

Keeping Nursing Quality at its Peak

Recognizing
the
2008 recipients
of the
NDNQI Award for Outstanding Nursing Quality®



2008 Winners:

University of Wisconsin Hospital and Clinics
Madison, WI

Poudre Valley Hospital
Fort Collins, CO

John Muir Medical Center, Walnut Creek Campus
Walnut Creek, CA

Shepherd Center
Atlanta, GA

Gillette Children's Specialty Healthcare
St. Paul, MN

Moses Cone Behavioral Health Center
Greensboro, NC



**The American Nurses Association (ANA)
National Database of Nursing Quality Indicators® (NDNQI®)**

A program of ANA's National Center for Nursing Quality

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The National Database of Nursing Quality Indicators® (NDNQI®) mission is to aid the registered nurse in patient safety and quality improvement efforts by providing researched-based national comparative data on nursing care and the relationship to patient outcomes. NDNQI is the only national, nursing quality measurement program providing hospitals with comparative data at state, national and regional levels. NDNQI is a program of The American Nurses Association National Center for Nursing Quality.

2008 NDNQI Award Recipients

Embody Excellence in Nursing

Recognizing the best

The NDNQI Award for Outstanding Nursing Quality® is a recognition program from the American Nurses Association that acknowledges NDNQI participating hospitals that have achieved overall excellence in nursing-sensitive quality indicators. This award reflects nursing quality excellence in RN satisfaction, patient outcomes, and nurse staffing. The nursing professionals whose institutions have received 2008 awards represent a shared, deep-seated passion for excellence and commitment to continual improvement.

The American Nurses Association is proud to announce the recipients of its 2008 NDNQI Award for Outstanding Nursing Quality:

- **Academic medical center** — **University of Wisconsin Hospital and Clinics**, Madison, WI
- **Teaching** — **Poudre Valley Hospital**, Fort Collins, CO
- **Community** — **John Muir Medical Center, Walnut Creek Campus**, Walnut Creek, CA
- **Rehabilitation** — **Shepherd Center**, Atlanta, GA
- **Pediatric** — **Gillette Children's Specialty Healthcare**, St. Paul, MN
- **Psychiatric** — **Moses Cone Behavioral Health Center**, Greensboro, NC

Award Methodology

What is unique about the award is that it is based on performance of nursing measures. It is not an award hospitals can apply for. To be eligible for the award, hospitals had to report nursing sensitive indicator data to NDNQI for seven consecutive quarters from 2006 to 2008, and participate in at least one RN survey. Narrowly specialized hospitals with only one unit type, except rehabilitation hospitals, were not considered.

Indicators evaluated were: total nursing hours per patient day, percentage of all nursing hours supplied by RNs, total fall rate, hospital-acquired pressure ulcer rate, average number of pain assessments initiated in a 24-hour period, injury assault rate, job enjoyment, time in seclusion, time in restraints, RN opinion of quality of care provided on unit, and hospital case-mix index.

To arrive at the final pool of candidates, total nursing hours per patient day, percentage of all nursing hours supplied by RNs, RN job enjoyment score, and quality of care rate had to be above the median in each hospital category, while total fall rate, hospital-acquired pressure ulcers rate, injury assault rate, time in seclusion, and time in restraints had to be below.

Hospitals were ranked in their respective hospital type on each measure and then rankings were added to determine overall placement in group. Hospitals with the smallest sum of rankings in all relevant indicators were selected as potential candidates for the award. If the top-ranking hospitals were relatively equal, or had offsetting rankings on indicators (for example, one was better on staffing measures and the other was better on outcome measures), the hospital with the highest case mix index – most acutely ill patients was selected.

In each category, the quarterly and survey reports for the top-three ranking hospitals were examined in detail. The top one or two ranking hospitals in each category were investigated for evidence of negative publicity about poor patient outcomes, publicity about union disputes and previous awards for patient care.

Congratulations to all colleagues who have participated in NDNQI to assess and improve the quality of care and work environments in hospitals. The ANA is proud to see nurses and hospitals share its commitment to constant improvement in nursing services in every type of hospital setting. The following profiles highlight the award winners for 2008 and key aspects of their success.



