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Reducing Restraints through Patient Involvement in Care Plans

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Abstract

Background: Restraint use has been demonstrated to pose a risk of psychological and physical injury to both clients and staff in health care facilities and programs. Evidence from the literature suggests that including patients in the planning of their care has been demonstrated to reduce problem behaviors, violent outbursts, instances of self-harm, and the need for restraint.

Purpose: The aim of this quality improvement project was to promote collaborative care through the attainment of provider knowledge of best practices to prevent and reduce restraint use at three group homes in St. Petersburg, Florida.

Methods: The intervention involved presenting evidence-based information from the literature to group home leadership, counselors and staff regarding the importance of patient involvement in care plans, and the correlation of decreased use of restraints when care is collaborative. Additionally, a tool kit was presented inclusive of best practice guidelines to reduce restraint use applying the Tidal Model framework. Acquisition of the material presented was measured by the DNP student's analysis of changes in restraint report data, as well as the use of descriptive statistics to assess participant feedback regarding the educational intervention at two month follow-up.

Results: At two month follow-up, restraint use had decreased by 16% across all group homes, and feedback received from the participant questionnaire was largely positive in nature.

Keywords: Phil Barker, Tidal Model, Mental Health, Restraints, Patient Centered Care

Introduction

This Qualitative Improvement (QI) Project focused on a psychiatric organization inclusive of three group homes for children located in an urban area of St. Petersburg, Florida. Evidence from the literature has demonstrated that restraint use places children and staff in danger of physical injury and increases the strain on mental wellness (Cusack et al., 2018). Dealing with behavioral and safety issues in a group home setting can be challenging for staff to navigate. Historically these three group homes have had a high restraint rate as evidenced by report logs kept at each home. Additionally, although less restrictive interventions were preferred, often restraints were selected as the course of action for group home residents who exhibited aggressive and/or destructive behaviors.

Larue et al. (2013) note that patients that have been restrained often feel shame, helplessness, humiliation, and may relive previous traumatic events. To date, there has been strong support from the literature that the Tidal Model framework has been impactful on the promotion of collaborative care and reduction of patient restraint. For example, Recupero et al. (2011) discuss an Oregon facility that was able to reduce restraint use by 87% by involving patients in treatment planning and utilizing a patient centered collaborative care approach. Further, Berger (2006) found that after the Tidal Model was implemented in a psychiatric facility, restraint use declined, and patients expressed feelings of increased involvement and respect in terms of the care provided. The need to provide collaborative patient centered care is well established in the literature. This DNP Quality Improvement project assessed the current trends at a group home organization and provided training, as well as a tool kit, to promote

knowledge attainment and utilization of Tidal Model framework concepts aimed at improving safety by building resident trust and provider / staff collaboration.

Background

Group homes were developed to provide a therapeutic home environment for their residents. The organization selected for this DNP project provided homes to children and adolescents who ranged from eight to seventeen years of age. Most of these residents had been removed from their homes or foster care system, and many were currently in the custody of the Florida Department of Children and Families (DCF). Two of the group homes housed eight to twelve male clients at any given time, while the third home housed eight to twelve females. Of note is that the majority of residents had abuse histories and exhibited severe emotional and behavioral issues. Despite care plan development by trained providers, a large number of outbursts occurred during evening and weekend hours which often resulted in restraints instituted by staff in an attempt to repress negative behaviors. Per report logs restraints were used five to seven times per week at each location, with the nurse practitioner being notified by the shift manager when a restraint was used.

In 2019, restraint use in the three homes averaged twenty-five per month at each location. According to several counselors at each home, high restraint use had not led to a decrease in problem behaviors, and often had adverse effects on the clients as well as the staff performing the restraint. Recupero et al. (2011) discusses that while restraints are often necessary in emergency situations, the procedures can compromise safety if performed incorrectly or monitored inadequately. Although the staff members at the home went through restraint training

at hire and are recertified annually, injuries occurred to both clients and staff. Also, due to the younger age of the clients in this facility and the small size of many of the younger clients in relation to staff, extra care had to be taken during the restraint process to avoid harm. Therefore, in order to reduce the possibility of injury to both clients and staff, the organization implemented procedures to reduce restraint use by finding other alternative means of addressing problem behaviors.

Other facilities have worked to reduce the use of restraints due to negative effects with varying levels of success. Wale, Belkin and Moon (2013) found that with education, leadership involvement, culture change and utilization of de-escalation skills, restraint use in New York City inpatient facilities was reduced. Furthermore, when restraint use was required it was safer and more targeted. Additionally, Bak, Brandt-Christensen, Sestoft and Zoffmann (2011) found that patient-centered care can have a significant effect on reducing the need for restraints in inpatient settings.

Problem Statement

High rates of restraint usage within group homes place residents and staff at risk for physical and psychological harm. Additionally, high restraint use may result in a regression of behaviors and, per discussions with leadership at the group homes, have a negative financial impact on facilities as a result of staff and/or resident injury and/or poor treatment outcomes secondary to the use of restraints. This quality improvement project addressed these issues by introducing aspects of the Tidal Model into the treatment modalities utilized within the group homes. By educating the staff and providing a best practice tool kit for utilization, the

counselors and staff were able to gain a better understanding of why restraint use should be prevented and reduced.

Review of the Literature

A literature review search was conducted to determine the detrimental effects of restraints as well as the effects of involving patients in the development of their own care plans in practice. Searches were conducted utilizing PsycINFO and Medline Journal databases, accessed through the University of Massachusetts at Amherst Online Library. Searches were limited to peer-reviewed journal articles. The first search focused on restraint use in mental health and focused only on articles from 2014 forward. Key words for this search included Restraints, Mental Health, Detrimental or Harmful or Negative or Impact. 117 results were found for this search, and this number was narrowed down to include only studies focused on mental health. A second search, focusing on the Tidal Model, went back to 2001 as this is when the model was first introduced and landmark studies began. PsycINFO was utilized as the primary search tool as the model chosen for this approach, Phil Barker's Tidal Model, deals mainly with mental health. The Tidal Model was selected for this project due to its focus on involving patients in their own care to improve outcomes. Key words utilized included Barker, Phil Barker, Tidal Model, Mental Health, Restraints, and Patient-Centered Care. While conducting this research, it became apparent that the body of literature utilizing this theory in practice is limited. Roughly seventy-five studies were found, but many were duplicates. After removing duplicates, there were just over 30 articles to choose from in the PsychINFO database and 15 from Medline. Of note, most studies using this model were conducted outside of the United States; however, the results are

applicable to this project as mental health care in these nations closely resembles the approach to mental health care in the United States.

