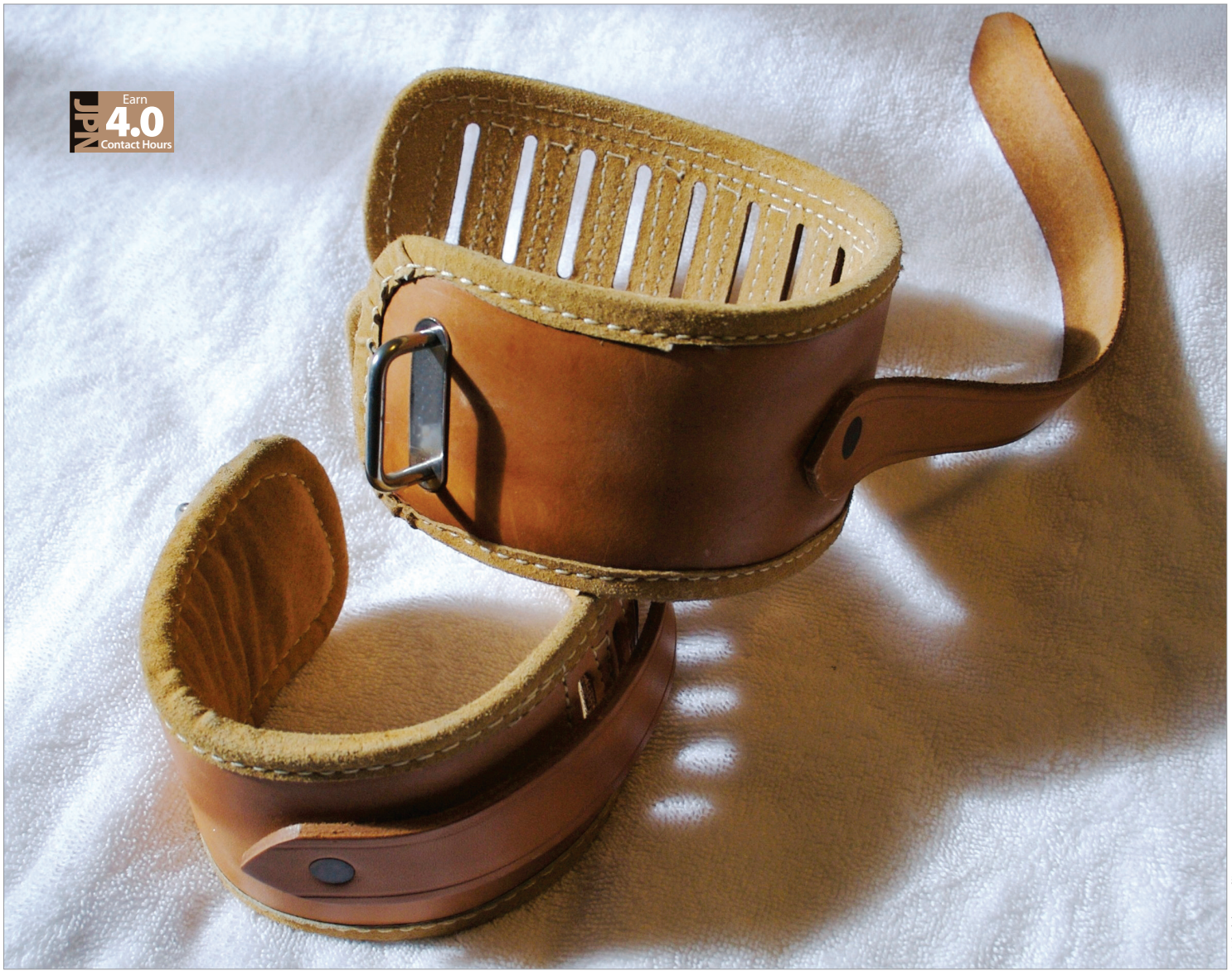

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Reducing Use of Restraints and Seclusion to Create a Culture of Safety

Genevieve E. Chandler, PhD, RN

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ABSTRACT

The purpose of this article is to describe the structure that empowered staff of a locked community hospital unit to reduce the use of restraints and seclusion to create a culture of safety. Themes garnered from interviews with and observations of key informants fit into the categories of a structural empowerment model, with leadership creating opportunities available for staff to develop new knowledge, information on trauma-informed care, support for feedback, and resources for the unit; thus, relationships with patients flourished. In turn, staff engaged in relationships with patients to provide opportunities to develop new knowledge and offer information, support, and resources.