University of Wisconsin Hospital and Clinics

Madison, Wisconsin

Academic Medical Center Category Winner

Engaging nurses to ensure quality

Thanks in large part to its dedicated nursing staff, awards for quality of care are almost common for the **University of Wisconsin Hospital and Clinics** (UWHC), an academic medical center and not-for-profit, independent organization with 536 beds, located on the campus of the University of Wisconsin.

“Our mission and vision is core in improving the level of nursing care at UWHC,” states Kristine Leahy-Gross, BSN, RN, nursing data analyst at UWHC. Through the leadership of past senior vice president of Nursing and Patient Care Services and chief nursing officer, Maureen McCausland, DNSc, RN, FAAN, data is a major driver in performance improvement. UWHC uses ‘Focus, Display, Distribute and Reward’ as a process improvement framework to communicate results as well as assist in the use of data at the unit level.

Through data collection and analysis, one of the UWHC units, the Trauma and Life Support Center (TLC), a 24-bed high-acuity ICU, was identified with a high incidence of pressure ulcer incidence. The TLC staff worked to decrease the rate of pressure ulcers by developing guidelines for skin care and placing a skin-care cart in each room thereby assuring that appropriate supplies were available.

In 2007, after various interventions were implemented, an integrated data analysis was performed and included a review of the RN vacancy rate, location of pressure ulcers and cost of care for patients with hospital acquired pressure ulcers. The data did not show the kind of overall improvement that the nursing staff expected. Despite staff education on pressure ulcers and a demonstrated decrease in the rate of sacral, occipital and heel pressure ulcers, the overall high rate of pressure ulcers remained a concern.

A thorough analysis of data, or “drilling down” of the data, by including and monitoring facial pressure ulcers (due to endotracheal tubes, nasogastric tubes and oxygen tubing) helped the nursing staff focus their efforts. Staff worked in close collaboration with wound and skin clinical nurse specialists to decrease the rate of facial pressure ulcers.

Keeping Nursing Quality at its Peak

UWHC's commitment to quality extends to their rehabilitation unit. With its high-risk fall population in mind, UWHC's rehabilitation unit has successfully focused on fall reduction strategies. In February 2007, the unit had a fall rate of 21.65 falls per 1,000 patient days. Strategies implemented in response included:

- an admission script to review fall prevention with patients and families;
- a review of interventions that might prevent falls;
- a patient safety contract for patients to sign on admission that outlines nursing and patient responsibilities in fall prevention;
- a STOP sign posted in the patient room and bathroom that says, "Call – Don't Fall" as a reminder to patients to ask for help rather than risk falling;
- a "frequent fallers club" – a listing of patients who have fallen and, thus, require extra diligence;
- a reinforcement of the fact that red bathroom indicator lights indicate emergencies and everyone must respond to them immediately; and
- an hourly patient rounding practice to focus on the "three Ps": pain, potty, positioning.

The results have been stunning: Fall rates on the rehabilitation unit decreased to 3.63 falls per 1,000 patient days by the end of FY 2007 (June 2007). The rehabilitation overall fall rate for FY 2008 was 4.67 falls per 1,000 patient days. The pressure ulcers and fall improvements are just two examples of the work done by UWHC.



UWHC also uses a nursing professional practice model with a nurse: patient/family relationship as its focus. The hospital adopted primary nursing as its care delivery system throughout the organization. The professional practice model concept supports the primary nurse as she or he cares for the patient and family.

The Nursing services are well-established at all levels within the organization and the nursing professional practice model is aligned with all parts of UWHC. Nurses at all levels of the organization actively participate in decision-making, which has led to strong accountability and increased professional satisfaction and ultimately contributed to nursing quality.

