Implementation of Comfort Rooms to Reduce Seclusion, Restraint Use, and Acting-Out Behaviors

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ABSTRACT
The use of seclusion and restraint as methods to control acting-out behaviors by individuals with mental illness continues, despite deaths and other negative outcomes to both the clients themselves and the staff members applying these techniques. Additionally, client-to-client and client-to-staff assaults and self-injurious behaviors can lead to injury or possible fatalities to both parties. Thus, there is a need to find alternative approaches to mitigate or even eliminate some of these behaviors. The use of comfort rooms is one such approach. With the institution of comfort rooms, one small, rural, tertiary mental health hospital demonstrated a reduction in seclusion and restraint use and assaultive behaviors of clients. In addition, 92.9% of the clients who used these rooms found them to be helpful when they experienced increasing levels of distress. With the provision of an area for clients to go voluntarily to self-manage their distress, nurses play a role in promoting autonomy and person-centered care, while reducing environmental stress and potential negative outcomes.
According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2011), approximately 150 people die each year as a result of practices used to seclude or mechanically restrain someone with a mental illness, and myriad others are injured or traumatized. The National Association of State Mental Health Program Directors (NASMHPD) stated that there is empirical evidence showing that use of seclusion and restraint has led to psychological harm, physical injury, and even death for both the clients subjected to these events and the staff members who apply these techniques (Haimowitz et al., 2006). In 1998, the Hartford Courant published a series of articles entitled, “Deadly Restraint” that chronicled 142 deaths nationwide related to the procedures used in seclusion and restraint in mental health facilities from 1988 to 1998 (as cited in Haimowitz et al., 2006). This report was prompted by the death of an 11-year-old boy who died when two aides sat on his back and crushed him to death after his refusal to move to another breakfast table (NASMHPD, 2009). This article will examine the positive impact on clients and nursing staff when comfort rooms are implemented at one small, rural, tertiary mental health hospital.

BACKGROUND

According to the Centers for Medicare & Medicaid Services (CMS, 2005), a restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a person to freely move his or her arms, legs, body, or head. Seclusion is the involuntary confinement of a person alone in a room or area from which the person is physically prevented from leaving (CMS, 2005).

LeBel and Goldstein (2005) developed a model that determined the cost of an average duration of mechanical restraint use; including for pre-restraint, the actual restraint episode, and post-restraint, the process cost $309.21. This figure included number of tasks involved, number of staff disciplines, and staff time in all three phases (LeBel & Goldstein, 2005). Additionally, they posited the facility's annual inpatient service budget to be $3,998,741 and the cost evoked from annual use of restraints to be $1,446,740. Therefore, approximately 36% of the budget was consumed by the use of mechanical restraints.
Curie (2005) stated that use of seclusion and restraint and enforcing external control is keeping clients in a margin that prohibits them from learning how to manage their illnesses and lives. Through these practices, dependence and learned helplessness and hopelessness are encouraged, and clients are not seeking the necessary treatment due to the fear of losing power and control (Curie, 2005). Staff members do not look at clients as individuals but as pejorative labels. Glover (2005) asserted that many inpatient psychiatric settings focused on characteristics of clients that staff considered negative, such as substance abuse, age, race, and childhood environment, which is responsible for an atmosphere where staff members view the clients as the only cause of unit violence and aggression. By identifying clients this way, staff may expect them to live up to the self-fulfilling prophecy of negative behaviors and staff may also abdicate themselves of any responsibilities for clients’ aggressive acts.

NASMHPD (2009) concluded that the “worse possible punishment” in prisons is seclusion or solitary confinement, yet in psychiatric settings clients who are presumed to have behaved inappropriately are placed in seclusion and it is termed “therapeutic.” As a cogent argument, Bloom (2002) asserted that clinicians should assume that clients in psychiatric settings, especially women, have been exposed to violence, and coercion and forceful actions could trigger previous experiences that lead to retraumatization. Placing these clients alone in a locked room or having staff forcibly hold them against their will so other staff members can apply mechanical restraints to all four extremities could cause these clients to relive past similar experiences that were done to punish or torture them.

**NEW AND PROMISING DIRECTIONS**

No evidence supports the therapeutic value of seclusion and restraint, and the current focus is moving from a medical model that defines individuals as mentally ill patients toward the recovery model aiming to define clients with mental illness. There is renewed optimism that new interventions will support those with serious mental illness and treat them as individuals with a sense of hope and personal choice (Hucks-how, 2004). The recovery model is becoming the cornerstone for the future of the treatment of people with mental illness (SAMHSA, 2010). Some of the tenets of recovery for mental health include hope, empowerment, individualized and person-centered care, peer support, and respect (SAMHSA, 2010). Although no one method is identified as the best, it appears a multifaceted approach of numerous methods all grounded in the movement toward the recovery model should be used as methods to reduce the use of seclusion and restraint.