On inpatient units, reducing use of restraints and seclusion is essential to creating a culture of safety for staff and patients. Following the reports of the harmful effect of restraining and isolating patients, including potential injury and death (Weiss, Altimari, Blint, & Megan, 1998), state and federal agencies issued recommendations to change practice (Childs, 2004). Reports on

restraint reduction have been primarily from either a problem-based model focusing on reducing the potential for violence on the unit (Bowers, Brennan, Flood, & Allan, 2008; Hahn, Needham, Abderhalden, Duxbury, & Halfens, 2006; Pollard, Yanasak, Rogers, & Tapp, 2007) or from models based on recovery that are designed to create a safe environment (Ashcraft & Anthony, 2008; Barton, Johnson, & Price, 2009; Chandler, 2008; Cummings, Grandfield, & Coldwell, 2010; Huckshorn, 2004; Johnson & Delaney, 2006; Koivisto, Janhonen, & Vaisanan, 2004; Sivak, 2012).

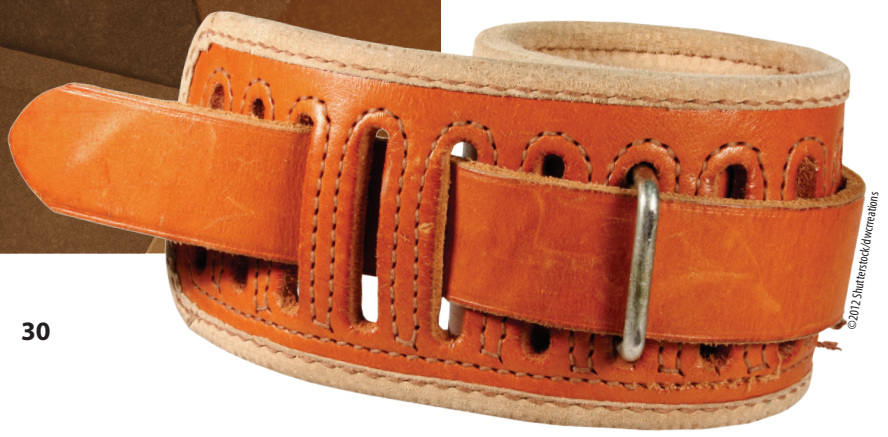
In 2010, SAMHSA selected 10 units for national recognition as leaders in preventing use of seclusion and restraints (Blank, 2010). This article details a case study of an award-winning unit that empowered staff and patients to develop a trauma-informed care approach to minimize coercive practices and create a culture of safety. The specific aim of the study was to describe the structure and processes that empowered the staff to make the change to build an evidence-based practice.

Information about patient preferences is critical. Once the admission assessment is complete, the RN or mental health counselor collaborate with the patient to methodically review the four sections of the safety plan:

- **A comprehensive list of physical, emotional, and cognitive responses to stress.**
- **Triggers that create stress.**
- **Activities that are calming.**
- **Past experience with restraints and seclusion.**

BACKGROUND

Each inpatient unit is unique, with diverse patient populations and staff with varying levels of education and experiences who are working with unit philosophies and practices that have evolved over the years. One major problem is that some of the practices that have developed over time do not support trauma-informed care, a recovery approach, or the reduction of restraints and seclusion. Trauma-informed care begins with the recognition that 85% of the patients admitted to inpatient units have experienced serious maltreatment from physical abuse, sexual abuse, or physical neglect (Hodas, 2006). A *traumatic event* is defined as when an individual has experienced, witnessed, or is confronted with an event that involved actual or threatened death, serious injury, or threat that causes intense distress (American Psychiatric Association, 2000). Trauma that results in mental health problems is often repeated, prolonged, and severe, extending over time (van der Kolk, 2006). Restraint and seclusion practices may re-traumatize individuals and those witnessing the experience (Jennings, 2004). *Restraint* refers to the use of belts or ties that restrain the movement of an individual. *Seclusion* is isolation from others through containment, often in a bare room without furniture with a small observation window in the door.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THEORETICAL FRAMEWORK

