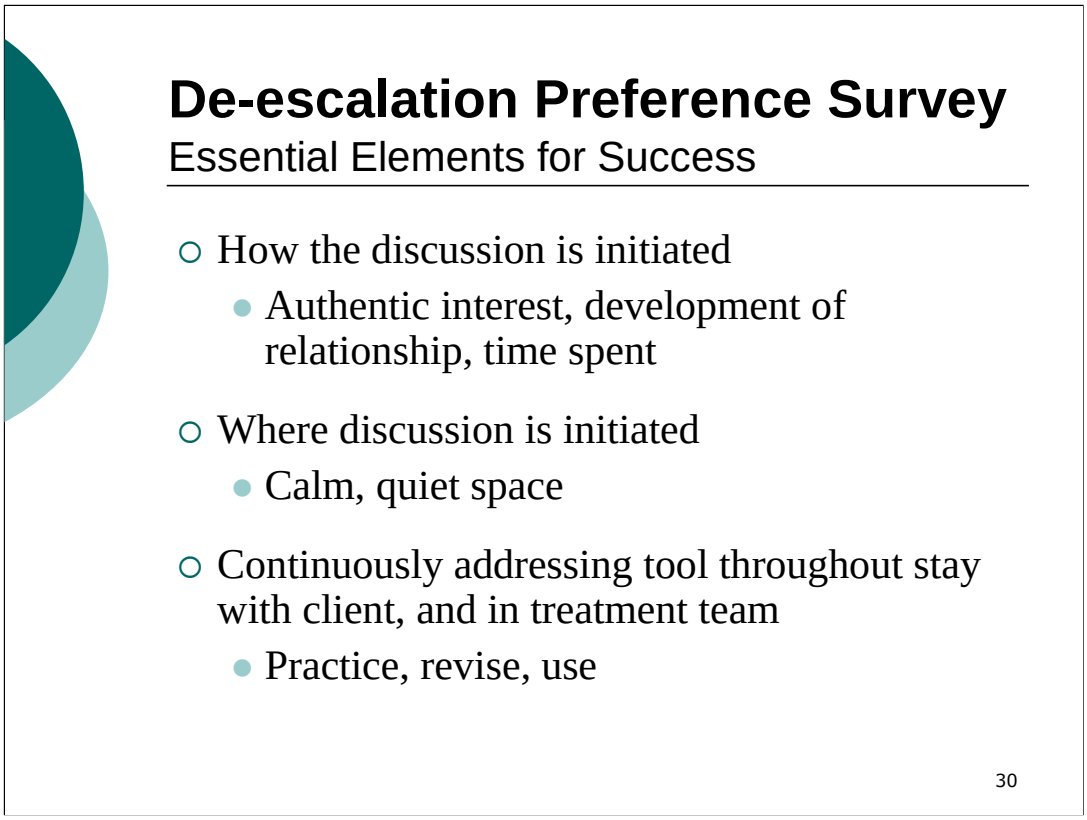
Other information to gather.



It is very important how this plan is crafted. If you're doing it right at admission, within the first 10 minutes, if somebody is really agitated, you're not going to create a very effective plan through that process. It needs to be authentic; it needs to be genuine. The time needs to be spent for an individual dialogue. So right at admission may not be the best time to ask for that information. You may have to wait and come back later when you can have calm, quiet time to have this discussion. The most important part of the tool; making sure that it's used; that it's accurate; when it's working to be able to broadcast that, share that, talk about it in treatment team and if it's not working go right back to that tool. And again, the process is not a dialogue for one; it's not a dialogue with the treatment team; it's a dialogue that goes right back to that consumer. What happened? Why didn't this work? What do we need to do Let's regroup.

Example of Successful Crisis Planning Susan

Susan:

Is a 21 yo woman with a diagnosis of Bipolar DO and history of sexual abuse. She finds bedrooms and bedtime frightening. This is the time she becomes most agitated and vulnerable to losing control.

Warning Signs:

Susan starts to sing loudly, stops listening, and interacts aggressively with other patients

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Now we've got six examples of really interesting, really effective crisis interventions and I'm not going to read them to you, just pieces of them. But this is Susan, with a terrible history of trauma. When she gets upset, she starts to aggress actively towards other people. What's the strategy for her?

