Report to the Workers Compensation Board Of Manitoba

Research and Workplace Innovation Program

Pilot Project on Seclusion and Restraint Free Mental Health Services

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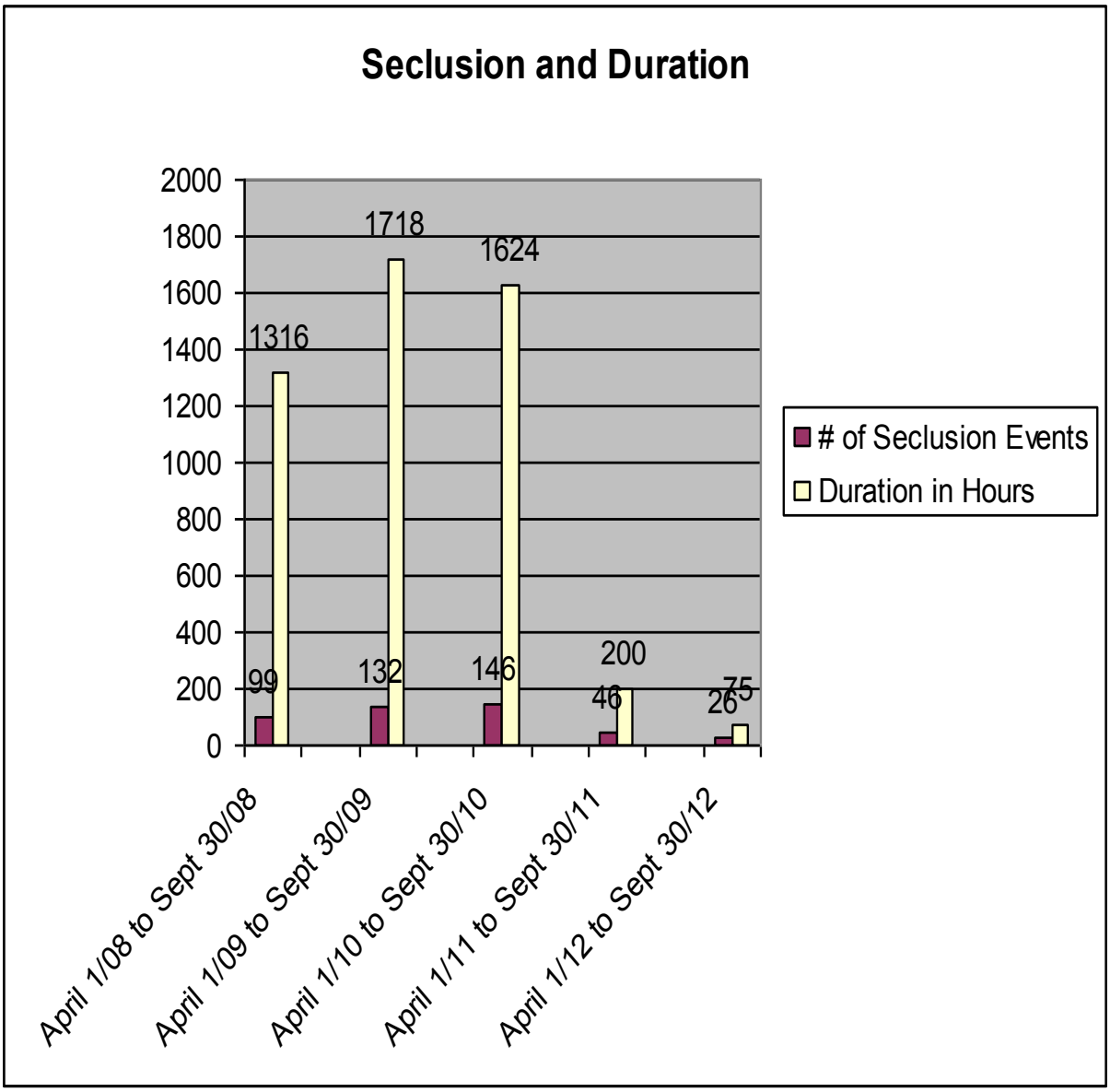
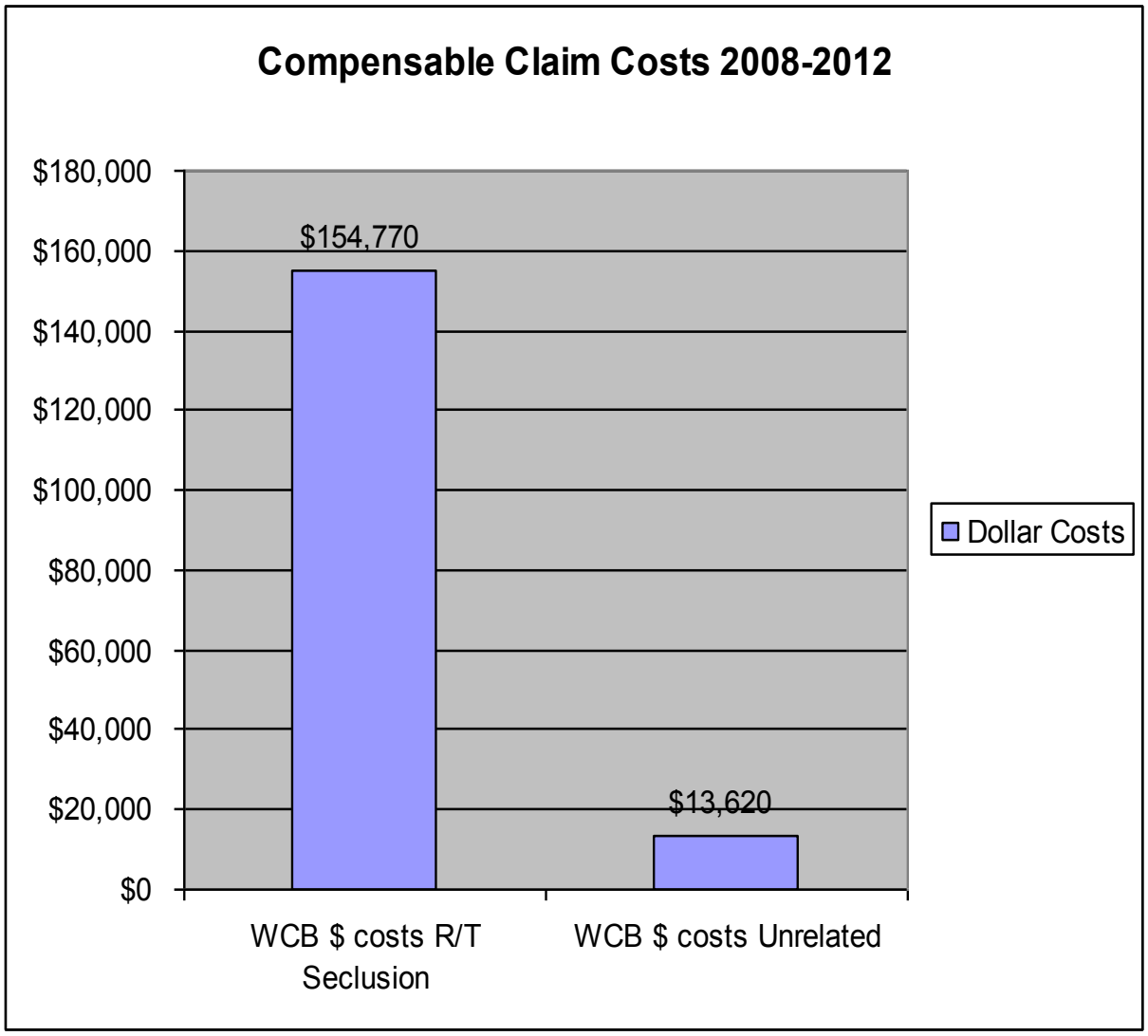
I am pleased to report to the Workers Compensation Board of Manitoba (WCB) our continued success in the pilot project; Fostering Practice Change and Cultural Shifts in the Management of High Risk, Violent Patients While Enhancing Patient and Staff Safety. Funding from the Research and Workplace Innovation Program has had significant impact on patient and staff safety and wellbeing.