The appreciative inquiry approach is a way of viewing organizational problems through a positive lens (Cooperrider & Whitney, 2005). With appreciative inquiry, the assumption is that even though there are problems in the current system, solutions already exist in the setting that can be identified by addressing what is working well, describing moments of success from the past, and using the resulting positive attitude to build on strengths. Solutions do not need to be brought in from the outside and imposed on the current culture. Rather, using questions that inquire about strengths and successes, solutions are generated from within. Thus, the study interview began with the broad question, "How has the unit decreased use of restraints and seclusion?"—looking for what has been successful—followed by "How has the unit promoted safety?"—to identify the unit's strengths.

METHOD

The method for this study was a qualitative design using a single case study. The unit of analysis was a 20-bed, locked inpatient unit in a community hospital. The principal investigator (G.E.C.) interviewed staff and leadership; reviewed unit policies on restraint and seclusion; and used participant observation to (a) describe the perceptions of the leadership and staff on how they reduced use of restraints and seclusion, (b) observe interaction of staff and patients in the milieu, and (c) observe the structure and process of the milieu.

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Sample and Procedures

The sample included 11 key informants; procedures included document review and participant observation. Key informants came from a staff of 12 nurses, 9 mental health counselors, an occupational therapist (OT), an OT aide, and 3 members of the unit leadership team. The informants who volunteered to participate in the study included 3 nurses (2 women and 1 man with 2 to 20 years of experience), 3 mental health counselors (1 woman and 2 men with 6 to 25 years of experience), 1 female OT with 10 years of experience, 1 female OT aide with 2 years of experience, and 2 female and 1 male administrator, each with more than 20 years of experience. The document review included the unit philosophy on trauma-informed care, the unit policies on restraint and seclusion, and the application to SAMHSA's recognition program (Blank, 2010). More than 40 hours of participant observation occurred during staff meetings, spontaneous staff-patient interactions, and patient group meetings.

Setting

The setting was a locked, 20-bed inpatient unit in a general hospital located in a small northeastern U.S. city. In 2005, prior to reduction efforts, 27 instances of restraint and seclusion occurred; since then, incidents have dramatically decreased with a few small peaks, often with the same patient (**Table**). Recent episodes are currently being studied. For their efforts to decrease the use of restraints and seclusion, the unit received a state Department of Mental Health award in 2007 and the SAMHSA recognition in 2010.

Data Collection

The institutional review boards of the investigator's university and the study hospital approved the study. The investigator introduced the idea of the study to the unit manager, who then invited the investigator to a staff meeting to determine the staff's interest in the study. At the meeting, the investigator described the purpose of the study, ensuring that participation was completely voluntary and would have no effect on employment status. Following the meeting, individual staff let the investigator know they would be interested in volunteering for the study; individual interviews were arranged at a convenient time in a private location. The hour-long interview began with the question, "How has the unit decreased the use of restraints and seclusion?", followed by prompts to describe details; the second question, "How has the unit promoted safety?", was also followed by prompts to deepen the description. Voluntary informed consent was obtained, anonymity was maintained through numerically coding digitally recorded and transcribed interviews, and confidentiality was assured through data stored in a locked office in a locked drawer with access only by the principal investigator. Bracketing was used prior to data collection to note the investigators' preconceptions and biases.

The reason for the investigator's visit to observe the unit was announced to patients in a community meeting. During observations, patients quietly approached the investigator and asked if they could recount their experience of the difference between this unit and others where they had been admitted. The patients, in fact, had been on many more units than any of the staff. As the investigator listened, patients took turns sharing their experiences. Due to the focus of this study and previous human subjects review approval, the patient stories are not part of findings; however, the patients' experiences repeatedly corroborated the staff reports of the importance of trusting, respectful patient-staff relationships in decreasing coercive practices and creating safety.