Restraint use in mental health settings is a topic that stirs a lot of debate. While there are many negative connotations around restraint use, it is still a practice that has widespread use in mental health facilities. Due to the behaviors exhibited at times by patients undergoing mental health care, restraints are often viewed as a necessary intervention to maintain patient and staff safety. Wilson, Rouse, Rae and Ray (2017) conducted a study focusing on determining the necessity of restraint use in mental health settings. They found that after a restraint, patients reported feelings of distress, fear, and of being dehumanized. Staff reported that restraint use can be injurious to all parties involved, has a profound negative impact on staff-patient relationships, and leads to decreased job satisfaction. At the same time, staff involved in this study did state that restraints were necessary at times to ensure safety. A similar theme was found in a 2018 meta-analysis study conducted by Cusack, Cusack, McAndrew, McKeown and Duxbory. Cusack et al. (2018), in an integrative review of the literature, found evidence of the physical and psychological impacts of restraint use on mental health patients. This review determined that restraint use can lead to injury, trauma and re-traumatization, distress, fear, and feelings of being dehumanized and ignored. However, the authors did note that restraint use often cannot be avoided in some situations.

Knowles, Hearne and Smith (2015) focused on patient response to restraints using semi structured interviews with patients after they were placed in a restraint. They identified five themes from these interview sessions. The first theme was that restraint use reinforces inequality

of power between mental health staff and patients. The second theme was that restraints were considered an abusive, degrading, and traumatic experience for the patients. The third theme identified by Knowles et al. (2015) was that a patient was more likely to accept the use of a restraint against them if they felt it was justified by their behavior. In contrast, the fourth theme found that patients felt restraints were often a tool used to express negative attributes and motives of many staff members. Lastly, the fifth theme was that patients had a difficult time coping with powerlessness during and following restraint use. Similarly, Spinzy, Saed, Aviv and Cohen-Rappaport (2018) also conducted patient interviews to gain the patient perspective surrounding the use of restraints. They found that restraints were viewed as the most aversive experience patients faced during their hospitalization, leading to feelings of loneliness and loss of autonomy. They did find, however, that two-thirds of study participants viewed the use of restraints as justified when the patient was exhibiting behavior that was dangerous to themselves or others.

A different approach was taken by Kinner, Harvey, Brophy, Roper, McSherry and Young. Kinner et al. (2017) conducted large survey consisting of quantitative and qualitative questions that was sent to both consumers and mental health professionals across Australia concerning feelings and attitudes surrounding restraint use in mental health settings. They found that respondents considered restraint use harmful, a breach of human rights, and detrimental to therapeutic relationships and trust. At the same time, some benefits of restraints were reported as well. These include increasing consumer safety, increasing staff safety and setting boundaries for behaviors. The literature on the impact of restraints illustrates the negativity surrounding

restraint use, and the physical and mental harm it can cause not only to patients, but mental health staff as well.

In order to look for ways that restraint use could be reduced, the second literature search on the Tidal Model was conducted. Several studies from around the world utilizing the Tidal Model were identified, and the vast majority reported positive results such as increased patient satisfaction with care, reduced instances of violence, reduced time in treatment, reduced use of restraints, and increased response to therapy. The first study ever completed using this model was undertaken in Newcastle, England in 2001. Barker (2001) implemented the Tidal Model in one ward of a mental health facility in the city health trust campus, simply to determine if it could be implemented successfully in an actual setting. He was able to successfully implement the program and staff adapted to the new approach to patient treatment. Fletcher and Stevenson (2001) expanded Barker's hallmark pilot study, putting the Tidal Modal into practice in two additional wards and eventually all nine wards housed in the city health trust campus. After this expansion, questionnaires were provided to nurses six months prior to and six months after the model was implemented. The results were largely positive, with reports of violent incidents, incidents of self-harm, and the use of restraints all showing a statistically significant decrease. For unknown reasons not related to the study, admission rates increased during this period, but length of stay decreased even with the added patient load. Nurses reported a positive perception of the changes the model introduced. This study directly shows a correlation between the Tidal Modal and reduction in the use of restraints.

An action research study conducted in Birmingham England by Gordon, Morton and Brooks (2005) demonstrated that one year after use of the model began in all wings of a psychiatric facility, physical assaults, violence and harassment incidents decreased by 57%, nurse satisfaction improved, and nurses stated the model was superior to the ways they had worked in the past. By reducing violent behavior and assaults, this indicates the implementation of the Tidal Model should reduce the need for the use of physical restraints.

Cook, Phillips and Sadler (2005), in a qualitative study, focused on a small group of four nurses in a secure mental health unit along with a group of four patients. The Tidal Model was implemented for the entire unit, but these authors felt that an in-depth study of a small group of individuals was needed to truly identify the benefits seen in this particular facility. While the small size of this study was a bit concerning, it was included here due to its different approach of including both nurses and patients as participants. Over the course of the study semi-structured interviews were used to gather information on the nursing care experience from the perspectives of both the patients and nurses involved. The patients' own narratives were used during nursing assessment and care plan development. The authors described their findings in terms of the following five major themes: hope, levelling, relationships, working together, and the human face. Nurses reported feeling like they were making a difference in patients' lives, and patients expressed optimism and their own feeling of hope for recovery. Furthermore, study results indicated that patients felt more empowered in their own care and that nurses were viewed as a part of the patients' care experience. Patients expressed great appreciation for being involved in setting goals, planning and working out solutions and both patients and nurses stated that they felt that they had more than just a patient/caregiver relationship.

A meta-analysis study mentioned earlier by Recupero et al. (2011) discusses Salem Hospital in Oregon, which implemented a patient-centered approach to care utilizing components of the Tidal Model creating therapeutic environments and involving patients in treatment planning. This facility was able to reduce the use of restraints by 87% utilizing the Tidal Model approach. Recupero et al. (2011) also noted that after tight regulations in Massachusetts forced a reduction in restraint use, several unexpected findings were noted including improvement in adolescent outcomes, decreased costs, and decreased injuries to patients and staff. Moreover, these findings add further to the evidence that the Tidal Model can have a positive impact on restraint use.

In Norway, several principles of the Tidal Model were applied around patient-centered care in patients that practice self-harm. In this study, Tofthagen, Talseth and Fagerstrom (2014) studied five adult care units, working with fifteen mental health nurses. Semi-structured interviews were used to collect data. Although the researchers used some of the model's concepts, such as being non-judgmental and allowing patients to participate in care, they did not undergo a full implementation of the model because they believed that advanced clinical competence was required before doing so. They found that incidents of self-harm and staff harm both decreased after the changes were made. As self-harming behavior and staff-harm are key components in the decision to restrain a patient, this again points toward a positive impact on restraint use when the Tidal Model is put in place.