Providing care to patients that are a high risk of violence to others is extremely challenging and staff have frequently been the target of patient violence. There have been multiple patient to staff assaults that resulted in significant compensable time loss to the staff on PY3-South over that last several years. Over the last four fiscal years, with the exception of a slip and fall on a wet surface; every single compensable time loss on this unit were as a direct result of needing to use physical force with a patient who was aggressive to others and required seclusion. More globally, the same compensable injury rates are true throughout the PsycHealth Centre. With the implementation of The Six Core Strategies for Preventing Violence, Trauma and the use of Seclusion and Restraint in Mental Health Settings, our seclusion rates and duration of time patients spent in seclusion has had a statistically significant decrease as measured by an independent statistician. In contrast, the control group had an increase in both the number of seclusions and the duration of time spent in seclusion. The independent statistician confirmed that the implementation of the Six Core Strategies were responsible for the significant decline and could not be explained by chance alone.

The graphs on the following pages demonstrate the success of seclusion reduction on PY3-South and outlines the compensable injuries related to seclusion and restraint as well as the compensable time loss associated with use of seclusion and restraint verses time loss related to “other”.



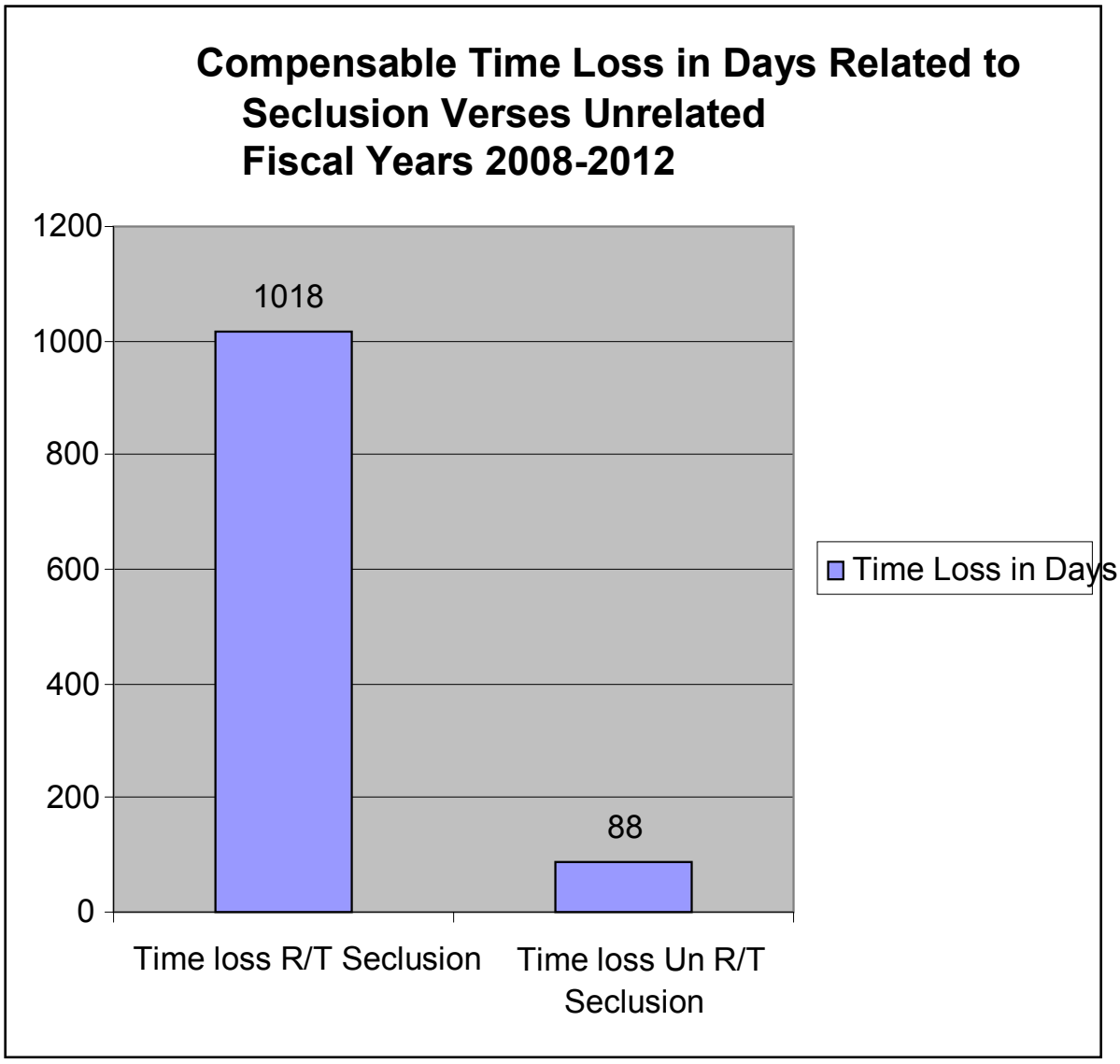
Progressive implementation of the Six Core Strategies began on April 1/11 and for the most part fully was fully implemented June 1/12. The results demonstrate a continual decline in both seclusion and duration.