TABLE

RESTRAINT AND SECLUSION STATISTICS FROM THE STUDY HOSPITAL, 2005-2011

Year	Total	Seclusion	Restraint
2005	27	17 (14 were the same patient)	10 (6 were the same patient)
2006	9	4	5
2007	2	0	2
2008	3	3	0
2009	6	2	4 (all involved the same patient)
2010	2	2	0
2011	6	1	5 (involving 2 patients)

Data Analysis

Inductive content analysis was used with the verbatim interview transcripts following each interview and for field notes (Hsieh & Shannon, 2005). The analysis consisted of eight steps: reading the entire text to obtain a sense of the whole; making memos of initial impressions; completing more careful, word-by-word readings; highlighting significant statements that appeared to capture key concepts; developing themes that represented key concepts; grouping themes into descriptive categories; developing definitions for each category; and identifying exemplars of stories, themes, and categories from data. This step-by-step analysis was an iterative process that occurred after every interview. Trustworthiness or confirmability of the findings was established by auditability, credibility, and fittingness (Lincoln & Guba, 1985). Auditability, the ability of readers to follow the process of decision-making

during analysis and interpretation, was developed through a memo log that was written following each interview and during analysis. Credibility was established by triangulating the sources between interviews, document review, and participant observation; sharing the transcripts, findings, and discussion with two informants for comments and feedback; and reviewing findings with an outside expert. To establish fittingness, or how themes represent data, the interview transcripts were read and coded several times, with each of the themes defined and supported by quotes from informants.

FINDINGS

As the responses to the interviews were analyzed, data themes fit into the five categories of the structural empowerment model: opportunities, information, support, resources, and relationships (Roche, Morsi, & Chandler, 2009). *Opportunity* is defined as work that provides challenge, growth, knowledge development, and skill refinement. *Information* is the individual's perception of being informed of knowledge, values, and plans that relate to their job, their patients, the unit, and the institution. *Support* is the perception of the availability of guidance, hands-on assistance, or recognition for the job being done. *Resources* refer to availability of personnel, supplies, or equipment and time to do the job. *Relationships* are the individual's perception of the opportunity to establish trusted connections with mentors, peers, and colleagues.

Opportunities

In 2004, the Massachusetts Department of Mental Health committed to eliminating the use of restraints and seclusion (Childs, 2004). On this unit, the change began with unit leadership providing an opportunity for a group of administrators and staff to participate in SAMHSA's National Center for Trauma-Informed Care training. Following the training, leadership and staff committed to reducing restraint and seclusion use by building on the six core strategies (National Association of State Mental Health Program Directors, 2009) and adopting a trauma-informed care approach. To involve all staff, a retreat, followed by a series of mandated workshops on trauma-informed care, were created that included education on the neurobiological and psychosocial effects of trauma, the relationship of dissociative symptoms and self-harm to posttraumatic stress disorder (PTSD), and the retraumatization that occurs from being restrained or witnessing use of restraints and seclusion.

Next, leadership scheduled weekly staff discussions to explore patient autonomy, staff safety, patients' responses to a crisis, and staff response to patients. Staff's freedom to voice their opinions, concerns for their safety, and the day-to-day implications of a trauma-informed approach to their role was critical to developing a cohesive team. A recent unit document describing alternatives to restraints states:

> The concept of patient autonomy continues to generate controversy. We have worked together to create an atmosphere where staff is encouraged to articulate their concerns and express their opinion. This approach has resulted in robust and diverse opinions in our weekly staff meeting and periodic staff trainings.

Many informants admitted that it is hard to change the way they were trained, yet they recognized the importance of using a trauma-informed perspective with their patients. For example, the director observed,

> We changed the way we identified escalation. We began to tolerate patient distress without reacting in a punitive way. We began to see clearly that trauma was a primary cause of much of the escalating behavior. It became imperative to understand trauma and what it does to a patient's ability to tolerate difficult affect.