The overarching theme amongst all of these studies is that through the implementation of aspects of the Tidal Model, specifically involving the patient in the development of their own

care plans and seeking patient feedback about their care, yields positive results. Cook et al. (2005) found that patients felt the model assisted them greatly in making steps toward recovery, and the nurses involved reported it radically improved their professional satisfaction. Berger (2006) found that patients reported improvement in how they perceived their care and felt more involved, acknowledged and respected after the Tidal Model was put in place. Additionally, the nurses reported increased job satisfaction and increased involvement with patient care. Tidal Model implementation leading to reduced violence, outbursts, restraint use and self-harm is a recurring theme in the majority of studies found in the literature review.

Due to the positive results found in the research, it is apparent that utilizing portions of the Tidal Model at the group homes could have a positive effect on the number of restraints being used at the facility. By involving the clients in the creation of their care plans, and allowing them to suggest ways in which restraints can be reduced, the number of restraints used on a weekly basis is expected to decrease. The Tidal Model provides a framework upon which to build a project targeted on educating group home staff in ways they can attempt to reduce the use of restraints. This in turn can improve quality of life and safety for both the patients and staff at the group homes.

Theoretical Framework or Evidence Based Practice Model

Barker's Tidal Model focuses on a patient-centered, spiritual-based approach to nursing. According to Barker, the theory can be summarized using water as a metaphor. Just as water flows in often unpredictable ways and paths, human life is also unpredictable and undergoes constant changes. Barker (2001) states that life is simply a journey on an ocean of experience.

Everything that happens in life, including health issues and illnesses, is a part of that journey. He takes this further utilizing the analogy of a boat upon the ocean. Furthermore, Barker describes a crisis as events in a person's journey where they experience storms or piracy. Barker then goes on to describe a breakdown as the ship taking on water and being in danger of sinking, and rehabilitation as then guiding the person to a safe haven to undergo repairs and recover from trauma. Finally, he describes recovery as the ship being made intact allowing the person to once again set sail and resume their life course (Barker 2001).

In essence, according to Barker, no one's course in life is wrong; it is just part of their journey. In his view, health care providers should focus on how to get a person out of a crisis or breakdown and back on to their journey. Barker initially felt his theory could be applied universally across any care setting, but eventually began to focus primarily on its use in mental health settings. No studies were found of its use outside of mental health care.

The Tidal Model presents as lifeguards or first responders, as well as partners of the patient. The nurse must establish a relationship with the patient, but the care must be patient centered and ultimately the patient knows what is best for them. The patient is the teacher and the nurse is the learner. In this approach, the patient will let the nurse know how best to help them through their dilemma and get them back out on the water. Barker (2015) notes that empowering the patient and allowing them to be an active participant and leader in their own treatment is at the heart of the Tidal Model. The idea behind this project is that by allowing these group home residents to have a voice in developing their care plans, and by providing an

outlet for their suggestions about different ways to pull them out of crisis to be heard, that the need to place them in a restraint will decrease.

The Tidal Model approaches mental health care with a focus on the following ten values, referred to by Barker (2001) as the Ten Commitments. An abbreviated version is listed here. For a more detailed version written by Barker, see Appendix C.

1. Value the voice: Everything revolves around the person's story. The story is the beginning and end of any encounter, and contains not only the difficulties and struggles the person is having, but also her hope that these issues can be resolved.

2. Respect the language: Every person has a unique way of speaking about his life experiences, using his own words and metaphors.

3. Become the apprentice: Only the person is the expert on their own story. Learn from the person what she needs instead of trying to lead her.

4. Use the available toolkit: The person's story may have some examples of interventions that worked for him in their past, and beliefs about what could work for him again. Only use evidence-based practice if his toolkit is lacking.

5. Craft the step beyond: Work together with the person to determine what needs to be done now in order to advance to the next step.

6. Give the gift of time: Nothing is more valuable than generously giving the person your time.

7. Develop genuine curiosity: Express interest in the story and help the person open up in order to better understand the person.

8. Know change is constant: Change is inevitable and nothing lasts, but growth is optional. Help the person be aware of how change is occurring and support he or she in making decisions about what they will do next. Help steer them away from danger and toward recovery.

9. Reveal personal wisdom: Help the person understand that his personal wisdom about himself is valuable. He knows what works for or against him. By knowing more about himself and embracing it, he can use it for sustainment.

10. Be transparent: To be part of a team, the practitioner must always help the person understand exactly what is being done and why. Use the patient's own language and complete all assessment and care plans with the person as a team member (Barker, 2015, para 2).

Through the use of the Tidal Model approach to caring for the mentally ill, Barker feels the patients are treated the way anyone would hope to be treated when they are experiencing distress or difficulty in their lives. The residents of the group homes that this project revolved around had often been shuffled through different care homes and facilities for large parts of their lives. By giving them a voice and the opportunity to participate in their own care, the hope was that restraint use would decrease amongst all three group home locations. While the residents in these homes were not yet adults, they could still provide insightful information about past and previous treatments received over their lifetime. By asking them to provide the staff with information on ways that they felt would be successful in reducing incidents of disruptive behavior and how they are approached during these events, care plans could be adapted to each

of their individual needs. Over time, as care plans started to become more individualized, the aim was that the patients' behaviors would become modified as well, hopefully resulting in a reduction in restraint use. The Tidal Model was used as a guide to educate the staff of the group homes on the rationale for the implementation of portions of the Tidal Model stressed in this project. Several of Barker's ten commitments were used in this process, including valuing the voice, respecting the language, becoming the apprentice, using the available tool kits, and crafting the step beyond (Barker, 2015, para 2).

Methods

This DNP project began with communication via email with the group homes' Director of Programs. After completing an assessment of clinical support needs of the organization, this DNP student gained knowledge that the leadership team was exploring methods to reduce restraint use. After discussions with the leadership team regarding this Restraint Reduction Quality Improvement project, approval was granted, and all staff were informed that an upcoming educational session would be provided at their next staff meeting in two weeks. Subsequent weeks following the leadership meeting were devoted to staff recruitment. This DNP student attended the next staff meeting and provided a 60-minute instructional presentation to the clinic management team, licensed counselors and non-clinical staff regarding best practices on the prevention and decreased use of restraints, as well as an overview of the Tidal Model. After the presentation the counselors were provided with a tool kit containing a copy of the presentation, Barker's Tidal Model Manual, and examples of patient-centered approaches to care.

Goals, Objectives and Expected Outcomes

There were two main goals for this project. First, following the educational presentation and provision of the tool kit, staff would implement changes resulting in a decrease in number of restraints per month versus the current monthly average of twenty-five. Second, the participants' responses to the follow-up questionnaire would demonstrate staff satisfaction with the presentation and tool kit as evidenced by an overall 4 out of 5 rating on a 1-5 Likert scale. Additionally, the expected outcomes were that participants would gain improved knowledge regarding methods in reduction and prevention of restraints and that the training would result in a more collaborative culture of improved safety and trust among staff, providers, and residents within the group homes.