The following graph demonstrates compensable salary costs related to the use of seclusion and restraint verses "other" over four fiscal years of inpatient wards in the PsycHealth Centre. It should be noted that of the WCB salary replacement cost unrelated to seclusion and restraint, one claim accounted for the majority of the costs. ($10,600.00). Factoring the one claim out of the WCB costs unrelated column as an unusual outlier the WCB salary costs related to other would have been approximately $750.00 per year. The WCB salary costs related to staff injury in the seclusion/restraint process equals approx $38,700.00 per year.

It should be noted that PY3-South has not had a compensable injury related to the seclusion and restraint process in 17 months. This is a historic record for this unit and establishes further the successes related to the cultural change on the unit in terms of "Safe Work" strategies.

One time loss incident unrelated to seclusion was for 73 days duration.



Again, factoring out the outlier of one incident for 73 days, the total compensable time loss unrelated to seclusion and restraint would average less that 4 days per fiscal year for the entire Inpatient PsycHealth staff. Conversely, compensable time loss related to the seclusion and restraint process averaged 255 days per fiscal year.
There is a clear cause and effect relationship between use of seclusion and restraints and compensable injury that is financially burdensome to all stakeholders.

The next phase of the pilot project to reduce the use of seclusion and restraints in mental health settings will require significant adaptation from the initial phase of the pilot project. Although high risk for violence situations do occur on other wards within the PsycHealth Centre, the new focus would be related to employee safety with emphasis on trauma informed care and principles of violence prevention.

Promoting Employee Safety Through Cultural Change, Trauma Informed Care and the Principles of Violence Prevention: Applicability and Evaluation of Evidence Informed Care to Maximize the Safety of Employees and Hospitalized Individuals Affected by a Variety of Mental Illnesses:

The vast majority of PsycHealth Centre inpatients come with a history of trauma. Trauma includes such things as abuse: physical, psychological, sexual, homelessness, history of being assaulted or assaulting others, gang affiliation etc.

Further we have several "specialty wards" within the PsycHealth Centre and adaption and modification would be essentially different from the previous pilot project that focused primarily on the aggressive/assaultive patient.

PX2 is an inpatient unit that provides services for hospitalized persons that meet the diagnostic criteria for Mood Disorders. This includes both mania and depression. The geriatric patient population of this unit ranges anywhere from 25-40 % of the inpatient population. Included in this subset population are persons with Alzheimer's or other dementias. The often confused state of these patients leads to hospitalization because the

person is unable to be adequately cared for in the community due to agitation and aggression. As the disease progresses so to does the likelihood of violence to others. Mood Disordered patients are another challenging patient population to work with because, as the name suggests, these patients moods fluctuate from elation and euphoria to anger and agitation. The angry, agitated state presents an increase in the propensity of violent acts including assault of staff. Over the last couple of years there has been a marked increase in WCB compensable claims from this unit.

PY2 is an inpatient unit that specializes in Eating Disorders, Post Traumatic Stress Disorder as well as Schizophrenia. Many individuals with post traumatic stress disorder have extremely high risk for violence to those around them. Individuals with schizophrenia also have potential for violence when in a psychotic state. In fact on recent study found that when well controlled with medication the individual with schizophrenia was no more likely to be aggressive than the general population at large. The same study however concluded that when in a psychotic state the individual is eight times more likely to be violent.

PX3 is an inpatient unit that services solely the Forensic population. Psychiatric examination is done typically through a court ordered psychiatric assessment request to determine if the patient is fit to stand trial for a crime they have committed. It is estimated by staff that 80% of the patients admitted to this unit have committed crimes of violence. The propensity of violence by the patient is staggeringly high. There are often six to eight Winnipeg Remand guards present on the unit on a 24/7 basis to assist in

protecting staff safety during the psychiatric assessment. Most, if not all patient on this unit come from a personal traumatized background.