A nurse stated, "Now, when a patient is yelling or throwing things, we give them space, remove the audience, and stay with them." Trauma-informed care is a work in progress on this unit, with evidence of success, such as several newer staff commenting that they could not imagine getting to know their patient *not* being a priority.

Information

Patients who dissociate or self-harm can be frustrating to staff. Providing information to increase understanding that such behaviors can be the result of a neurobiological response to trauma enabled staff to develop a different perspective on the symptoms of PTSD. Informants described that when a patient is dealing with stress and responds with unhealthy coping skills such as self-mutilation behaviors, the staff approach is to remain calm and nonpunitive. The unit director observed, "We allow people to fail. People will superficially cut themselves. We help clean them up and see what else they could do the next time they feel that way." A mental health counselor echoed this approach, reporting that cutting was viewed as a coping mechanism, and their job is to find healthy alternatives that fit the patient's needs.

Staff and patients openly acknowledged their awareness of the effects of past trauma on current relationships and behaviors. An advanced practice nurse (APN) shared, "We let patients know that we have people who have all kinds of experience with being abused, and when you are doing that [being aggressive] it is very upsetting to others…. The curative factors of the group is [*sic*] amazing!"

Patients and staff are mindful of the unit objective to use trauma-informed care to create a safe environment. On the central bulletin board is a sign that indicates the number of days since the last restraint so everyone can work toward a restraint-free unit. Both staff and patients have opportunities to develop trauma-related knowledge and skills and be recognized for their efforts.

Information about patient preferences is critical. Once the admission assessment is complete, the RN or mental health counselor collaborate with the patient to methodically review the four sections of the safety plan:

- A comprehensive list of physical, emotional, and cognitive responses to stress.
- Triggers that create stress.
- Activities that are calming.

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Organizational structural empowerment										
If staff have opportunities, information, support, and resources	THEN	Relationships with patients, peers, and leadership improve	AND	Staff experience empowerment.						

Therapeutic structural empowerment										
If staff have opportunities, information, support, and resources	THEN	Relationships with patients, peers, and leadership improve	AND	Staff experience empowerment	THEN	Staff provide patients with opportunities, information, support, and resources	THEN	Relationships with peers, staff, and community improve	AND	Patients experience empowerment.

Figure. Organizational and therapeutic structural empowerment.

- Past experience with restraints and seclusion.

Patients' calming preferences on the safety plan are listed on the patient board in the staff room and often referred to during their stay.

Support

Collaboration between staff and leadership in scheduled meetings and during the shift provides the support required for the sensitive, intensive work necessary to create a safe environment. For patients, groupwork such as the goals group and the psychoeducation group augment the safety plan by providing support for recovery. With the recovery focus of the daily goals group, participants identify their treatment goals, grounding skills, something they do well, and self-soothing practices. In the psychoeducation group, the nurse teaches patients about the effects of past trauma on their current emotional and physical responses. Consumers (former patients) volunteer to facilitate recovery groups, host Sunday morning coffee, and help in other ways. As the manager described, "A very fine carpenter did some work for us."

Resources

The OT conducts a formal or informal sensory assessment to identify individual sensorimotor preferences, increase patients' awareness of their bodies' responses to positive or difficult situations, and develop individualized resources. The OT aide said, "We are the 'go-to' people if a patient has troubles with anxiety or depressive symptoms; staff send them to us, then I sit with them to figure out the activities that would help." Sensory interventions commonly used on the unit were listening to patient-preferred music to quiet inner voices, watching a mechanical aquarium to diminish hallucinations, tasting a sour candy or smelling an aromatic oil to interrupt dissociative episodes, or lying under a weighted blanket to calm anxiety. For the off-shift nursing staff, the OT left packets of activities and sensory items that were individually designed for each patient. A mental health counselor described:

> We have a woman that when she gets angry she yells and screams. We know she likes to bead, so we offer her a beading project. At first she is beading and still mad and yelling, but then she is just beading.

The OT provides resources and relationships to empower both staff and patients.