Example of Successful Crisis Planning Susan (continued)

Effective Strategies:

- Susan is not "made to go to bed,"
- She built a protective structure out of cardboard
- Susan was given a flashlight
- She will watch TV in day hall until she is very tired

Institutional Obstacles:

- Rules have been more important than individual support

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She's not made to go to bed at night when she gets particularly activated, particularly anxious and upset. She's allowed to watch TV in the day hall so she gets tired. They built her protective structure out of cardboard for her and most importantly the flexed institutional rules that we know can be sometimes tough barriers.

Example of Successful Crisis Planning Mr. Smith

Mr. Smith:

Is an 85 year old moderately demented man on a geri-psych unit who wanders, becomes combative and is a fall risk

Effective Strategies:

Mr. Smith is given a baby doll to hold. He refused to get out of his chair until he handed the doll to another person because he wanted to keep her "safe" thereby alerting staff and decreasing risk of falling.

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And here's Mr. Smith, an elderly gentleman, 85 years old. He's demented and he's at risk for restraint and fall. What do they do? They gave him a baby doll to hold. As long as he's holding a doll, he's not going to try to get out of bed; he wants to keep that baby safe. Now, he's going to let people know when he wants to get up. And when he gets very agitated, he's at risk for restraint.

Example of Successful Crisis Planning Mr. Smith (continued)

Effective Strategies:

When agitated, given a soft Teddy Bear that had been warmed in the microwave.

Benefits:

Integrated response to restraint and fall risk.

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I love this. Staff, this all came from staff creativity. They took a stuffed animal, put it in the microwave, warmed it up and gave it to him to hold and it calmed him right down. The beauty of all of these strategies we will look at, slide after slide, comes from staff creativity.

Example of Successful Crisis Planning Mr. Weeks

Mr. Weeks:

- Is a very large 62 year old man with chronic schizophrenia who has a history of lifelong institutionalization including treatment at Bridgewater State Hospital for assaultive behavior. He is not able to verbally process but does admit to "bad thoughts." Due to a history of and reliance upon extensive restraint use, Mr. Weeks would ask or precipitate situations in which he was restrained.

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And this is Mr. Weeks. Mr. Weeks is a large, very large 62 year old gentleman who has schizophrenia, who had been at Bridgewater State Hospital which is our maximum security forensic hospital. He's seen as intractably aggressive; can't really articulate or verbally process his upset; highly institutionalized and would typically, as perceived by staff, ask or precipitate situations in which he was restrained. What did they do?

Example of Successful Crisis Planning Mr. Weeks (continued)

Effective Strategies:

- Staff made a deal with him to use a "vibrating pillow" in exchange for restraints
- Mr. Weeks liked the softness, buzzing sound and motion of pillow. He couldn't identify warning signs but would ask staff to use pillow if needed.

Historical Experience:

- One of the highest "users" of restraint at Northampton State Hospital and was considered "untreatable."

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They made a deal. They gave him a vibrating pillow to use, that he could hug. It was soft, he liked the vibration; it helped calm him; not too dissimilar from folks with cognitive limitations or infants or children, who love the sensation of rhythmic vibration. They find it very calming.

Example of Successful Crisis Planning Shoniqua

Shoniqua:

- Is an 18 year old young woman diagnosed with Post-Traumatic Stress Disorder who impulsively attacks other residents and staff.

Effective Strategies:

- Shoniqua is able to feel safe and smile during pet therapy hour
- She is able to verbally express discuss upsets when stroking her favorite golden retriever

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Shoniqua; an 18 year old young lady, also with a significant trauma history. She gets verbally aggressive. She finds great comfort, great satisfaction and pleasure in pet therapy. What do they do?

Example of Successful Crisis Planning Shoniqua (continued)

Effective Strategies:

Shoniqua is given the "job" of meeting pet therapists at hospital door and walking them out

Institutional Obstacle:

"We could never allow animals into a general hospital."