PY3-North is an inpatient unit specializing largely with patient having the diagnosis of schizophrenia. Many of these patients have a high recidivism rate and increasingly are treatment resistant requiring longer hospitalizations. As mentioned earlier, in the psychotic state they are eight times more likely to be violent than the general public at large,

PY1-North/South are inpatient areas specializing in the evaluation and treatment of children and adolescents. Many of these patients are involve with various social services agencies and have extensive trauma histories including neglect, to having been physically or sexually assaulted. Increasingly these children and adolescents are involved with gang affiliation. As such, there is often disregard for positions of authority and violence is used to achieve their means. As with the Forensic patient, the need to provide trauma informed care is essential with the child or adolescent. The compensable time loss paid through WCB has been steadily increasing over the last few years.

The E.R. Lastly, the psychiatric emergency room is the area most patients attend prior to becoming an inpatient. Therefore, the psychiatric emergency staff deal with all the patients; with the exception of the forensic patient. On average 50% of psychiatric patients brought to the E.R. are brought by Winnipeg Police Service. The E.R. is a triage area which directs patients to the appropriate unit based on the patient presentation.

Many patients are mechanically restrained by their ankles and wrists due to aggressive behaviour or risk of flight.

The Roll out Plan:

It is the intention of the PsycHealth Centre Leadership to establish a six member working group to develop, organize and deliver educational content to all adult mental health inpatient staff. The working group would consist of Psychealth staff including but not limited to the Director of Patient Services-Mental Health and Regional Nursing Lead Adult Mental Health, the Manager of Quality and Patient Care, a Manger of Patient Care, a Clinical Resource Nurse with expertise in violence prevention in acute care mental health settings, a Psychiatrist with expertise in violence prevention as well as member of the Worker's Compensation Board with healthcare sector experience.

The intent of this committee would be to direct outcome goal activities and monitor the performance of the project implementation lead.

All inpatient mental health staff: Psychiatrists, Nurses, Unit Assistants, Unit Clerks, Social Workers and Occupational Therapists will attend a two day training session. These educational sessions will be delivered by two internationally renowned experts with evidence informed expertise in organizational approaches in managing violence in inpatient mental health settings. Researchers found that study participants were more likely to believe, and make use of information from a source identified as an expert. (Yifing, Hu. Shyman Sundar, "*Effects of Health sources on Credibility and Behavioural Intentions"* Communications Research, Feb 2010, 37(1) p.105-132). These experts will also assist in establishing project focus and priorities. "Such expert reviews will assist in measuring current practice against best practice and industry standards". (Burkell, J.

Ellis, K. *"Principles of effective Anti-Violence Education"* Center for Research on Violence, 2005).

Once the two day training is complete, the Clinical Resource Nurse, under the direction of the "Leadership Working Group" will be responsible for over-seeing project implementation, mentorship and guidance, as well as data collection and evaluation. Implementation will involve the introduction of a multitude of tools and strategies related to trauma informed care. Mentorship will involve hands on assistance in managing potentially violent situations and effective de-escalation of mental health inpatients. Data collection and critical analysis of each violent or potentially violent situation will be reviewed with emphasis on behavioural analysis including antecedent behaviour, attempted interventions to de-escalate and safety planning to prevent future occurrences.

Initially, the inpatient units of PY2 and PX2 will have intensive implementation of the various strategies over the first few months. Once mastery of each strategy is achieve a new strategy will be introduce. As the two units work on developing mastery of the strategies, PY3-North and the E.R. will be introduced to the first few implementation strategies as previously delivered on the two initial units. Then, as each unit progresses, additional strategies will be introduced on each of these four units until all strategies are completed and mastered.

Once these units are well on their way, the Forensic unit and the Child and Adolescent units will be introduced to the first few strategies and further strategies as tolerated and mastered. Formal evaluations of staff will take place after one full year of implementation on each unit. Mentorship, compliance and evaluation will be ongoing as

will data collection and problem solving through the Clinical Resource Nurse. Bi-monthly meetings will be led by the Clinical Resource Nurse to update the clinical leadership group. Implementation and evaluation will be completed on all units over an eighteen month period.