Relationships

The nurses, counselors, and OT commented on the need to be flexible in their roles so they can be responsive to patients' needs. For example, the OT attends shift reports and community meetings to "get directions from the patients as to what they need for that day." The OT staff use their discretion to change activities daily from art to exercise to relaxation, according to the tenor of the current patient population. The attitude of being genuinely interested in the patients' lives describes the leadership philosophy that influences the staff's day-to-day decisions. A nurse observed, "We get to know our patients well so we can tell before they get to the point of agitation. I stay present on the unit, make eye contact, and smile." On routine checks, staff members intervene if someone is crying on the telephone or upset in their room: "I ask how they are doing, just let them have their feelings, and give them their space. If someone is beginning to escalate, I validate their

feelings and let the team know what could set them off," said a mental health counselor. Staff make decisions based on knowing the individual patient. As one nurse described:

> The more time you spend with them, the easier it will be to calm them down when they are stressed or angry. That's why I am always on the unit. Catch them when they begin to act up, interrupt, stay with them.

Developing trusting relationships with patients is a core unit value.

Key informants recognized that the groundwork for having a patient feel understood begins on admission by immediate engagement through attentive listening to the patient's perspective. Several staff commented that by being invested in developing a relationship with their primary patient, they felt more comfortable assisting the patient when he or she became distressed. Informants consistently reported that the critical factor in interrupting the path to coercive practices was being respectful and attentive to fluctuations in the patient's mood, while also being aware of their own responses to the patient. "In individual or group interactions, staff need to act mindfully," a nurse commented. A counselor stated, "We give people more choices here; if they are being disruptive we ask, 'Do you want to go to your room, go on a walk, talk to me, have a snack?' These are adults, choice is very important." A nurse commented:

> We are role models for patients, demonstrating how to deal with difficult situations in a reasonable manner; for example, if a patient walks away muttering negative comments under their breath, we let that go. They are letting off steam. Other units are not like that, those comments could have staff come down on you, and the situation may escalate. We let it go and don't bring it up again and patients respect that.

The unit director asserted:

> We are not a behavioral unit, we focus on relationships. There is no magic to it—it is just very simple, the authenticity in relationships has a huge schmooze factor. We hang out…people feel like they are in a relationship, rather than a coercive environment, besides, behavioral interventions always have a punitive spin with rewards and punishments, like 'If you don't go to the group, you don't go on a walk.' How does that make sense?

The APN observed:

> Most units seem to want to impose their will and get perfect behavior. You get what you want in the short term—people behaving themselves—but you're imposing external controls, not energizing their own internal controls. So are they getting anything useful out of their stay?

Staff relationships with each other were essential to develop comprehensive treatment plans. Several informants reported statements similar to "Initials, indicating professional degrees, don't matter; we work as a team." On all three shifts, the team works closely with the patient to develop a comprehensive treatment plan; for example, patients newly admitted are matched with a primary staff member by the night shift counselors, and daily rounds are held three mornings and two afternoons per week. A nurse commented, "Teamwork is huge, communication is enormous. We flow, we change hats, we have each other's backs." A counselor observed, "We complement each other; I am good with women diagnosed with BPD [borderline personality disorder], and [another counselor] is better with the male population and older women." The APN reflected that nurses need to have the responsibility to make decisions and to be empowered to act, which may mean breaking some rules such as unlocking the kitchen at night for a snack or taking a patient outdoors for a break.

During the researcher's direct observation, staff interaction with unit leaders was visible, and team involvement in treatment was evident. The medical director emphasized patient autonomy and equal partnership with patients. The APN was frequently on the unit talking with patients, and the unit manager led the 15-minute daily community meeting in which all staff, OTs, and social workers participated. The APN observed, "I think nurses benefit from seeing somebody in leadership actually doing the same work, rolling up their sleeves, and being involved."

A nurse commented, "Teamwork is huge, communication is enormous. We flow, we change hats, we have each other's backs."

DISCUSSION

In previous studies, when nurses had opportunities to develop knowledge and skills and to access information, support, and resources, they were more engaged in their work (Laschinger, Wong, & Greco, 2006), more committed to their job (Laschinger, Finegan, Shamian, & Casier, 2000), and the safety of patients improved (Armellino, Quinn Griffin, & Fitzpatrick, 2010). The level of nurse expertise increased when staff had access to opportunities, information, support, and resources that could facilitate relationships with patients, peers, and mentors (**Figure**) (Roche et al., 2009). Thus, positions that had access to opportunity, information, support, and resources empowered staff to develop the relationships necessary to be effective in their work.