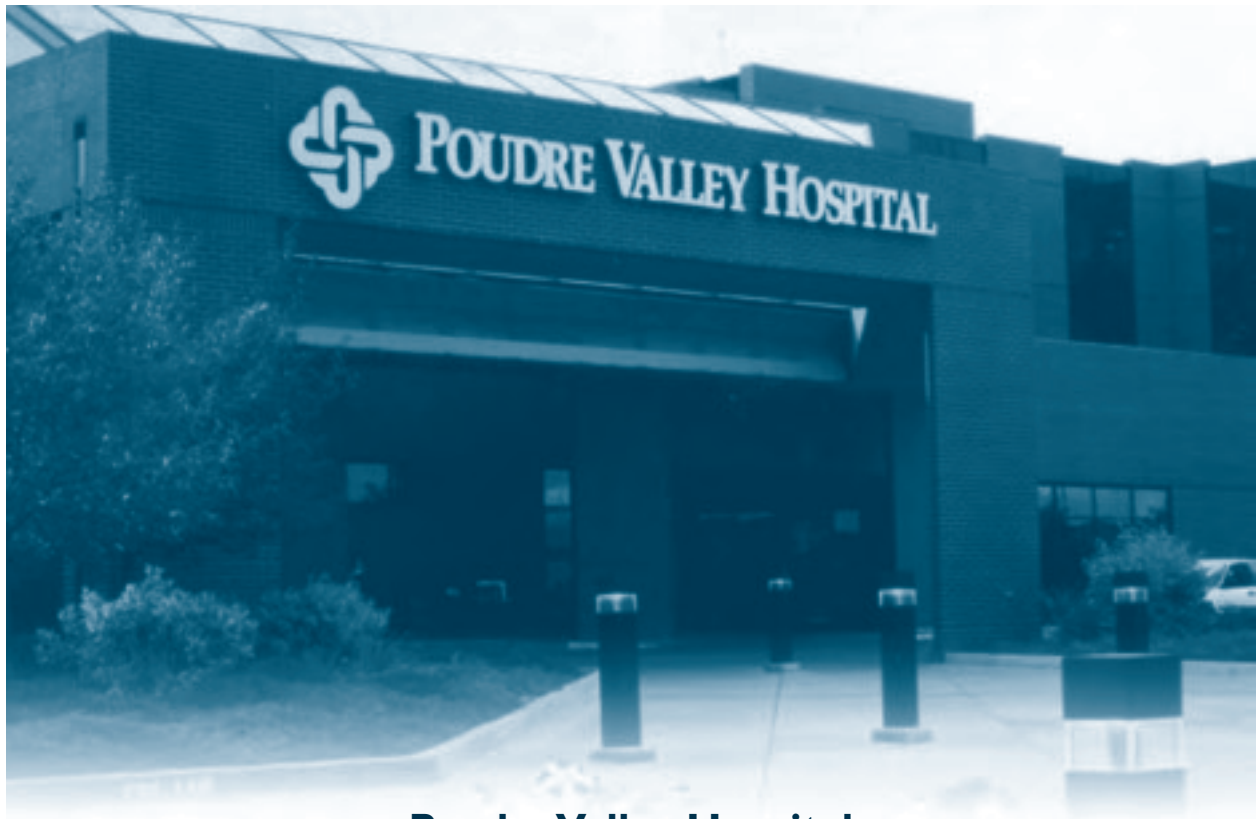
Unifying Quality Principles at UWHC include:

- Put patients and families first.
- Treat patients and families with dignity and respect.
- Understand the needs and wants of patients/families and meet or exceed their expectations.
- Actively communicate with patients regarding treatment goals and options and promptly respond to questions/concerns.
- Care for all patients/families regardless of ability to pay.
- Provide a safe environment for patients, visitors, and staff.
- Demand excellence by continually improving clinical care, service, operations and levels of service.
- Provide an integrated continuum of care.
- Base clinical care, delivery methods and operational processes on the best available evidence from the best available sources.

Following these principles has led UWHC to its success in improving nursing quality and its resulting status as an ANA NDNQI award recipient.



"Drilling down" ... in their data helped the nursing staff focus their efforts.



Poudre Valley Hospital
Fort Collins, Colorado
Teaching Hospital Category Winner

Linking nursing quality to institutional vision and mission

Nursing quality is key to the vision of **Poudre Valley Hospital (PVH)** a two-time NDNQI award recipient. PVH is a locally owned, 291-bed, private, not-for-profit organization providing a full spectrum of medical care to residents of Northern Colorado, Nebraska and Wyoming that aims to “Provide World-Class Health Care.” In addition, the nursing staff has its own, complementary vision of “providing excellence in nursing care.”

The hospital is part of the regional Poudre Valley Health System (PVHS), headquartered 60 miles north of Denver in Fort Collins, CO. In addition to the hospital, PVH has a behavioral health facility and numerous outpatient clinics.