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She's allowed to greet the pet therapist at the door; that becomes her job; she starts caretaking the pets, overcoming the institutional obstacles of never allowing animals into the hospital. They maximize pet therapy and Shoniqua shines.

Common Attributes of Each Plan

- Individual-specific
- Linked to the person's history of trauma
- Tailored the environmental resources
- Encourages creativity
- Incorporates sensory interventions
- Needs of the individual supersedes the rules of the institution

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So what are the common attributes of a plan? Well first of all, they're incredibly creative. There's great resource and creativity in staff ingenuity. But they're fully applied and staff is on board. They are linked specifically to an individual. They're responsive to trauma histories. They incorporate people's sensory experiences and the needs of the individual are allowed to supercede the rules of the institution.

Individual Crisis Plan
Guidelines for use

- Condense and make usable
- Clear staff communication system
  - Kardex
  - Blackboard
  - checks sheets
- Consumers have copies - “own” their tool
- Re-visit if unable to do on admission
- Some consumers prefer to fill it out by themselves
- Revise and re-tool after escalation using all de-briefing information

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Communicating the crisis plan is absolutely key. The crisis plan is absolutely worthless if it’s stuck in the file cabinet or the back of the medical record and no one knows what it is. We have one particular program for adolescents of which we post their crisis plan, labeled as their “coping skills” -- right on their bedroom door. It’s as much to help remind staff as it is a reminder for the kids about what to do if there is a problem. There are other ways that you can communicate it, like putting it in the Kardex, or putting it on the reverse side of check sheets. It’s hard -- when you’ve got people coming in and out -- and you’re trying to get to know them and remember what they’re particular cues and triggers and strategies are. You can do a synopsis on the back of the check sheets so people can constantly stay reminded about those strategies.

Individual Crisis Plan
Additional Guidelines for use

- Communicate/document successful use
- Review at every treatment team
- Acknowledge relationship between trauma history and triggers
- Teach about the impact of external and internal triggers and stressors & learn new skills to manage reaction
- Support in “coping skills” group

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Communicating; as we’ve already said, making sure that we know what works; what doesn’t work and some of our programs we’ve had great success now are making the point of actively broadcasting the success. We do a great job at tracking restraints and those negative interventions. We don’t track well the positive interventions. Looking at the crisis plan, examining those successful moments and then reporting on it are what some of our programs are now doing. They are documenting their successful interventions and using it at staff meetings and recognizing staff who have done fabulous work.

Individual Crisis Plan
Additional Guidelines for use

Help consumers “practice” strategies before they become upset

Conduct training with staff and consumers regarding guidelines for development and use

Make sure a safety tool is filled out and placed in the record to help insure individual preferences about what is helpful and what is not in times of stress

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Read/summarize slide

Individual Crisis Plan
Additional Guidelines for use

Strong preferences or considerations can be posted on the cover of the medical record like an allergy alert

Information gathered could be used for education groups in future

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Read/summarize slide

Individual Crisis Plan

Population-specific Considerations

- Fully adaptable across the lifespan
- Consider strategies that are developmentally responsive & population specific:
  - Adolescents may need intense physical work-outs or write rap music
  - Elderly may find classical music appealing
  - For dementia or cognitively impaired - rely more on family and caregivers, inquire early as part of admission process
  - Children use pictorial descriptions of difficult states and strategies may not be language based

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And there are population-specific considerations; part of this is common sense. Adolescents; you can bet your plan with adolescents is going to be much more physically charged and activated and animated for kids. Elders; on the other hand, may find other calming strategies more helping, like appealing to the auditory senses, music. We may have to pull in others to help us with this planning. For those that are very young who don't have language, demented folks, cognitively impaired, you may have to really solicit a lot of input from the family or other care givers or other resource people who know these folks better than we do. And for little ones, kids, who you don't know or are unable to recognize what helps them, we sometimes have to develop pictorial crisis plans for them. We've got pictures of feeling states that they can identify and with the help of someone who knows them well, we can then craft a specific plan.

So what do consumers say they need in crisis planning?

What do Consumers Find Helpful?