Project Site and Population

The project focused on a psychiatric organization consisting of three youth group homes located in the St. Petersburg, Florida area. The residents were from diverse backgrounds and ranged in age from eight to seventeen years old. At any given time there were eight to twelve boys living in two of the homes, and eight to twelve girls living in the third. All residents had been placed in the homes by the state due to histories of abuse and/or severe behavioral issues. The residents of the group homes lived there full time and attend school locally. All residents are required to participate in individual and group counseling sessions throughout the week, with additional family counseling when guardians are involved in the resident's care.

The organizational professional structure included 24-hour care, seven days per week with after-hours and weekend staff largely comprised of non-clinical mental health technicians.

The provider / staff make up included six licensed counselors (two at each group home location), one clinical psychologist, a part time nurse practitioner, three group home managers, four administrative staff, one director of programs, and twelve mental health technicians.

Project Design

The educational presentation took place at the largest group home site in November of 2019, with the tool kit being provided at the conclusion of the session. Those in attendance included the six licensed counselors, the clinical psychologist, three group home managers, the director of programs, and nine of the twelve mental health technicians. The 60-minute Power Point presentation reviewed many facets of the Tidal Model and best practices for collaborating with residents in building a safe and collaborative environment, which are reviewed in the subsequent section.

The presentation began by discussing the need for the elimination and reduction of restraint use in mental health settings. Several references from the literature including the previously mentioned studies by Recupero et al. (2011) and Knowles et al. (2015) were highlighted as evidence for why changes in restraint use are needed. The presentation then moved on to cover aspects of the Tidal Model including the origins of the model, the water metaphor, the Ten Commitments, and the focus on patient-centered care by involving patients in the development of their own care plans. This DNP student then suggested multiple ways the counselors could improve their current treatment approach in order to involve the residents in their own care. Also, the licensed counselors were encouraged to utilize resources from the tool

kit provided in the subsequent weeks and advised to keep an open dialog in order to gain a better understanding of the residents' perspective on safety and the prevention of restraints.

As building a collaborative care approach was one of the goals of the project, the DNP student encouraged counselors to approach the residents with curiosity. Specifically, recommendations to facilitate trust and collaboration involved several examples of suggested questions for providers which are included subsequently. Such questions posed to residents pertained to new ways that could help the client de-escalate, process events that occurred pre-restraint, explore missed opportunities that could have prevented the restraint, and review identified triggers that could have been avoided. Furthermore, the presentation emphasized that once these questions were developed by the counselors and implemented, the residents should be empowered to answer these questions freely without fear of consequence and be instructed that there are no wrong answers. Counselors could then compile any information gathered during these activities and work with the staff to implement any changes in the treatment plans they felt were warranted based on the residents' responses.

The hope was that enough information would be attained through the use of the question technique in order to work with the residents to develop alternative approaches to diffuse negative situations as they occurred. Secondly, once the counselors established a treatment plan, they could in turn educate the mental health technicians on the newly developed plan to help address and prevent behaviors that may lead to restraint. Therefore, by treating each resident individually and based on their treatment needs, the expectation was that the number of restraints used in the group homes would decrease over time.

Measurement Instruments

The DNP project included two forms of assessment to evaluate outcomes: a retrospective review of paper restraint logs and a DNP developed tool titled the Restraint Reduction Utilizing Tidal Model Concepts Questionnaire (Appendix E). The detailed restraint logs are kept by staff at each group home location in which every instance of restraint use is recorded daily. A retrospective analysis of the restraint log data was conducted three times over the course of this project. The data was first reviewed prior to the education session in early November 2019 in order to obtain the monthly average number of restraints used in the group homes pre-intervention. Second, following the implementation of the presentation and the provision of the tool kit, data from the restraint logs was once again requested from the leadership team and reviewed by this DNP student at the end of December 2019, and then again at the end of January 2020. Microsoft Excel was utilized to perform a statistical analysis on this post-intervention data to determine if there was a marked drop in the number of average restraints per month since the presentation was conducted.

The second measurement tool utilized for this Quality Improvement Project entailed a brief questionnaire (Appendix E) that was administered to six of the seven clinicians via email in February 2020since the seventh clinician (the clinical psychologist) was not available. The questionnaire was designed to determine if the counselors found the presentation and tool kit to be useful in their practice. The questionnaire consisted of one yes /no question, a comment section, and five questions that asked participants to answer using a Likert scale by choosing a

rating of one to five, with one being strongly disagree, two being disagree, three being neutral, four being agree and five being strongly agree.

Data Analysis

Data was collected from the restraint logs a total of three times over the course of this project. This quantitative data was placed into an Excel spreadsheet for analysis via descriptive statistics. Results from this retrospective restraint log review are posted in the following section as averages as well as in the attached table to show trends in restraints prior to and post-intervention. Quantitative data was also collected through the questionnaire covering how well the staff believed the intervention helped and/or did not help in reducing restraint use. This data was also placed into an Excel spreadsheet and descriptive statistics such as frequency and median were utilized to measure the results from the participant evaluation of the intervention.

Ethical Consideration / Protection of Human Subjects

The group homes where this intervention took place did not require IRB approval for this project. The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) approval was obtained prior to initiating the DNP Project via a letter of support for this Quality Improvement Project. All participants in this project were protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which, among other guarantees, protects the privacy of patients' health information (Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, 2013). Additionally, the DNP student and practice personnel who participated in this project followed the Standards of Care for practice in a group home environment. All information collected as part of evaluating the impact of this project was

aggregated data from the project participants and did not include any potential patient identifiers. In addition, the names of the facilities were not included in this paper to protect the privacy of the facilities themselves and their residents.

The risk to clients participating in this project was no different from the risks of clients receiving standard care in this facility prior to the intervention. Participant confidentiality was assured by coding the participants using individual identification numbers. The list of participants and their identifying numbers were kept in locked filing cabinets in a locked office within the group homes, only accessible to group home staff. No electronic files containing identifiable information were utilized for this project.

Results

The 60-minute educational presentation took place in November 2019 in a conference room located at the largest group home site. Recruitment for attendance at this presentation was conducted at the request of this DNP student by the group homes' Director of Programs. Those in attendance included six licensed mental health counselors, a clinical psychologist, three group home managers, the director of programs, and nine mental health technicians. While the target audience for much of the presentation was the group of counselors, the mental health technicians and management team were important addressees as well when information was provided about the need to reduce restraint use, the harms it can cause, and the need to find alternative methods to address problem behaviors. The presentation concluded with a review of the DNP-designed tool kit with general practice guidelines to help reduce restraints and foster a safe environment.

Retrospective Restraint Report Data

Data was collected from detailed restraint logs at each location prior to the intervention in November of 2019 at which time this DNP student was advised of the previous monthly group home average of 25. Data collected for the month of November 2019 prior to the presentation of the education intervention and toolkit validated that information, showing an average of 24.67 restraints for the month across all three group home locations. Data from these restraint logs was collected after the intervention at the end of December 2019 and again at the end of January 2020. The average number of restraints was recorded at each location, which can be seen in table 1 below.