The nurse-led governance committee structure at PVH actively encourages clinical staff from all levels in all areas of the organization to be involved in performance and quality improvement efforts, according to Chief Nursing Officer Craig Luzinski, MSN, RN, NEA-BC, FACHE and Director of Resource Services Donna Poduska, MS, RN, NE-BC, NEA-BC.

One of the most active and visible entities is the Nursing Quality Committee, which is led by direct care nurses and uses a nursing scoreboard to review nursing quality indicators, comparing current outcomes to identified goals and/or available benchmark data. Indicators that do not meet or exceed established goals lead to committee discussion and action plan development.

Keeping Nursing Quality at its Peak

NDNQI's database helps PVH by providing the top-decile benchmarks of the NDNQI indicators that nursing staff can use to assess levels of performance and identify evidence-based best practices. Staff also uses the database in modifying and changing current practice and setting realistic goals, which are all combined with effective deployment and follow-up for successful outcomes.

To improve nursing practice, PVH nursing responds to indicators that do not meet or exceed established goals through committee discussion and developing action plans. An action plan can be as simple as monitoring a potentially negative trend or as comprehensive as forming an interprofessional Plan-Do-Check-Act (PDCA) team. The Nursing Quality Committee at PVH receives regular reviews and statuses of any action plan.

Each nursing unit or department has committees to further analyze the data and implement action plans.

The Nursing Quality Committee reports to the PVH Clinical Quality Improvement Committee, which, in

turn, reports to the Health System's Quality Committee of the board of directors.



Reduction in unassisted falls and urinary tract infections (UTIs) are just two examples of why PVH is a NDNQI Award for Outstanding Nursing Quality winner. When unassisted falls increased, the nursing staff formed a committee composed of representatives from all departments plus ancillary areas, including physical therapy and pharmacy. The committee had great success in reducing the rate of unassisted falls. PVH's action plan to reduce the rates of unassisted falls included new equipment; assessment tool development that identifies criteria for low-, moderate-, and high-risk patients; video monitoring implementation on a neuroscience unit; and education for all staff regarding factors that increase a patient's risk of falling. These interventions have been identified as industry best practices and resulted in reducing unassisted fall rates by 55 percent within one year.

When the UTIs increased, PVH nurses took immediate action to re-educate staff regarding catheter care and removing catheters as soon as possible. In addition, nurses now use a physician order sheet every day to remind physicians if catheters are still present and ask if they can be discontinued thereby reducing the length of time of catheter placement and decreasing the risk of developing an UTI. PVH also changed the type of urinary catheter, changing to silver-coated urinary retention catheters. Rates of UTIs decreased from 29 to 14 in one year.

Achieving high levels of performance and world-class outcomes does not happen without the efforts of many dedicated individuals. "As we teach all our new employees in orientation," says Poduska: "At Poudre Valley Health System, we are all healthcare providers, no matter what your position, focused on providing quality care and excellent service in a safe environment." Poudre Valley Hospital is proud to be recognized for its efforts.



New employees in orientation are taught they are all health care providers regardless of position.



John Muir Medical Center, Walnut Creek Campus Walnut Creek, California *Community Hospital Category Winner*

Connecting nursing quality to institutional values

At the **John Muir Medical Center** (JMMC) in Walnut Creek, CA, improving nursing quality arose out of the hospital mission which includes improving the health of the community with quality and compassion.

JMMC is a private, not-for-profit, community hospital with 330 beds. It has a tertiary center with Level 2 Trauma and Level 3 Neonatal Intensive Care Unit (NICU) and service lines in neuroscience, oncology, orthopedics, and women's and children's services. Quality is "the cornerstone of our mission and vision," according to Andrea Segura Smith, director of Nursing Practice and Operations, and Beverly Jones, RN, MPS, NEABC, senior vice president, Patient Care Services.

JMMC has a Nursing Performance Improvement Plan that calls for continuous quality improvement of patient care by analysis and evaluation of nurse-sensitive patient outcomes; creating a safe environment for patients and families; and interdepartmental collaboration on performance improvement activities. Adopting a zero defect as its goal for nurse-sensitive indicators in 2007 as part of a Nursing Strategic Plan, led to the use of evidence-based and best practices by direct care nursing staff to improve quality.

