ABSTRACT
The reduction of seclusion and restraint is a national patient safety focus in psychiatric settings. Studies have demonstrated that multisensory or comfort rooms contribute to higher consumer satisfaction and lower rates of seclusion and restraint in general hospitals. As an alternative to the traditionally uncomfortable time-out room, a comfort room was constructed on an acute adult inpatient unit. This space was designed with comfortable furniture, soothing colors, soft lighting, quiet music, and other sensory aids to help reduce unsettled patients’ level of stress. The frequency and duration of seclusion and restraint use on the pilot unit was studied before and after implementation of the comfort room. The use of seclusion and restraint was also compared with a similar admission unit without a comfort room. Results supported the hypothesis that the presence of a comfort room significantly reduced seclusion and restraint, and that the use of the comfort room helped reduce patients’ stress.

Kathleen S. Cummings, BSN, RN-BC; Sylvia A. Grandfield, RN-BC; and Craig M. Coldwell, MD, MPH
New Hampshire Hospital (NHH) is a 238-bed, university-affiliated acute public psychiatric facility for children and adults in Concord, New Hampshire. The hospital serves as the primary direct receiving facility for the state and admits more than 2,000 involuntary patients annually. The patient population includes individuals who require the highest level of security and complex psychiatric services. The purpose of this project was to assess the effectiveness of a comfort room as a means to reduce the use of seclusion and restraint and to promote the use of positive coping skills.

SECLUSION AND RESTRAINT PRACTICES

In keeping with nationally recognized initiatives to reduce seclusion and restraint, our hospital is examining seclusion and restraint practices, with the intent to eventually eliminate their use. However, we recognize seclusion and restraint as legitimate safety interventions of last resort.

Traditional time-out, seclusion, or quiet rooms offer little or no opportunity for patients to regain self-control in a positive environment. During the time of our project, minimal published literature existed on the use of a comfort or calming room. Champagne and Stromberg (2004) reported multisensory environments are used in psychiatric units, despite having roots in occupational therapy. Comfort or calming rooms have become a growing nationwide trend in the attempt to prevent seclusion and restraint. Bluebird, who is considered an expert in the area of comfort rooms (2004), noted that “It is important to make clear that the comfort room is not an alternative to seclusion and restraint; it is a preventive tool that may help to reduce the need for seclusion and restraint” (2002, p. 18). She further suggested that “comfort rooms can reduce seclusion and restraint through stress reduction” (Bluebird, 2005, p. 5).

COMFORT ROOM PROJECT

The comfort room project at our hospital was based on meeting patients’ immediate needs and reducing their level of distress in the moment. The nurse-patient relationship is the key to assessment in the use of a comfort room. When a patient shows signs of distress, the nurse enters into a dialogue with the patient to determine the meaning of the behavior. It is imperative that the nurse understands the meaning of the displayed behavior. If the patient is in distress, then the nurse may offer the comfort room as a first step in helping the patient progress to a calmer space. Patients are shown the comfort room on admission and encouraged to use the room as needed.

Finding Our Way

In 2001, NHH leadership committed to reduce the use of seclusion and restraint, which Huckshorn (2004) identified as a core strategy. Huckshorn (2004) noted the reduction of seclusion and restraint involves many
methods, including “creative changes to the physical environment” (p. 30). At nursing department leadership meetings, nurse managers were charged with using creative problem-solving techniques to reduce the use of seclusion and restraints on their units. At the unit level, nurse managers empowered nursing staff to accept the challenge of developing interventions to assist patients in managing their distress without the use of seclusion and restraint.

The dual purpose of the unit’s time-out and seclusion room did not always promote an environment of calmness, and hence the room was frequently described as punitive, aesthetically unpleasing, acoustically unsettling, and uncomfortable. In March 2002, the nursing staff at the unit level were asked to make written suggestions for creatively designing a room that would promote a calm and safe atmosphere for patients in distress. Twenty-six suggestions were submitted and included painting walls with soft colors or murals depicting ocean or nature scenes; providing music; purchasing comfortable furniture; soundproofing the room; and encouraging the use of aromatherapy, stress balls, or objects that patients state would decrease their distress.

As a result of the written suggestions, a Continuous Quality Improvement team was organized. The team included unit nursing staff, executive staff, and managers, as well as representatives from maintenance, engineering, staff development, and rehabilitation departments. Multiple meetings were held throughout a 2-year period to explore financial and policy constraints on room design. The financial constraints and availability of resources in a public institution would further dictate the accessibility of furniture, lighting, and sound system options. A communication system consisting of an intercom into and out of the room was also factored into the room design. In addition, the room design needed to meet hospital safety standards, which are governed by state law.

The primary purpose of this room was to promote a healthy therapeutic, supportive, and safe environment. Three local area hospitals with psychiatric units were contacted; none had rooms that were similar to what we were looking to create. Other facilities were contacted to determine whether they used interventions that promoted a calm and safe environment other than seclusion and restraints, and it was noted that one state psychiatric hospital in Florida used a calming room. Subsequently, a site visit to this Florida hospital was completed in October 2003.

Designing and Creating the Comfort Room

The concept of establishing a calming/comfort room was a new and challenging task for the staff to embrace. The staff had to evaluate their own issues of control while exploring new ways to help patients manage distress and maintain safety. Unit staff were ambivalent about the possibility of not having a traditional seclusion room available, stating they were unsure how to manage difficult patients in a lesser restrictive environment. Following multiple intense staff meetings, a decision was made to continue with a tra-
ditional seclusion room and to proceed with the development of a comfort room in a different space on the unit. The decision to keep the traditional seclusion room decreased staff anxiety and therefore allowed the staff to embrace change as an opportunity for growth.