Table 1

Restraint use per month at each group home location.

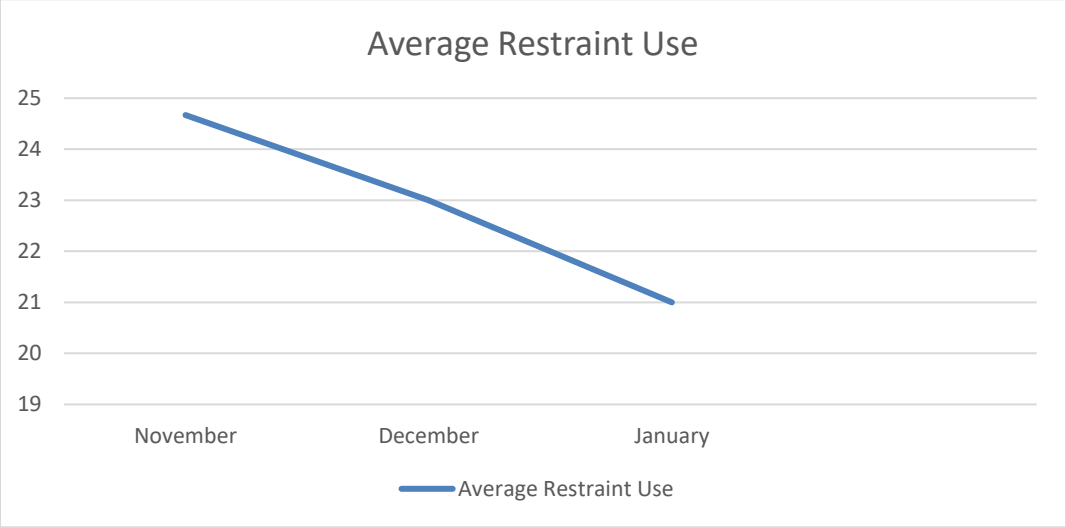
Date	Group Home 1 Restraints	Group Home 2 Restraints	Group Home 3 Restraints	Average # Restraints
11/01/2019 - 11/30/2019	24	27	23	24.67
12/01/19 – 12/31/19	26	23	20	23
01/01/20 – 01/31/20	22	20	21	21

As table 1 illustrates, restraint use fluctuated between the three group home locations. Group home one recorded 24 restraints in November, prior to the intervention, then 26 restraints in December and 22 restraints in January post intervention. At this location an upward trend occurred in the first month post-intervention before a decrease was seen in the second month. Group home two recorded 27 restraints in November, prior to the intervention, then 23 restraints in December and 20 restraints in January post intervention. This group home showed a consistent downward trend post intervention. Group home three recorded 23 restraints in November, prior to the intervention, then 20 restraints in December and 21 restraints in January post intervention. This location had a decrease in the first month post intervention but then a slight uptick in January. What was consistent from this data, however, was that all three group home locations had fewer restraints in January of 2020, post intervention, than they did pre intervention in November 2019.

While the use of restraints remains high in these group homes, restraint use did decrease over the two months post-intervention. The average number of restraints across all three group homes fell from the pre-intervention average of 25 restraints per month to a post-intervention average at the end of January 2019 of 21 restraints per month. This downward trend can be seen in figure 1 below.

Figure 1

Restraint reduction over the course of the Quality Improvement Project



As figure 1 further illustrates there was a reduction in restraint use across all three group homes post-intervention. By reducing the average number of restraints from 25 per month to 21, the group homes realized a 16% decrease in restraint use over the two-month period since the presentation and tool kit were provided in November 2019. This downward trend indicates that the group home staff have implemented changes post-intervention that helped reduce the number of restraints utilized on a monthly basis.

Restraint Reduction Utilizing Tidal Model Concepts Questionnaire

After the restraint log data was collected the final time at the end of January 2020, a questionnaire was provided to the six licensed counselors in early February 2020 and results were collected one week later. Statistical analysis utilizing an Excel spreadsheet was used to interpret the results. The first five questions on the questionnaire utilized a Likert scale with possible ratings of one to five, with one being strongly disagree, two being disagree, three being

neutral, four being agree and five being strongly agree. Each question and the responses received are discussed in the following section.

Question 1: I found the Tidal Model and the key concepts it covers to be helpful.

For question one, 33% of respondents selected five (strongly agree), 33% selected four (agree), and 17% selected three (neutral) and two (disagree) respectively. This resulted in a mean answer of 3.83, with a median of four and a mode of four and five. While the target of this survey was to have all participants choose scores of four or above for all questions, only 66% did so for question one. This shows that while the majority of participants found the information provided to be helpful, others felt differently. This may be due to the difficulty of implementing this type of change with the residents suffering from severe behavioral issues, or possibly to resistance by providers to attempt to change their method of practice.

Question 2: The material presented was helpful in providing information on how to reduce restraint use.

Question two resulted in a higher positive response, with 50% of respondents selecting five (strongly agree), 33% selecting four (agree), and 17% selecting two (disagree). This resulted in a mean answer of 4.17, with a median of 4.5 and a mode of five. For this question 83% of the participants found the information provided in the presentation and tool kit to be useful in reducing restraint use. Only one participant felt the information was not helpful. This again may be due to resistance to change or perceived difficulty with enacting change.

Question 3: I think that the material presented would be helpful to other mental health facilities.

Question three was included for two reasons: to gather information on whether or not the participants felt that this type of intervention would be helpful to other organizations, but also an attempt to see if any participants who may have felt that this type of change was too difficult in their environment would answer positively that it would be helpful elsewhere. For this question 50% of respondents selected five (strongly agree), 33% selected four (agree) and 17% selected three (neutral). This resulted in a mean answer of 4.33, with a median of 4.5 and a mode of five. Similarly to question two, 83% of respondents answered positively, but of note is the higher mean of 4.33 due to the lone respondent that did not respond with a positive answer selecting three (neutral) rather than a negative response. This DNP student theorized that the responses collected thus far may show that one particular participant did not embrace the material presented, and this question swayed them more toward a positive response.

Question 4: I feel the methods mentioned, including interviews, individualized counseling sessions, and journaling were good options to collect information in an attempt to reduce restraint use.

Question four had a higher positive response than any previous question, with 67% of respondents selecting five (strongly agree), 17% selecting four (agree) and 17% selecting three (neutral). This resulted in the highest mean of any of the five questions at 4.5. Both the median and mode for this question were five. Again, 83% of participants responded positively with one participant responding neutral, representing 17%.

Question 5: I was able to implement at least one change in my practice that reduced restraint use.