Keeping Nursing Quality at its Peak

Because JMMC is data-driven, nursing quality analysts provide timely and detailed information to identify trends in practice. Teams known as Performance Improvement Priority Teams engage direct care nurses, identify system issues and problem solve to improve care. The Falls Performance Improvement Priority Team, for instance, is comprised of direct-care staff, nurse educators, geriatric CNS and a nursing quality analyst, and has a goal of no falls with injury.

JMMC also uses the Hendrich Fall Risk Assessment II tool on admission for all adult patients and reassesses findings every shift. Highlights for 2008 included implementing fall huddles, in which staff reviewed any fall incident as they occurred and took corrective actions before the end of a shift; placing bedside commodes over the toilets on orthopedic units to provide support; and revising documentation to capture fall-risk score and interventions. Interventions previously implemented in 2007 were hourly rounding by nursing staff, development of a preliminary fall report with monthly and quarterly details for each fall.



A Wound and Skin Performance Improvement Priority Team includes a nurse leader, direct-care wound resource nurses, wound and ostomy nurses, the medical director of the Wound Care Center, and a nursing quality analyst. Its goal is zero hospital-acquired pressure ulcers (HAPUs). In 2008, JMMC trained 26 wound resource nurses to help with assessing and training staff on inpatient units and installed new cameras to take pictures of community-acquired pressure ulcers and HAPUs. The nursing staff also focused on Braden subscale interventions identified with risk assessment, provided nasal cannulas with built-in pressure relief, and encouraged orthopedic technicians to follow patients who receive devices to assure proper fit. The hospital implemented hourly rounding for HAPUs, as well as conducting prevalence studies on a quarterly basis.

JMMC views nursing care across a continuum, with all departments engaged in achieving its zero-defect goal. Posting nursing performance improvement scorecards at every unit leads to a competitive environment for excellence. A strong partnership with the hospital risk manager enhances nursing quality. A peer review program offers the framework of Collegiality, Accountability, Respect, Evidence and Safety (CARES) to improve nursing practice. Twice-monthly discussions of care, makes it possible to improve quickly whenever problems are identified. "At JMMC, nursing quality is a factor in achieving high-quality care for patients" say Jones and Smith.



***Identify system issues,
problem-solve and engage nurses
in quality improvement.***

Keeping Nursing Quality at its Peak



Shepherd Center Atlanta, Georgia *Rehabilitation Hospital Category Winner*

Excellence driven by mission and more

At **Shepherd Center**, a 132-bed, private, not-for-profit rehabilitation hospital in Atlanta, GA, nursing practices are guided by its mission: “to help people with a temporary or permanent disability caused by injury or disease rebuild their lives with hope, independence and dignity, and advocate for their full inclusion in all aspects of community life while promoting safety and injury prevention.”

The hospital has nearly 200 nurses on staff and more than 30 on-call (PRNs). Last year Shepherd Center admitted 947 people to its inpatient rehabilitation programs and 538 people to its day rehabilitation programs. In addition, Shepherd Center saw more than 6,000 people on an outpatient basis. Shepherd Center has participated in the NDNQI RN Survey three times.

With a patient population that has sustained spinal cord or acquired brain injuries, impaired mobility complications such as pressure ulcers and falls are expected risk factors. Regular nursing orientation includes special training with competency checks and peer mentoring. Teams of nurses are recruited as content specialists to answer questions regarding skin care and promote excellence in the practice of wound management.

In assessing quality, “we always look at anecdotal concerns and occurrence reports,” says Tammy King, MSN, RN, CCM, CRRN, chief nurse executive, who initiated the quality improvement process at Shepherd Center. “Nursing care is driven by staff ratios, training and daily practice that set high standards that are assessed in part by data collection and analysis. Nurses collect data at the point of care and analyze the information in work groups. Changes are based on analysis of trend data versus episodic occurrences.”

Keeping Nursing Quality at its Peak

Shepherd Center's quality of nursing care is driven in large part by nurse leadership and the hospital's Nurse Senate, a gathering of professional nurses and unlicensed staff, such as technicians, who meet monthly to discuss nursing practice. For example, literature reviews are done for evidence-based information, and analysis of nurse and physician behavior for compliance to hospital policy. Anyone can attend meetings of the Nurse Senate, and it has voting representatives from each unit of the hospital.

Shepherd Center's nursing staff closely follows three nurse-sensitive measures within the NDNQI: ventilator-associated pneumonia (VAP), hospital-acquired pressure ulcers (HAPUs) and falls with harm. Outstanding outcomes have been achieved by following these measures.