The current study is the first that used an empowerment model to describe the therapeutic environment where staff with access to critical opportunities and key relationships were able to provide patients with access to critical opportunities and key relationships as well. As staff were pro-

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vided with opportunities to develop knowledge and skill—and as relationships with leadership and between staff provided information, support, and resources—staff, in turn, provided patients with opportunities to develop their skills and provided the information, support, and resources necessary to facilitate the therapeutic relationships that were central to this unit's success in decreasing use of restraints and seclusion.

CLINICAL IMPLICATIONS

The structural empowerment model provides a map for leadership and staff to decrease use of restraints and seclusion to create a safe environment. Using appreciative inquiry—keeping in mind solutions can be found within the existing setting—each unit is encouraged to create opportunities for staff to develop their knowledge and skills; to determine the decisions staff have the discretion to make; and to describe the information, support, and resources needed so the relationships with patients, peers, and mentors can flourish. As this unit demonstrated, engaged relationships provide the base from which a safe environment can grow.

CONCLUSION

When leadership created relationships with staff that provided the opportunities for information, support, and resources to implement trauma-informed care, staff were able to engage in connected, empowering relationships with patients. Knowing the potential effect of a trauma history on current behaviors and attitudes increased staff's understanding of the patient experience. A deeper understanding with support from leadership and peers with resources to assist patients led to the trust, connection, and awareness necessary to decrease restraint and seclusion. Staff modeled the relationship they had with leadership with their patients. When staff felt empowered to create a safe milieu, they could provide the necessary opportunities, information, support, and resources to empower their patients. From focusing on micro moments of interactions to macro changes in policy, this unit was able to create an environment where staff and patients felt safe enough to reflect on their values to facilitate well-being.

KEYPOINTS

Chandler, G.E. (2012). **Reducing Use of Restraints and Seclusion to Create a Culture of Safety.** *Journal of Psychosocial Nursing and Mental Health Services, 50*(10), 29-36.

1. Leadership empowering staff with opportunities, information, support, and resources facilitates engaged, trusting relationships that, in turn, facilitates staff in empowering patients by providing opportunities, information, support, and resources to reflect on values to enhance their well-being.
2. Ongoing staff and patient learning about the effects of trauma on the body and brain is essential to decrease coercive practices and thus create safety.
3. Engaging in respectful relationships immediately upon patient admission and learning about sensorimotor needs increases staff knowledge of the patient's response to stress. Requiring regular staff/leadership reflective discussions increases staff awareness of their own responses to patient stress.

Do you agree with this article? Disagree? Have a comment or questions? Send an e-mail to the Journal at jpn@healio.com.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Armellino, D., Quinn Griffin, M.T., & Fitzpatrick, J.T. (2010). Structural empowerment and patient safety among registered nurses working in adult critical care units. *Journal of Nursing Management, 18*, 796-803. doi:10.1111/j.1365-2834.2010.01130.x.

Ashcraft, L., & Anthony, W. (2008). Eliminating seclusion and restraint in recovery-oriented crisis services. *Psychiatric Services, 59*, 1198-1202.

Barton, S.A., Johnson, R., & Price, L.V. (2009). Achieving restraint-free on an inpatient behavioral health unit. *Journal of Psychosocial Nursing and Mental Health Services, 47*(1), 34-40. doi:10.3928/02793695-20090101-01

Blank, K. (2010). Ending seclusion and restraint: Facilities honored for leading the way. *SAMHSA News, 18*(3). Retrieved from http://www.samhsa.gov/samhsaNewsLetter/Volume_18_Number_3/OrgsMakingADifference.aspx

Bowers, L., Brennan, G., Flood, C., & Allan, T. (2008). A replication study of the City Nurse intervention: Reducing conflict and containment on three acute psychiatric wards. *Journal of Psychiatric and Mental Health Nursing, 15*, 737-742.