- MA DMH conducted an Adolescent Survey:

  "***The Kids Perspective on Restraint & Seclusion***"

  (*MA DMH*, 2003)

- Scope and Description:
  - 185 Adolescents
  - 19 Hospitals
  - Average Age: 16.2
  - In Acute and Continuing Care Settings

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We asked our kids in Massachusetts; 185 adolescents who were hospitalized in the state in January of 2003, in 19 hospitals. We asked what should staff do differently so that restraint and seclusion did not have to be used.

What Do Consumers Find Helpful?

- Response to the question: "What could staff do differently so that restraint and seclusion would not have to be used?"
  - Talk to me 80
  - Leave me alone 75
  - Distract me 54

  Examples: music or dancing, sing to me, make me laugh, talk to me, activities or sports, keep comments to self, let me read or sing, drawing

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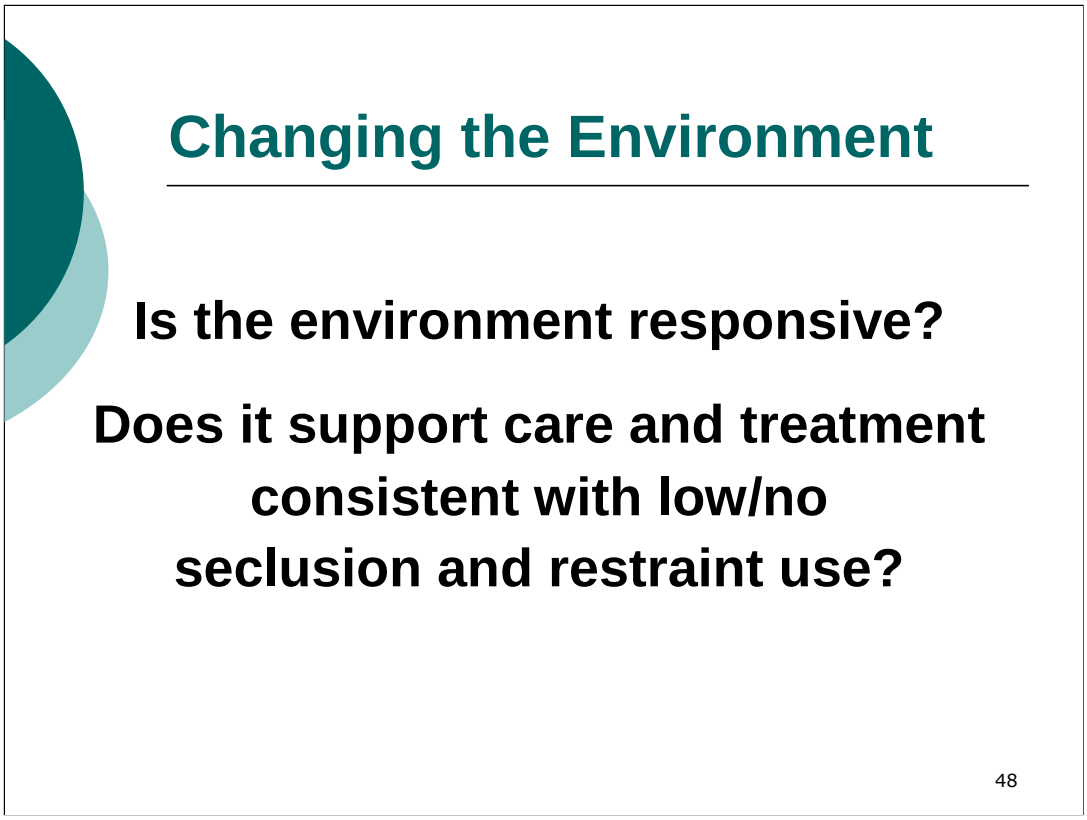
80 said talk to me, while 75 said leave me alone. The strategies are different. Talk about different needs – some say go away – others want staff support and attention. But that's the point; what works for one does not work for another.



Is the environment responsive and does it support care and treatment?