The objectives and goals of this project are multifocal. The fundamental goal of this project is to improve patient and staff safety, achievable through education and empowerment of staff with the tools and knowledge necessary to enhance their current skill set. One of the goals includes reducing the incidence and severity of compensable work related injuries to staff by at least 70% once the program has been fully implemented and to maintain injury reduction at this level, on average, on a "go forward" basis. Further objectives include enhancing patient involvement with treatment planning such as, the creation of Personal Safety Plans which fosters patient empowerment and allow patients to identify preferred treatment options. Another objective of the project is to enhance staff satisfaction and feelings of safety/security in their work environment. Outcome measures that will be assessed at the 6 month, 12 month and 15 month periods include: Number of staff injuries as they pertain to patient to staff abuse and compensable time loss related to same, costs associated with compensable time loss of patient to staff abuse verses other employee injuries, use of seclusion and restraint as well as duration of seclusion and restraint as a quality indicator of patient satisfaction as outlined in the benchmarking Canadian Institute for Health Information (CIHI), and lastly at the 15 month period staff's perception of workplace safety post project implementation.

Spot the Hazard

A recent review of a Psychiatric School of Nursing curriculum revealed that literally nothing is taught about staff/student safety in the healthcare setting. As one recent graduate nurse stated, “What I was taught about my personal safety in the healthcare setting could fit on the end of a pin head”. Perhaps this is why research shows that nurses with less than three years experience are more likely to make the most restrictive recommendations related to patient care. (Holzworth, R. J., & Wills, C. E. (1999). Nurses' judgments regarding seclusion and restraint of psychiatric patients: A social judgment analysis. *Research in Nursing and Health, 22,* 189-201). Giving staff the education and tools to keep themselves safe is a fundamental practice requirement and this program delivers exceptional results.

Since the educational facilities are not teaching safe work practices, it is incumbent to teach the new employees about their personal safety on the job, to assure a safe workplace for all.

Assess the Risk

There is evidence that violence has increased in Canadian workplaces over the past 5 years: 66% of organizations report an increase in aggressive acts within their workplaces and, 82% report an increase in both formal incident reports and grievances (CIWV, 2000). International Accident Prevention Assoc. Certain occupational groups tend to be more at risk from workplace violence. The Healthcare employee is at the top of the list;

above Corrections workers; according to the Canadian Centre for Occupational Health and Safety. (Website 2012). There is strong evidence that violence in our communities will continue to increase throughout the next decade. What exists in our communities, so to exists in our hospitals. We need to asses the risk and take action.

Find a Safer Way:

Staff in the PsycHealth Centre must learn to provide: a safe, calm, and secure environment with supportive care, system wide understanding of trauma prevalence, impact and trauma-informed care, cultural competence, consumer voice, choice and advocacy, recovery, consumer-driven and trauma specific services, healing, hopeful, honest and trusting relationships. (Sharp, C. *"Is Your Organization Trauma Informed?"* National Council for Community Behavioural Health). One can easily see the difference and the advantages to the Trauma Informed Care model which will be implemented throughout the PsycHealth Centre.

Everyday:

Promoting employee safety through cultural change, trauma informed care and violence prevention principles will reduce injury to both staff and patient. With the demonstrated success of other collaborative joint ventures we can make the workplace a safe and rewarding place of employment for everyone-everyday.

Total Injectable Medication Use in Health Sciences Centre, PY3-S Unit
And
Seclusion and Duration Pre/Post in Health Sciences Centre, PY3-S Unit and St. Boniface Hospital

Variables	Before Intervention (04/2008-03/2011)	After Intervention (04/2011-03/2012)	Increase rate	p-value
Medication Use (PY3S)				
LORAZEPAM 4 MG/ML INJ	**11.5(6.1)**	**9.8(5.7)**	**-15.7%**	**0.39**
LORAZEPAM 1-2 MG TAB	**202.4(83.6)**	**215.7(91.3)**	**6.2%**	**0.66**
HALOPERIDOL 5 MG/ML INJ	**11.7(7.4)**	**9.1(7.4)**	**-22.3%**	**0.29**
ZUCLOPENTHIXOL 50 MG/ML INJ	**7.8(4.5)**	**6.2(5.4)**	**-21.0%**	**0.30**
Seclusion Incidents (PY3S)				
Total Number	**18.1(7.3)**	**8.8(5.4)**	**-51.6%**	**0.002**
Duration	**13409(7665)**	**2200(2424)**	**-83.6%**	**<.001**
Seclusion Incidents (St Boniface)				
Total Number	**13.6(6.5)**	**19.8(10.3)**	**45.5%**	**0.05**
Duration	**4155(3143)**	**5707(3022)**	**37.4%**	**0.15**