The final question utilizing a Likert scale also resulted in a majority positive response, but not as positive as questions two through four. For question five, 33% of respondents selected five (strongly agree), 33% selected four (agree), and 17% selected three (neutral) and two (disagree) respectively. Similarly to question one, this resulted in a mean answer of 3.83, with a median of four and a mode of four and five. This again represents only a 66% positive response rate. This may have been due to the resistance to change and or the perceived difficulty of enacting change.

Question 6: Yes / No: Do you feel that learning more about Tidal Model concepts in the future would be beneficial to your practice?

Question six asked respondents to answer with yes or no as to whether they felt further learning about the concepts covered in the presentation and tool kit would be beneficial. The results were largely positive with 83% of the participants answering yes, while one participant answered no, representing 17%. As can be seen from the results published here, the responses to the survey were chiefly positive, with a mean of above four (agree) for questions two, three and four, and a mean above 3.5 for questions one and five. These results demonstrate that the majority of project participants found the material covered to be helpful in addressing the high restraint use in the group home setting. While a 100% positive response rate was not achieved, the 16% reduction in restraint use along with the majority positive response rate to the

questionnaire show that the educational intervention did have a positive effect on the group home facilities.

Discussion

As discussed earlier, the two main goals of this project were to have the staff implement changes in their approach to care resulting in a decrease in number of restraints per month, and that the participants' responses to the follow-up questionnaire would demonstrate staff satisfaction with the presentation and tool kit. The results discussed in the preceding section demonstrate that both of these goals were met. The number of restraints used in the group homes was reduced by 16% over the two-month period after the educational session took place. In addition, the survey results found that most participants agreed that the information provided in the presentation was helpful, with 83% stating Tidal Model concepts would be beneficial to their future practice. When building the educational material, several studies from the literature review were referenced in order to convey reasons that restraint use should be reduced. The study by Cusack et al. (2018) was used to explain that restraint use can lead to injury, trauma and re-traumatization, distress, fear, and feelings of being dehumanized and ignored. In addition, Wilson, Rouse, Rae and Ray (2017) were referenced for finding that after a restraint, patients reported feelings of distress, fear, and of being less than human. By including references to peer reviewed studies in the educational material, this DNP student was able to properly convey the necessity of reducing restraint use to the group home providers and help build desire to find ways in which to do so.

Barker (2015) notes that empowering the patient and allowing them to be an active participant and leader in their own treatment is at the heart of the Tidal Model. This concept was also at the heart of the educational presentation. Fletcher and Stevenson (2001) found that six months after implementing the Tidal Model in a psychiatric ward reports of violent incidents, incidents of self-harm, and the use of restraints all showed a statistically significant reduction. Recupero et al. (2011) noted that after implementing a patient-centered approach to care utilizing components of the Tidal Model restraint use decreased by 87%. Interventions utilizing these Tidal Model concepts that were put in place by the counselors in the group homes had a positive result as well, with a 16% decrease in restraint use over the project.

A full implementation of the Tidal Model is an enormous task that would involve completely changing the mindset and approach a facility uses to provide care. While such a momentous change was not possible in this project, it did show that by implementing just small portions of the approach that Barker developed, positive change can occur. The participants in this project were open to hearing new ideas and making changes in their approach to care, which helped them achieve the positive results that occurred.

There were few barriers to overcome in completing this effort, other than gaining approval from the clinic leadership team, and this again allowed for more positive outcomes. This DNP student was fortunate in that by developing relationships over time with the clinic staff through clinical rotations, the staff were open to the ideas that were presented and made an effort to try to incorporate some of the changes suggested. The results obtained from the changes that

were implemented here reinforce the approach that Barker developed, and hopefully at some point in the future these group homes will use the model on a larger scale.

Conclusion

Restraint use in the three group homes utilized for this DNP project had been commonplace, occurring five to seven times per week on average in each home. The literature demonstrates that the use of restraints increases the risk for physical and psychological injury to both patients and staff. Additionally, empirical evidence has shown that allowing patients to participate in their own care has been successful in reducing negative behaviors that lead to the use of restraints. An intervention such as the one utilized here in this Quality Improvement project, at little cost to the facility, had a positive impact on the use of restraints.

Sustainability is a concern as the group homes move forward into the future. It is unknown if the changes made will continue to be practiced, or if restraint use will continue to show a downward trend. In order to ensure the organization continues to make progress by further reducing restraint use, further educational sessions may be required. While a 16% reduction was achieved, the overall use of restraints in the group homes remains high. Careful monitoring of restraint logs will need to continue by the leadership team and interventions may be necessary if restraint use begins to move upward again. The concepts of the Tidal Model involve a long-term change in approach to care, and a new way of thinking for clinical staff. For long term success to be possible, the facilities must continue to empower their residents and focus on patient centered care. If this is not continued now that this project has concluded, the organization will likely return to their old way of thinking and restraint use will again increase.

The tools and knowledge have been provided to the counselors and staff, and one can only hope they continue to follow these practices and improve.

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Appendix

Appendix A – Tool Kit Content List

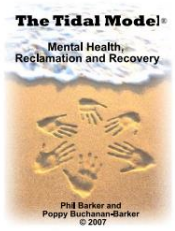
Copy of PowerPoint Presentation

- Topics Covered
    - Need for reducing restraint use, as evidenced by the literature
    - Overview of Barker's Tidal Model, including references to literature evidence of efficacy
    - Possible Interventions to Reduce Restraint Use
        - Detailed questioning of residents during counseling sessions
        - Adding targeted questions to resident journaling sessions
        - Empowering residents to participate in care plan development

Sample Questions to ask Residents

- What can the counselors / staff do differently to help me avoid triggers that lead to poor behavior outcomes?
- What can the counselors / staff do differently to help me being restrained?
- When I am acting out or behaving in a way that normally leads to a restraint, what other ways could the counselors / staff calm me down before a restraint is needed?

Copy of Barker's Tidal Model Manual



Appendix B

Timeline

Table 1

Project Timeline

Task	September	October	November	December	January	February	March
Recruitment of eligible participants	X						
Project Approved			X				
Intervention takes place			X				
Data collection point 1			X				
Data collection point 2				X			
Data collection point 3					X		
Data collection point 4						X	
Analysis of outcomes						X	
Results provided to facility						X	
Results added to final paper							X

Appendix C

The 10 tidal commitments (Barker, 2015)

Values Guiding Practice

The 10 Commitments

The values of the **Tidal Model** are to be found in the **Ten Commitments.** These reflect the philosophy of how we would hope we would be treated should we experience distress or difficulty in our lives.

The caring relationship is interpersonal and exists *between* persons. One is the helper, the other the person in need of help. Such help might also be called 'aid' or 'support'. In the Tidal Model we appreciate how both the 'helper' (whether professional, friend or fellow traveller) and the person need to make a *commitment* to change: bringing into existence a situation that previously did not exist.. This commitment binds them together. For this reason we named the core values supporting the practice of the Tidal Model, **The Ten Commitments.**

These **Ten Commitments** need to be in place if any team, or individual practitioner, wishes to develop the practice of the Tidal Model.