Promising research offers numerous approaches that lead to the reduction of seclusion and restraint. SAMHSA (2010) asserted that a focus on the recovery model would
include client involvement, development of partnerships between clients and staff, and data collection. Some studies concluded that the following were necessary components in the reduction of the use of seclusion and restraint (Ashcroft & Anthony, 2008; Kontio et al., 2010):

- Strong leadership direction.
- Specific staff training.
- Debriefing.
- Nursing interventions such as nurse presence with clients in conversations that provide clients a sense of safety and comfort.
- Interprofessional agreements with nurses and physicians and the client that negotiate behaviors in a written or verbal contract.

Champagne and Stromberg (2004) voiced the need for a national initiative that would focus on the reduction of seclusion and restraint use in inpatient psychiatric facilities through the use of creative methods that include the client in the recognition of self-care and positive change. They asserted that to ensure a person-centered care environment, it is the health care worker’s responsibility to develop strategies that respond to clients’ needs and essentially to design interventions with clients’ input that show responsiveness to these daily needs. Bloom (2002) stated that for an environment to be truly safe it must be safe for clients and staff and that staff cannot create an environment that is safe without the active participation of the clients.
Use of Comfort Rooms

Champagne and Stromberg (2004) posited that all human brains seek information through the senses such as to look, listen, touch, taste, and smell. According to Bluebird Consultants (n.d.), a comfort room is a preventive tool or alternative to the use of seclusion and restraint, as it is a sanctuary and place for clients to go to experience their feelings of anger or anxiety within acceptable boundaries, a place to participate in various activities of their choice that could engage all of their senses. Bluebird (2005) also asserted that among the numerous approaches toward the reduction of seclusion and restraint, comfort rooms are one of the most popular tools cited by both staff members and clients in the psychiatric facilities. She also posited that by using these rooms the use of seclusion and restraint can lessen through stress reduction, and the rooms are cost effective and require no specialized education to use. She strongly emphasized that use of a personal safety plan increases the effectiveness of a comfort room. A safety plan is a form given to clients to complete on admission to the facility that provides them the opportunity to identify difficulties and potential triggers, as well as what helps them during times of distress (Bluebird, 2005).

As part of a pilot project, Cummings, Grandfield, and Coldwell (2010) studied the effects of a comfort room on an admission unit at one institution. The intent was to promote a therapeutic, safe, and supportive environment for clients at the facility. To decrease staff anxiety levels, it was decided to keep one existing seclusion room on the unit instead of converting that room to a comfort room so the project could move forward with equal optimism from the staff members and the clients (Cummings et al., 2010). They concluded that overall, the comfort room—a converted alcove area—was effective for the majority of clients in providing the tools for them to successfully manage distress or anxiety; however, it was not effective for the small number of select high-risk clients that use a disproportionate amount of more restrictive measures.

CLIENT PERSONAL SAFETY PLAN

1. It is helpful for us to be aware of the things that can help you feel better when you’re having a hard time. Please place a check mark beside any of the following items that have worked for you in the past.

| Sitting by the nurses’ station | Taking a hot shower |
| Talking with staff | Deep-breathing exercises |
| Talking with another patient | Lying down with cold cloth on face |
| Calling a friend | Putting hands under cold water |
| Writing a diary/journal | Exercising |
| Listening to music | Punching a pillow |
| Reading a newspaper/book | Going for a walk with staff |
| Watching TV | Pacing the halls |
| Cold milk/cookies | Voluntary time out in your room |
| Eating something | Voluntary time out in quiet room |
| Wrapping up in a blanket | As-needed medication |

2. What are some of the things that make it more difficult for you when you’re already upset? Please check any of the following “triggers” that you know will cause you to escalate.

| Being touched | Being isolated |
| Yelling | Any loud noise |
| Particular time of the day (name) | Particular time of the year (name) |
| Other: | Not having control/input (explain): |

______________________________  ________________________________
Client signature  Psychiatrist signature

Figure 3. Personal safety plan form, to be completed by the client. The information should be incorporated into the client’s treatment plan.
COMFORT ROOM INITIATIVE

In support of this recovery-focused initiative, an interdisciplinary team led by the author was formed to develop a comfort room on each of the female and male inpatient admission units of a small, rural, tertiary mental health hospital. The comfort room doctor of nursing practice Capstone Project was approved through the Institutional Review Board at Waynesburg University and received authority approval from the practice site. This project was developed to provide an alternative tool in the mission to cease the use of seclusion and restraint in the institutionalized mental health patient population.