Creating Therapeutic Treatment Environments

- Incorporate important role of Occupational Therapy:
  - Assessment: What is the sensory diet for consumers served?
- Understand sensory experience, modulation and integration
- Determine sensory-seeking & sensory-avoiding states and behaviors.
- Develop sensory rooms & use the physical environment to respond to differing sensory needs

(*Champagne*, 2003)

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We have expanded the role of occupational therapy and focused on sensory modulation, integration and sensory experience as a way to help create alternatives to intercede in crisis moments and to give staff and consumers something else to use as a way to calm very difficult moments. We appreciate the importance of sensory experience and the need to understand people's sensory diet. What is that? Well what's calming for one can be agitating for another. In developing sensory spaces and environments that respond to people's needs -- we need to give people a place to be able to try out different sensory experiences and to be able to relax and calm down. We need space within our facilities for people to practice of these skills.

people what they look for if stressed? - more stimulation, less sti
inpatient units)

Simple Sensory Enhancements

Keep the environment well-maintained;
add calming, attractive features:

- art work
- plants
- fish tanks
- music
- comfortable seating
- rocking chairs or gliding rockers
- bedrooms with new bedspreads
- place to exercise
- curtains

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But there are lots of very simple sensory environmental enhancements that you can make at low or no cost. Much is common sense or good Feng Shui, but look at this list: it's art work, it's plants, it's fish tanks, its things that are just naturally very comforting to the eye. When you look at your facility, would you like to spend the night there?

Sensory Modulation Approaches

- Sensory modulation and integration activities can be particularly beneficial for those with sensory sensitivity/acuity such as symptoms of ADHD, impulse control and trauma.
- People are drawn to certain sensory experiences
- Activity examples include:

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Okay, you've been sitting for a long time and you I'm sure are getting a little bit sensory saturated and sometimes it's very easy to become just a little bit detached; a little bit sleepy and we absolutely understand it. So I think this crowd might need a little bit of sensory grounding. So we've got our sensory faculty who are going to be coming through and helping you have a sensory moment. What's important to remember about sensory experiences, these are low, no cost things. You can get very elaborate in your sensory of interventions or you can remember that sensory experience can be appealing to any number of the senses; taste, so we have Nan Stromberg who is going to offer a little taste sensory experience; things that are grounding that are sweet, that are sour. We also have sensory experiences that will appeal to the touch and we have Greg Smith walking around with the olfactory sense so that we can appeal to a sense of smell, the things that can be alerting; scents of cinnamon, cloves; these are basic sensory experiences. So it's important to remember your senses and it's basic. You can get very elaborate or you can keep it very, very simple. So I'm going to let the sensory faculty continue to go around and share the sensory experiences with you and we'll keep going.

Sensory Modulation Approaches

- **Grounding physical activities**:
  - Holding, weighted blankets, arm massages, “tunnels,” body socks, walk with joint compression, wrist/ankle weights, aerobic exercise, sour/fireball candies

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Read slide

Sensory Modulation Approaches

- **Calming self-soothing activities:**
  - Hot shower/bath, drumming, decaf tea, rocking in a rocking chair, beanbag tapping, yoga, wrapping in a heavy quilt, meditation

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Read slide

Sensory Room: Definition

- Appealing physical spaces painted with soft colors & filled with furnishings and objects that promote relaxation and/or stimulation.
- Sensory Room Equipment:
  - Peach colored walls
  - Lava Lamp
  - Gliding Rocking Chairs
  - Mats with weighted blankets

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There are a number of things that you can include in your sensory room. Some of these I have in my office. I do have a lava lamp, music, large balls. Things to help calm; rocking chairs. Think about your own living room, what is it like? Grounding? Calming? In your sensory rooms, you want to make sure you've got things that are fundamentally safe; that are fire resistant. I can see our tactile sensory group likes the lotion, very good.