The Competencies

We have also developed 20 'competencies' - two for each individual Commitment. These competencies may be used to assess whether or not pr actioners are demonstrating the Commitments in their practice. To date, they have been used by senior managers to audit practice and by researchers studying specific care settings.

N.B. To simplify the language we use 'their'/'them' and 'they' as an alternative to 'his/her' and 'he/she'.

The 10 Commitments

1. Value the voice.
The person's story represents the beginning and endpoint of the helping encounter. It embraces not only an account of the person's distress, but also the person's hope for its resolution. The story is spoken by *the voice of experience*. The practitioner seeks to encourage the true voice of the person – rather than enforce the voice of authority.

Traditionally, the person's story is 'translated' into a third person, professional account, by different health or social care practitioners. This becomes not so much the person's story (**my stor**y) but the professional team's view of that story (**history)**. Tidal seeks to help people express their unique experiences in a formal version of 'my story'. All assessments and records of care are written *in the person's own 'voice'.* If the person is unable, or unwilling, to write the details of the story in their own hand, then the practitioner acts as 'secretary', recording what has been agreed, taking care to write this *verbatim* - in the person's own 'voice'.
Competency 1: The practitioner demonstrates a capacity to *listen actively* to the person's story.
Competency 2: The practitioner helps the person record their story in their own words, at every stage of the caring relationship.

2. **Respect the language**
People develop their unique ways of talking about their experience, telling their stories. This is how they help others appreciate what only they can know. The language the person uses – complete with its unusual grammar and personal metaphors – is the ideal medium for illuminating the way to recovery. We encourage people to *speak their own words in their distinctive voice*.

Stories written about 'patients' by professionals are, usually, framed by the technical, professional language. By valuing – and using - the person's own language, the Tidal practitioner shows the simplest, yet most powerful, *respect* for the person.
Competency 3: The practitioner helps the person express themselves at all times in their own language.

Competency 4: The practitioner helps the person express their understanding of personal anecotes, similies or metaphors.

3. Become the apprentice

The person is the world expert on the life story. Professionals may learn something of the power of that story, but only if they apply themselves diligently and respectfully to the task by becoming apprentice-minded. We need to *learn from the person*, what needs to be done, rather than leading.

No one can ever know another person's experience. Professionals often talk 'as if' they might even know the person better than they know themselves. However much information we might acquire within, for example, an assessment or 'history' this is a mere drop in the ocean compared with the knowledge of their own life story, possessed by the person.
If we wish to learn anything of any real value about the person, we must become the pupil - allowing the person to teach us something of their story.
Competency 5: The practitioner develops a care plan based, wherever possible, on the expressed needs, wants or wishes of the person.
Competency 6: The practitioner helps the person identify specific problems of living and what might need to be done to address them.

4. Use the available toolkit

The story contains examples of 'what has worked' for the person in the past, or beliefs about 'what might work' for this person in the future. These represent the main tools that need to be used to unlock or build the story of recovery. The professional toolkit - commonly expressed through ideas such as 'evidence-based practice' - merely describe what has 'worked' for other people. However potentially useful, this should only be used if the person's available toolkit is found wanting.
Competency 7: The practitioner helps the person develop awareness of what works for or against them in relation to specific problems in living.
Competency 8: The practitioner shows an interest in identifying what the person thinks specific people could do, or might be able to do, to help them deal with specific problems in living.

5. Craft the step beyond:

The helper and the person work together to construct an appreciation of what needs to be done ‘now’. Any ‘first step’ is crucial, revealing the power of change and potentially pointing towards the ultimate goal of recovery. Lao Tzu said that the journey of a thousand miles begins with a single step. We would go further: any journey begins *in our imagination.* We need to imagine moving forward. Crafting the step beyond reminds us of the importance of working with the person in the ‘me now’: addressing what needs to be done *now*, to help advance to the *next step.*

Competency 9: The practitioner helps the person idenfy the kind of change that might represent a step forward in resolving, moving away from or living better with a particular problem in living

Competency 10: The practitioner helps the person identify what would need to happen to help them experience this particular step forward.

6. Give the gift of time

Although time is illusory, nothing is more valuable. Time is the midwife of change. Time flows through us - and our lives. We only become aware of its passing when we check our watches. Although we often complain of 'not having time' to do this or that, we have all the time there is. The real issue is what do we choose to do with the time available.

Given the chance to look back on our lives, what we would want to see our younger selves doing? Shuffling papers in an office? Locking/unlocking doors? Doing any number of routine tasks? Or would we like to see our younger selves spending time with a person who needed our help? Ultimately all we have to give is our time. We need to give that time generously and wisely.

Competency 11: The practioner helps the person become aware that dedicated time is being given to addressing specific problems in living.

Competency 12: The practitioner shows appreciation of the value of the time the person is giving to the process of assessment or care delivery.

7. Develop genuine curiosity

The person may be trying to write a life story but is in no sense an ‘open book’. We need to help the person to 'open up'. However much we think we have learned about human psychology no one can ever know another

person’s experience. Practitioners need to express genuine interest in the person's story so that they can better understand both the storyteller *and*the story.

Often, professionals are only interested in ‘what is wrong’ with the person, or in pursuing particular lines of professional inquiry – for example, seeking ‘signs and symptoms’. Genuine curiosity reflects an interest in *the person* and the person’s *unique experience.* Classifying and categorising features, which might be common to many other ‘patients’, is one thing. Discovering what is *unique* about *this particular person* is quite another thing. This aim must be our focus. Genuine curiosity is the means to realise it..

Competency 13: The practitioner shows interest in the person's story by asking for clarification of specific points and asking for further details and examples.
Competency 14: The practitioner helps the person unfold the story at their own pace.

8. Know change is constant

Change is inevitable for change is constant. **Nothing lasts**! This is the common story for all people. However, although change is inevitable, growth is optional. Decisions and choices have to be made if growth is to occur. The task of the professional helper is to develop awareness of how change is happening and to support the person in making decisions about what she or he will do next. That next step will determine the course of the recovery voyage. In particular, we need to help the person steer clear of danger and keep focused on the course of reclamation and recovery.
Competency 15: The practitioner helps the person develop awareness of the subtlest of changes in thoughts, feeling or actions.
Competency 16: The practitioner helps the person develop awareness of how these subtle changes have been influenced by their own actions, the actions of others or by other circumstances.

9. Reveal personal wisdom

Only the person can know him or her self. The person develops a powerful store of wisdom through living the life story. They may not be aware of it, but

they have learned what works 'for' them and what, usually, works 'against' them. Often, people cannot find the words to express fully the sheer breadth of their personal knowledge. Often they have not stopped to consider what they know about themselves. The practitioner needs to help the person reveal and value that personal wisdom, so that it might be used to sustain the person throughout the voyage of recovery.