Team Formation

In January 2010, a comfort room plan was presented to the executive staff members and leadership team at the mental health hospital. The comfort room committee recommended that with the institution of comfort rooms, clients could volunteer to use the rooms for up to 30 minutes when they first feel anxious or angry. Use of the comfort rooms would be effective in decreasing negative acting-out behaviors such as self-injury, assaulting other clients or staff, or any other similar behaviors that could result in the use of seclusion or restraint for clients. The goals of the project included:

- Within 4 months of instituting the comfort rooms, there would be zero use of seclusion and restraint at the hospital.
- Within 4 months of instituting the comfort rooms, there would be a 50% reduction in client-to-client assaults, client-to-staff assaults, and self-injurious behaviors at the hospital. (The hospital defines assault as an aggressive act involving physical contact that may or may not result in injury, while self-injurious behavior is a self-directed act that injures the client.)

The project team leader invited all hospital division leaders to present the development of comfort rooms to their subordinates and solicit volunteers. Members of the team included a financial office representative to approve the costs, a representative from the procurement office to assist with ordering the necessary items, someone from the performance improvement department to assist with data collection, a psychologist to assist with procedures and current practices in mental health, a member of the activity department to guide the committee on various tools used as comfort measures, two direct-care RNs, and two nursing supervisors. Client representation was imperative, and the first four clients who volunteered were chosen to join the team. One male and one female client attended each meeting, and the other male and female clients served as alternates. Clients who participate on committees receive minimum wage for their attendance time at the meetings.
Mission

Prior to the second and subsequent meetings, an agenda and meeting minutes from the previous meeting were sent to all committee members. By group consensus, a mission statement was developed to communicate the shared vision of the project: “The mission of the comfort room initiative is to provide clients an opportunity to practice self-management techniques in a low-stress environment.” The committee met every 2 weeks. Committee members presented this initiative to stakeholders both within and outside the hospital, in addition to including information about the comfort rooms in the employee, client, and family newsletters.

Comfort Room Development and Design

The two admission units’ direct care nursing staff and clients chose the com-
comfort rooms would be covered by a wall mural. One wall in each of the rooms would initially only be located on two admission units, the committee decided that all clients in the building would have the same opportunity to vote on the different proposals. This led to increased client buy-in and created a sense of client pride and ownership in these rooms.

The first project proposal that sought all client participation was choosing a wall mural. Seven different calming murals were chosen by the comfort room committee members. A screenshot of all seven scenes was placed on a large cardboard poster. One of these posters was given to each of the five units, and at the units’ next community meetings, nursing staff asked the clients to pick their favorite mural through a show of hands. Approximately 75 male and 50 female clients were present, and the majority them voted. Both the male and female unit clients chose the scene titled “Mountain Stream.” This mural displays a small waterfall cascading through a forest of brown, green, and red hues.

The next project proposal aimed at increasing client participation was to hold a contest for each unit, allowing clients to suggest a name for each comfort room. The two winners received a $5 coupon book to the hospital’s canteen and were acknowledged publicly. The men chose the name “Tranquility,” and the women chose “Relaxation Station.” The names were placed on a plaque identifying the rooms and were unveiled in a ribbon-cutting ceremony in mid-November 2010, which signified the official commencement of the comfort rooms.

With the assistance of the clients, the committee selected the items to be placed in the comfort rooms. The walls were painted a pastel green, and one wall also had the mural on it. Another wall had an area covered with chalkboard paint near the floor so clients could sit on a mat and write on the wall if they chose to do so. Drop ceilings were installed to help decrease the noise level in the rooms. Light panels with sky scenes were used to improve the ambience and produce a feeling of being outside, as well as aid in decreasing the harsh lighting. The clients selected these last two items in the same manner they selected the wall mural, by choosing from screenshots on a large cardboard poster.

A recliner, rocking chair, foam chair, and lap desk were placed in each carpeted room, as well as a large liquid crystal display television and Blu-ray Disc™ player for DVDs with calming scenes. The televisions can only be used with these DVDs, as there is no cable connection. A surround-sound system is housed in the drop ceilings. Because the television and Blu-ray player needed to be housed safely in a cabinet, a carpenter was added to the committee. Additional items that are

## SIDEBAR

### RN OBSERVATIONS ABOUT COMFORT ROOM USE

1. **Why do you think women use the comfort room more often than men?**
   - “The men have other rooms on the unit they prefer to use such as a diversion room,” which allows the men to physically exercise on a treadmill or stationary bicycle.
   - “Men seem to tend to unwind better when they can listen to loud music of their choice, which is not always what women find comforting.”
   - “The women felt special using it, as well as it separates them from their peers. Men may typically prefer to be physical than calming.”
   - “The women appear to find more elegance with the room.”