Sensory Room: Definition

- Sensory Room Equipment: (continued)
  - Quiet Music
  - Large balls - bouncing
  - Small balls - pressure
  - Aromatherapy
  - Fish tanks
  - Large Tupperware container with raw rice

Sensory Room: Guidelines for Use

- Select fire resistant items, latex free, generally safe and washable
- Place selected items in locked cabinet
- Create policies and procedures for use and maintenance of room and equipment
- Train staff and supervise for appropriate use
- Schedule access 7-days/week & across shifts
- Use sensory room items on the Individual Crisis Plan (Safety Tool)

(*Champagne*, 2003) 56

You want to make sure you've got your policies and procedures in place so that your sensory room is staffed; that your staff are trained and that you've got access, this is important. When you have a sensory room and sensory equipment, you want that equipment available for that 2:00 am experience on a Saturday night when somebody needs help. You want to be able to grab the coush ball so that somebody can really rub it and get out some of that tension or sit in a gliding rocking chair and self-soothe.

Cooley-Dickinson Hospital - Quality Improvement Study

(Tina Champagne, OT/L, Edward Sayer, Psy.D.)

- Random data collection recording the effects of sensory-based treatment delivered in the sensory room with 46 people with varied diagnoses and cognitive abilities, over a total of 96 sessions.
- Results:
  - 89% reported: + results
  - 1% reported: – change
  - 10% reported: no change
- 75% Reduction in R/S over two year period (2001 – 2003)

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This is the importance of data. This is work out of Cooley Dickinson Hospital in MA, where they've got a fabulous OT director, Tina Champagne. Tina studied OT interventions on their inpatient unit and looked at the impact of OT with those they served. 89% reported a positive experience. And look what happened anecdotally. They weren't deliberately trying to reduce restraint and seclusion but because they actively developed the use of sensory experience, a sensory room, they also had a 75% reduction in the use of restraint and seclusion. Staff and those they served had alternatives that were calming; that were nurturing; that were grounding; and they weren't expensive.

Adapted & Expanded Sensory Rooms

- Snoezelen Rooms
- Sensory Integration Rooms
- Multi-sensory Rooms
- Sensory Gardens
- Comfort Rooms
- Peace Rooms
- Chill Room
- “Zen Falls”
- The Sanctuary

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Just like there are lots of names for crisis plans -- there are lots of names for sensory rooms; here are some of them: Snoezelen rooms, sensory integration rooms, sensory gardens, peace rooms. We have a number of these in our adolescent programs – recently we give the kids the task of to name the sensory room – they named it “chillville.” We’ve also got Zen Falls and more -- it’s all good.

Examples of Sensory Rooms

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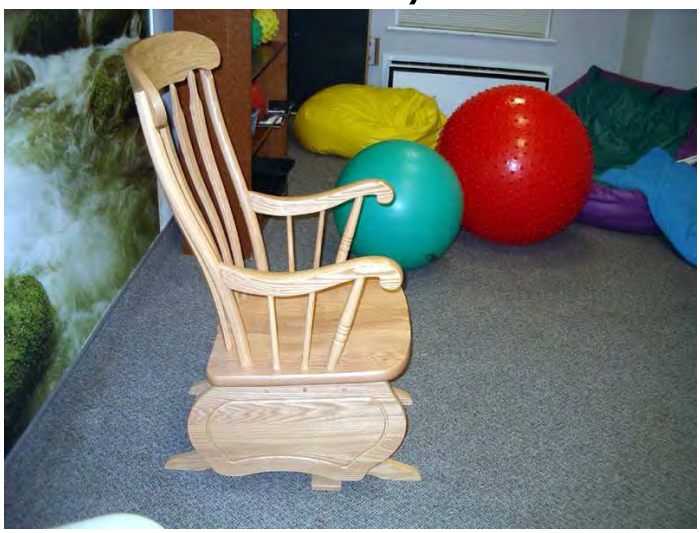
Here are some examples of sensory rooms.

Berkshire Medical Center - Pittsfield, MA



Gliding Rocking Chair

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This isn't the best photograph, but it's a good shot of a chair. Believe me when I tell you there are whole host of other interventions to have in a sensory room. The importance of this one -- is this rocker. We've got rockers on our units, which is nice, but what' special about this one is it glides. There's something far more soothing and comforting at being able to glide back and forth.

Snoezelen Sensory Rooms

Developed in the 1970's by two therapists in Holland who learned of positive responses from severely challenged clients after they were exposed to a sensory environment.