Nurses champion different work groups such as The Falls and Pressure Ulcer Committees. Audits are completed based Joint Commission Standards. The Falls Committee conducts audits to verify compliance with hospital policies, collect data on use and type of restraints being used. Shepherd Center is particularly interested in decreasing the rates of falls because brain injured patients are at an increased risk for falls. The Pressure Ulcer Committee looks at incidence of wound breakdown, assigns champions to assure dressings are done properly, and follows best practices in literature and policies.



Shepherd Center

Greater than 40 percent of the patients at Shepherd Center require the use of a ventilator. To reduce VAP incidences, nurses have implemented aggressive respiratory hygiene practices of quad coughing, suctioning and oral care. Shepherd Center nurses take on the responsibility to keep open airways clear and patient. Excellent staffing ratios ensure nurses have time to provide a high level of care to patients.

These processes are working: Shepherd Center has been HAPU free since 2005 and has not had any VAPs since 2006. Shepherd Center's low incidence of falls with harm also reflects the nursing staff's excellence.

Improving communications has been central to improving nursing quality. Problems occur when communication breaks down. Shepherd Center uses "SBAR" as a communication framework which consists of: present the *Situation*, provide *Background*, do an *Assessment* and make a *Recommendation* to ensure communication between staff, particularly nurses and physicians, is effective.

One thing that made a difference at Shepherd Center was to give its nurses laminated cards with the SBAR key terms to put behind their name badges, which reinforced the use of SBAR. The nursing staff also did surveys with respiratory staff and doctors, and gave that feedback to them through the Nurse Senate.



Excellent staffing ratios ensure nurses have time to provide a high level of care for patients.



Gillette Children's Specialty Healthcare

St. Paul, Minnesota

Pediatric Hospital Category Winner

Engagement enhances quality

Nursing quality at **Gillette Children's Specialty Healthcare** in St. Paul, MN, a pediatric specialty hospital with 60 beds that has participated in the ANA NDNQI survey at least four times, can be attributed to an experienced nursing staff with longevity and who are highly engaged, according to Karen Brill, RN, MHA, vice president of Nursing and Patient Services.

The hospital has 265 RNs, all of whom are invited to participate in the RN Survey. In 2007, participation in the survey was 67 percent; in 2008, it dipped slightly to 52 percent, being attributed to tremendous organizational growth. Participation is expected to rise again as the nursing staff adjusts to lessons learned about the most effective time of year to implement such a process: Participation in the NDNQI survey can depend on the season.

Improving nursing quality is not a *new* goal at Gillette. For at least the past 10 years, Gillette has been focused on patient safety and quality. To ensure constant improvement, 20 to 25 percent of the nursing staff participates in offsite sessions on quality and safety.

Evidence-based literature research and website reviews of the Minnesota Hospital Association (MHA) initiatives are completed to stay current as part of their ongoing commitment to professional development and nursing quality. Gillette partners with the Nursing Executive Center to assist with patient safety and quality improvement focused education.

Keeping Nursing Quality at its Peak

Gillette has made significant changes in falls and pressure ulcer prevention efforts. As a children's specialty hospital with rehab patients, Gillette is aware of their patient's risk for falls. Interventions implemented to reduce falls were hourly rounding and identifying high risk fall patients with "Falling Star" symbols. Staff completes the online NDNQI Pressure Ulcer Training Module; train-the-trainer; mentoring and one-on-one training to reduce the incidence of pressure ulcers at Gillette.

Fall rates have been dropping steadily at Gillette as a result of these approaches from 6.36 percent to rates as low as 1.79 percent. Total falls have gone from 1.09 in 2008 to 0.60 per 1,000 per patient days. Total falls with injury rates are below 0.25 per 1,000.



While acquisition – community vs. hospital – aspects of pressure ulcers were not recorded in 2008, pressure ulcers also have been dropping significantly. All areas have shown improvement.

"We are incredibly proud to have built our Engaged Professional Practice model," says Brill. "We expect our nurses to become engaged, not only to participate, but to lead with innovation." Therefore, the Gillette improvement process is staff led. For instance, the hospital holds an annual Nursing Leadership Seminar during which they bring in outside experts to share new information and findings. Additionally, the nursing staff works with the MHA in safety initiatives with a special focus on improving processes and systems in the operating rooms.