Chandler, G. (2008). From traditional to trauma-informed treatment: Transferring control from staff to patient. *Journal of the American Psychiatric Nurses Association, 14*, 363-371. doi:10.1177/1078390308326625

Childs, E. (2004). *Commonwealth of Massachusetts Department of Mental Health restraint and seclusion philosophy statement*. Retrieved from http://www.nasmhpd.org/docs/publications/docs/2008/SRBriefings/I_1MARS%20PhilosophyStatement.pdf

Cooperrider, D.L., & Whitney, D. (2005). *Appreciative inquiry: A positive revolution in change*. San Francisco: Berrett-Koehler.

Cummings, K.S., Grandfield, S.A., & Coldwell, C.M. (2010). Caring with comfort rooms: Reducing seclusion and restraint use in psychiatric facilities. *Journal of Psychosocial Nursing and Mental Health Services, 48*(6), 26-30. doi:10.3928/02793695-20100303-02

Hahn, S., Needham, I., Abderhalden, C., Duxbury, J.A., & Halfens, R.J. (2006). The effect of a training course on mental health nurses' attitudes on the reason for patient aggression and its management. *Journal of Psychiatric and Mental Health Nursing, 13*, 197-204.

Hodas, G.R. (2006). *Responding to childhood trauma: The promise and practice of trauma informed care*. Retrieved from the Pennsylvania Office of Mental Health and Substance Abuse Services website: http://www.dpw.state.pa.us/ucmprd/groups/public/documents/manual/s_001585.pdf

Hsieh, H.F., & Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*, 1277-1288.

Huckshorn, K.A. (2004). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services, 42*(9), 22-33.

Jennings, A. (2004). *Models for developing trauma-informed behavioral health systems and trauma-specific services*. Retrieved from the Anna Foundation website: http://www.theannainstitute.org/MDT.pdf

Johnson, M.E., & Delaney, K.R. (2006). Keeping the unit safe: A grounded theory study. *Journal of the American Psychiatric Nurses Association, 12,* 13-21. doi:10.1177/1078390306286440

Koivisto, K., Janhonen, S., & Vaisanan, L. (2004). Patients' experiences of being helped in an inpatient setting. *Journal of Psychiatric and Mental Health Nursing, 11,* 268-275.

Laschinger, H.K., Finegan, J., Shamian, J., & Casier, S. (2000). Organizational trust and empowerment in restructured healthcare settings: Effect on staff nurse commitment. *Journal of Nursing Administration, 30,* 413-425.

Laschinger, H.K., Wong, C.A., & Greco, P. (2006). The impact of staff nurse empowerment on person-job fit and work engagement/burnout. *Nursing Administration Quarterly, 30,* 358-367.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

National Association of State Mental Health Program Directors. (2009). *Training curriculum for creation of violence-free, coercion-free treatment settings and the reduction of seclusion and restraint* (7th ed.). Alexandria, VA: Author.

Pollard, R., Yanasak, E.V., Rogers, S.A., & Tapp, A. (2007). Organizational and unit factors contributing to reduction in the use of seclusion and restraint procedures on an acute psychiatric inpatient setting. *Psychiatric Quarterly, 78,* 73-81. doi:10.1007/s11126-006-9028-5

Roche, J., Morsi, D., & Chandler, G.E. (2009). Testing a work environment-work relationship model to explain expertise in experienced acute care nurses. *Journal of Nursing Administration, 39,* 115-122.

Sivak, K. (2012). Implementation of comfort rooms to reduce seclusion, restraint use, and acting-out behaviors. *Journal of Psychosocial Nursing and Mental Health Services, 50*(2), 24-34. doi:10.3928/02793695-20110112-01

van der Kolk, B.A. (2006). Clinical implications for neuroscience research in PTSD. *Annals of the New York Academy of Sciences, 1071,* 277-293. doi:10.1196/annals.1364.022

Weiss, E.M., Altimari, D., Blint, D.F., & Megan, K. (1998, October 11-15). Deadly restraint: A nationwide pattern of death. *The Hartford Courant*.

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