- ***"Snoezelen"*** is a blended term meaning to explore/seek out & to relax
- Used to stimulate, relax, calm or energize. It can provide a multi-sensory experience or single sensory focus.

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In the Snoezelen rooms; if you're interested in understanding more about Snoezelen, just go right on line (www.flaghouse.com). Flaghouse has a great website; with a number of Snoezelen devices; light tubes, bubbles, a whole host of interventions, but Snoezelen is based on a concept in the '70's that came out of Holland by two OT's who really expanded the use of sensory experience. They had significant positive results with a number of very tough folks who were difficult to treat. And they made up this term; it's a blended Dutch term to mean explore, seek out and relax, so they have different meanings inherent in the definition. But it's a multi-sensory experience that's designed to help a challenged folks by providing a sensory focus.

Snoezelen Sensory Rooms

- Used in more than 30 countries in many care settings for people with:
  - autism spectrum disorders
  - dementia
  - mental illness
  - chronic pain, challenging behaviors, acquired brain injury, and more

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This is a little bit more about Snoezelen; it's used around the world; a whole host of different populations, the cognitively impaired, the mentally ill, the autistic, people with chronic pain. If you haven't seen some of the interventions, they can be vivid or they can be calming. They have music; they have chairs; they have lights; a whole array of interventions.

Comfort Room

Definition

- The Comfort Room (formerly called the Quiet or Time-Out Room) is a room that provides sanctuary from stress, and/or can be a place for persons to experience feelings within acceptable boundaries.

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And comfort rooms. This is Gayle Bluebird's work from South Florida State Hospital. This is a project that she worked on to developing a comfort room project at South Florida State Hospital in which persons-served are an integral part of this process.

She took places that were formerly called a quiet room or the time out room and created a place of sanctuary right on the units. The intent was to be a place free from stress, for consumers to experience feelings within acceptable boundaries.

Comfort Room

Comfort items such as stuffed animals, soft blanket, headphones, audio tapes, reading materials, etc., can be made available to persons wishing to use the room.

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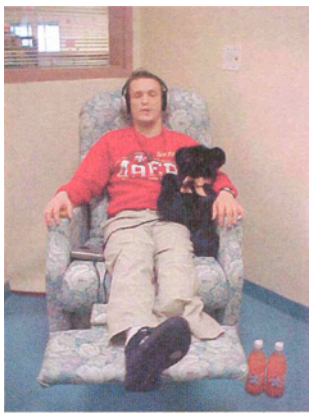
And these are the items that are in the comfort room in South Florida State Hospital.

Comfort Room

The Comfort Room is set up to be physically comfortable and pleasing to the eye, including a recliner chair, walls with soft colors, murals (images to be the choice of persons served on each unit), and colorful curtains.



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And here's a picture of a gentleman using the comfort room.

Comfort Room

The Comfort Room is not an alternative to seclusion and restraint; it is a preventative tool that may help to reduce the need for seclusion and restraint.

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And … at So. Florida State Hospital, the Comfort Room is not considered to be an alternative to restraint and seclusion, it is a prevention tool. So – again -- it's something you use it in advance.

Preventing Restraint & Seclusion

In order to prevent and eliminate restraint and seclusion,

each one of us, from administrative leader to direct care staff

is left with this challenge:

The Challenge

Can we change our inpatient cultures and become collaborative, responsive, and nourishing?

Can we offer places of sanctuary that remembers the person we are serving and facilitates healing and recovery?

How must we change if we want these changes to occur?

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And here are important elements to help foster the creation of a respectful community of care; making sure your values are well articulated. One of the best places you can start to articulate your values is by having a philosophy statement We just developed a restraint, seclusion reduction philosophy statement in MA. Make sure that you've got that. Make sure that your policies and your procedures speak to and reflect the philosophy of non-violence.

Look for coercive practices; where do staff keep their keys, are they right on the hip. Look at posture used on the unit, listen to the language used when we speak to consumers, look at all of the elements to make sure that our environments are speaking to compassion, to care, and to nurturing. Make sure we've got peer supports and natural supports, use the clergy, use the spiritual community, use our community partners.