2. **Are staff members suggesting the use of the room? If not, could you ask them why they do not suggest the room? Do they have any ideas how to increase room usage?**
   - “I do believe it is suggested at times, but the guys would rather go to their rooms. Men also tend to have less advanced notice before they become out of control. To increase its usage we need to be more proactive with new admissions.”
   - “Multiple times the room has been offered, however, by the point that some of them escalate, it is beyond helping per their statements. Sometimes staff are unavailable to accommodate when they [clients] feel they would like to use the room.”
   - “Staff do suggest the room but often times more than once the person has to be the one with the idea.”

1. Why do you think women use the comfort room more often than men?
2. Are staff members suggesting the use of the room? If not, could you ask them why they do not suggest the room? Do they have any ideas how to increase room usage?
is expected to again read the agreement form and date and initial the back of the form each time prior to using the room. The committee members unanimously believed it is imperative that the client be reminded of the importance of keeping the comfort room in good condition for all clients to use. The objective is that the client recognizes symptoms of increased anxiety, or accepts staff members’ suggestion to voluntarily use the room prior to engaging in any behaviors that could result in negative outcomes. If the client is unable or unwilling to initial the agreement form, then the committee felt use of the comfort room was not an appropriate option at that time.

Another form kept in a binder in the nursing station is a copy of the client’s personal safety plan (Figure 3). Prior to painting or other physical changes to the rooms, photographs of each room were taken (Photo 1) to later use as a comparison to the end product (Photo 2). The infection control nurse was consulted to identify any infection control issues with the items for the rooms, and the safety manager was consulted for any fire safety concerns.

The committee decided that the identified outcome data to measure the impact of this initiative would be to compare the average rate of occurrence per 1,000 days of the client care categories of seclusion and restraint, client-to-client assaults (CTCA), and self-injurious behaviors for the 4 full months prior to the implementation of the comfort rooms to the next 4 full months after implementation.

**FINDINGS AND RESULTS**

Table 2 shows data for the months of July through October 2010, and Table 2 shows data for the months of December 2010 through March 2011. November 2010 data were not used since the rooms opened mid-month. Additionally, a form was developed to monitor whether the client required an extra dosage of medication within the 30-minute time frame prior to and after using the comfort room. The purpose of this monitoring tool was to assess a possible positive relationship in decreasing agitation if extra medication were used in conjunction with the comfort room.

**Table 1** shows data for the months of July through October 2010, and **Table 2** shows data for the months of December 2010 through March 2011. November 2010 data were not used since the rooms opened mid-month. Additionally, a form was developed to monitor whether the client required an extra dosage of medication within the 30-minute time frame prior to and after using the comfort room. The purpose of this monitoring tool was to assess a possible positive relationship in decreasing agitation if extra medication were used in conjunction with the comfort room.

**Table 3** lists the number of clients who used the comfort rooms and the total times the rooms were used monthly. An average of 28 women and 42 men who could use the rooms were in the facility each month. Clients’ ages ranged from 18 to 79, with 36.6% of clients in the 50-59 age range. Approximately 63% of clients were at the facility less than 2 years, and 81.4% were Caucasian.

Fourteen voluntary feedback forms were completed during the 4 months. The forms asked clients to rate their level of distress before and after using the comfort room based on a Likert scale ranging from 1 (lowest level of distress) and 5 (highest level of distress); 8 clients stated the room lowered their levels of distress by at least a difference of 2. Five clients noted higher numbers post-comfort-room use, yet all 5 circled the choice that the room helped them. Those clients who circled increased levels of distress on the scale after use of the comfort room may not have understood the scale. One male client indicated that the room was not beneficial and had only identified his level of distress prior to use and did not rate his level after use. He was the only client who believed the room did not help him.

Since the initiation of the comfort rooms, there has been no use of seclusion or restraint. Previously, from October 2009 through October 2010, five occurrences of mechanical re-
KEYPOINTS


1. Among the numerous approaches toward reduction in seclusion and restraint use, comfort rooms are one of the most popular choices of both staff members and clients.

2. It is critical to include patient representatives along with staff members in the development of comfort rooms to develop a sense of ownership.

3. Comfort rooms are cost effective and require no specialized education to use.

4. In this study, positive outcomes were noted with decreased rates of client-to-client and client-to-staff assaults, as well as zero use of seclusion and mechanical restraints.

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the unit milieu. These same events could create fear, anger, and distrust among both clients and staff, which creates difficulty in promoting a safe and secure unit.

The author believes that if nurses encourage the use of the comfort room when a client first feels distressed or anxious, negative outcomes could be decreased, and thus, the use of seclusion and/or restraint could be prevented. Self-management empowers clients and promotes autonomy on their road to recovery. Comfort rooms should be considered an important tool in the goal toward the reduction of seclusion and restraint use.

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