Key to success has been including all nursing staff in the process, rather than making change a top-down mandate. Engaging nursing staff in quality improvement teams makes a difference. Staff members are more likely to adopt new techniques if they feel included and valued in the process. The hospital has dashboards on display throughout the facility for both the staff and the public to view, as a way of relaying positive information about nursing activities. All staff are encouraged to participate in quality improvement activities and meetings. Gillette also attributes successes in improving nursing quality with being a Transforming Care at the Bedside (TCAB) hospital.



***Engaged nurses participate
and lead with innovation.***



Moses Cone Behavioral Health Center

Greensboro, North Carolina

Psychiatric Hospital Category Winner

Relationship-Based Care influences nursing quality

The **Moses Cone Behavioral Health Center**, an 80-bed, free-standing psychiatric hospital, is one of five hospitals in the Moses Cone Health System (MCHS) in Greensboro, NC. It has 50 adult beds, 30 beds for children and adolescents, and an outpatient clinic providing both individual and intensive outpatient services for psychiatric and chemical dependency patients. In 2005, MCHS became the first system in North Carolina to be recognized as an accredited Magnet health system.

The hospital follows the MCHS Professional Model of care, which is patient- and family-centered, built upon the three main elements of evidence-based practice, shared governance and interdisciplinary care, and surrounded by 3Cs: Caring, Competence and Celebration. MCHS uses Relationship-Based Care (RBC) as a care-delivery method.

The improvement process was initiated and led by William Reeves RN, BSN, MHSc and began with a commitment from the leadership team.

Quality indicators focused on high-risk, high-volume activities in the hospital such as seclusion and restraints, falls, suicide risk documentation, pain management, and treatment team performance and documentation. Performance improvement teams did extensive reviews of the literature, consultations and training to overhaul nursing practices, which contributed to significant reductions in seclusion and restraint. Interprofessional groups also reviewed roles, schedules, content, documents and quantity of programming, which contributed to improvements in the quality and quantity of programs, as well as patient and staff satisfaction.

Keeping Nursing Quality at its Peak

The nursing staff created partnerships with community agencies to better transition patients, because Moses Cone views inpatient care as just one end of the mental health continuum.

Review of the data showed the rates of restraints and manual holds at MCHS had either risen or remained the same for three years necessitating the need to establish a quality goal of reduction in the use of restraints. “Our quality focus became eliminating the use of four-point restraints and reducing the use of manual holds and seclusion,” says Quality Outcomes Coordinator Kelly Southard, RN, BSN, MBA. Other influencing factors in setting the goal was pressure from regulatory agencies to reduce seclusion and restraint, and evidence in the literature that restraints could cause injury to patients and staff.



To implement the initiative, the Moses Cone nursing staff created a performance improvement team led by the director of the Child and Adolescent Department. The team initially consisted of charge nurses on the Child and Adolescent Unit and the Quality Outcomes Coordinator, and started the process with a thorough literature search on seclusion and restraint reduction.

As the quality initiative to decrease the use of restraints was shared with staff, it was determined the team needed to address staff concerns regarding patient and staff safety as the use of restraints were reduced requiring a shift in culture. Charge nurses on each shift on the Child and Adolescent Unit held team-building sessions where they discussed their concerns and shared information found in the literature of other hospital successes. As the initiative took shape other members of the team were added to include mental health technicians and staff from the adult unit.

Among the strategies were: implementing a formalized staff debriefing session after each episode of seclusion and restraint, led by a nursing leader, and a triggers assessment upon admission, as well as an assessment of the patient’s preferred de-escalation interventions; changes in managing aggressive behavior training, to stress the need to avoid use of seclusion and restraint as much as possible; and creating a “triggers board” to communicate findings to all staff. The team has remained in place three years later continuing to implement proven strategies to reduce the use of restraints and seclusion. Success is clear – there has been a 90-percent reduction in four-point restraint. The team has expanded to include staff from all shifts and plans for the future include expanding the team to include at least one physician and one physician extender; implementing a comfort room and Ross Greene’s Collaborative Problem Solving approach; and evaluating the verbal de-escalation program.



***Eliminating the use of restraints
became a quality focus.***

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