Following fire marshal approval, a rarely used alcove was designated as the area that would be developed into a comfort room. This transformation embraced all of the constraints of our public hospital while incorporating staff and patient suggestions. The hospital’s executive committee supported the entire process and determined that the comfort room would be financially supported by a combination of special trust funds and the rehabilitation department budget.

In December 2003, construction began. A door with a one-way lock that may only be locked from the outside was installed. The one-way lock allows patients to open the door from the inside and leave the room when they feel they are no longer in distress. Having the comfort room locked from the outside ensures no other patients may access the room, thus ensuring privacy to patients who use the room. Staff may enter the comfort room any time a patient demonstrates behavior the nurse assesses to be unsafe.

The room decor was based on patient and staff surveys. As a result, the room was painted a light blue and decorated with a matching wallpaper border and seascapes artwork. Lighting with a dimmer switch allowed patients to control the brightness of the room. To provide a safer environment, prior to using the comfort room, patients were informed that the room will be monitored by staff via video camera. We were unable to allow the use of aromatherapy due to the ventilation systems.

The next step was to find comfortable, safe furniture that met hospital fire safety regulations. A multisensory reclining chair was purchased to promote relaxation and mind-body skills to reduce distress. The room was further equipped with an oak entertainment center that contained a television with a built-in DVD/VCR and a CD player. A variety of calming music was purchased for the room; however, patients were encouraged to bring their own relaxation music and videos to the room. The comfort room also contained books, puzzles, weighted blankets, stress balls, and magazines.

The room was completed in September 2004, and an open house was held to celebrate the completion. The open house allowed patients and staff from the entire hospital to experience the uniqueness of the hospital’s first comfort room, which had been in the planning since 2002. Patients who attended this event verbalized their approval of a new and innovative intervention that would help them manage distress. Staff members indicated their willingness to try this intervention but remained skeptical.

**EVALUATION PLAN**

We sought a number of opportunities to measure the impact of the new comfort room on patient care. Institutional review board approval was sought due to the nature of a vulnerable patient population to ensure they would not be compromised or harmed in any way.

**Patient Survey and Staff Evaluation**

For a 3-month period, patients were asked to subjectively rate their level of distress with a 5-point Likert scale before and after they used the comfort room. All responses were voluntary. A total of 105 patients participated in the evaluation process. Eighty-nine percent of patients reported a reduction in distress after using the comfort room, and no patient reported an increase in distress following use of the comfort room.

After each use of the room, staff documented the date the room was used and whether the use of the room was considered effective. The room was considered effective if patients did not progress to needing seclusion or restraint and if they reported a decrease in distress. Data showed that 12% of interventions were followed by a restrictive measure.

**Changes in Seclusion and Restraint Use**

We hypothesized the addition of a comfort room would
reduce the use of seclusion and restraint. If we created a space that provided calming sensory interventions in a private area, would the reduction be achieved in an acute involuntary psychiatric hospital?

Using quality improvement data, we analyzed frequency and duration of seclusion and restraint use between an experimental unit (before and after comfort room intervention) and a control unit during a 9-month period. One-way analysis of variance (ANOVA) was used to analyze means for the three groups, followed by statistical process control (SPC) chart analysis to identify special cause variation.

The ANOVA showed no significant changes in seclusion and restraint use with the addition of a comfort room. The SPC analysis revealed significant special cause variation, particularly peaks of restrictive measure use. A chart review to better understand these peaks identified 11 “high-utilizer” patients (approximately 2% of admissions) accounting for 15% of seclusion and restraint episodes, 14% of seclusion hours, and 56% of restraint hours. High-utilizer patients were characterized by male gender, severe psychosis or personality disorder with assaultiveness, and traumatic brain injury or mental retardation. Between high-outlier peaks, SPC analysis also showed decreased frequency, duration, and variation in seclusion and restraint use.

Data were compiled by week and analyzed using SPC charts. The analysis showed several spikes of restrictive measure use, indicating special circumstances for further analysis. Apart from these high-utilizer patients, overall trends in data post-comfort room decreased.

These comfort room data are no longer being collected. However, the room is still in use, and several other units in the hospital have constructed comfort rooms.

CONCLUSION

Minimal published literature exists regarding alternative interventions to seclusion and restraint, despite the national efforts to reduce or eliminate their use. Our hospital developed a patient-centered comfort room as an intervention to reduce the number of episodes of seclusion and restraints on one inpatient unit. Administrative support was critical to validate staff efforts to initiate alternative interventions to seclusion and restraints, and unit staff also needed support and understanding in instituting change for nontraditional safety interventions.

Overall, we found the comfort room an effective tool in empowering the vast majority of patients to successfully manage anxiety and distress. The comfort room was not an effective intervention for select high-risk patients who accounted for a disproportionate segment of restrictive measure use in our institution. Alternative interventions, such as aggressive psychopharmacology, may be more effective in this group. We believe a comfort room is an important opportunity for acute psychiatric facilities to consider as a means of reducing seclusion and restraint use.

REFERENCES


Ms. Cummings is Nurse Specialist, and Ms. Grandfield is Nursing Coordinator, New Hampshire Hospital, Concord, New Hampshire; and Dr. Caldwell is Associate Chief of Staff and Mental Health Service Line Manager, Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts.

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Address correspondence to Kathleen S. Cummings, BSN, RN-BC, Nurse Specialist, New Hampshire Hospital, 36 Clinton Street, Concord, NH 03301; e-mail: kcummings@dhhs.state.nh.us.

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