Competency: 17: The practitioner helps the person develop awareness of personal assets, strengths or weakness.
Competency 18: The practitioner helps the person develop a sense of autonomy or self-belief thus promoting an awareness of their ability to help themselves.

10. Be transparent

If the person and the professional helper are to become a team then each must put down their 'weapons'. In the story-writing process the practitioner's pen can become a weapon: writing a story that risks inhibiting, restricting and delimiting the person's life choices. Professionals are in a privileged position and should model confidence by being transparent at all times; helping the person understand exactly *what* is being done and *why.* By using the person's own language, and by completing all assessments and care plan records (*in situ*) with the person, the collaborative nature of the practitioner-person relationship becomes even more transparent.
Competency 19: The practitioner tries to make the person aware, at all times, of the purpose of all processes of care.
Competency 20: The practitioner ensures that the person is provided with copies of all care-planning and assessment documents for their own reference.

Appendix D

Human Subjects Resources Determination Form

UMassAmherst

Human Research Protection Office

Mass Venture Center
100 Venture Way, Suite 116
Hadley, MA 01035
Telephone: 413-545-3428
Email: humansubjects@ora.umass.edu

OFFICE USE ONLY:

Determination #: *Received:*

Determination Form

Determination of whether an activity constitutes Human Subjects Research as per the federal regulation (45CFR46)

INSTRUCTIONS:

1. **Faculty** should complete this form and submit with any applicable attachments to the Human Research Protection Office (HRPO) at humansubjects@ora.umass.edu.
2. **Students** should provide the completed application to their Faculty Sponsor for review and approval. The Faculty Sponsor should submit the form along with endorsement of the project or activity to the HRPO.
3. The HRPO will send you a notice of determination or will contact you, if needed, within three business days.

1. PROTOCOL DIRECTOR(S) (PD) INFORMATION:	
PD Name: Matthew Thompson	Faculty Sponsor Name: Dr. Gabrielle Abelard
Department: NP Student	Department: PMHNP Program Coordinator
Affiliation: UMASS College of Nursing	Affiliation: UMASS College of Nursing
Email: MattThompsonTX@gmail.com	Email: gabelard@umass.edu

2. LOCATION:

Please state the location where this study will take place (i.e., online study, UMass Amherst, etc.):
Carlton Manor Group Homes – St. Petersburg, FL

3. COLLABORATION:

Please list collaborating institutions, if any, and describe their role:
UMASS Amherst – Faculty Guidance

4. PROJECT FUNDING:

Does external funding support this project?:

- X No
- ☐ Pending * Please identify your anticipated funding source:
- ☐ Yes * Please identify your funding source:

** If funded, please attach a copy of any associated grant proposal(s).*

5. PROJECT INFORMATION:

Project Title:

Reducing Restraints through Patient Involvement in Care Plans

Project Purpose:

The purpose of this education intervention, quality improvement project will be to increase provider knowledge of alternative ways in which they can work to reduce the frequency of restraint use at a group of three youth homes in St. Petersburg, Florida.

There are two main goals for this project. First, following the educational presentation and provision of the tool kit, staff will implement changes resulting in a decrease in number of restraints per month vs. the current monthly average of twenty four. Second, the responses to the follow up questionnaire will demonstrate staff satisfaction with the presentation and tool kit as evidenced by an overall 4 out of 5 rating on a 1-4 Likert scale. The expected outcomes are improved knowledge in the need to reduce restraints and ways to do so, reduced restraint use, and the development of a safer, more patient centered focus of care within the group homes.

Project Procedures:

The intervention proposed involves presenting evidence based information from the literature to the group home leadership, counselors and staff concerning patient involvement in care plans and how this can lead to a reduction in restraints. A tool kit will be provided to group home staff outlining different ways in which they can introduce new treatment approaches to reduce restraint use. The tool kit will focus on several ways to involve patients in care, including interviewing, detailed questions during counseling sessions, and journaling. The project participants can use the information they gather using these techniques in developing personalized care plans for each client using suggestions the clients' themselves propose. This DNP student will check with staff for any reports of reduction in restraint use over a two-month period, monitor restraint logs at each facility, and a follow up questionnaire will be provided to staff after two months to evaluate how helpful the education intervention was.

Please describe how you plan to use the study results (overall intent i.e., publication, presentation at conferences, etc.):

Results will be used for the final DNP project as well as the group homes use only. They will not be published or presented to the public. The results of the intervention will increase staff knowledge at the facility, and hopefully improve patient care.

Please describe the participant population (e.g., age range, gender, ethnic background, type of participant such as student, faculty, health care professionals, etc.), and approximate number of participants:

The project focuses on three youth group homes located in the St. Petersburg, Florida area. The clients range in age from eight to seventeen years old. At any given time there are eight to twelve boys living in two of the homes, and eight to twelve girls living in the third. The clients come from many different backgrounds, but all have been placed in the homes by the state due to histories of abuse and severe behavioral issues. There is an onsite clinical psychologist, several counselors, and non-clinical staff members. The homes are staffed 24 hours per day 7 days per week. After hours and on weekends, the staff is largely non-clinical. Children live in the homes full time. All meals and snacks are provided by the homes. The clients attend school during the school year at nearby schools for children with behavioral issues. Other than school hours and planned outings, the clients spend the majority of their time in the homes. All clients attend regular counseling sessions throughout the week and participate in group sessions as well. Those with willing guardians / parents attend family counseling sessions as well. Most of the clients are also assigned case workers who advocate on their behalf.

Please describe your recruitment procedures:

As a DNP student, I have been visiting all three of these locations on a regular basis with my preceptor, Dr. Phyllis Dougherty. AS I have developed relationships with the leadership at these group homes, they have granted permission for this project to take place with their staff. All staff have been directed to participate in the project by the group home leadership.

6. ATTACHMENTS

X I have included copies of any project proposals (e.g., Honors or MA Theses, DNP projects, Dissertation Prospectus, etc.), as well as surveys/questionnaires, interview questions, etc. with this form *OR* this is Not Applicable to this project.

7. PD RESPONSIBILITIES AND ASSURANCES:

☒ I certify that the information provided in this determination form and all attachments is complete and accurate.

☒ I certify that the proposed project has not yet been done, is not currently underway, and will not begin until IRB determination and/or approval has been obtained.

8. PD SIGNATURE(S):

Name:	Date: 08/01/19

OFFICE USE ONLY:

☐ **The project does NOT need IRB review.** Date:_____ Initials:_____	☐ **Project DOES need IRB review.** Date:_____ Initials:_____
☐ **Not Human Subjects Research (NHSR)** Determination based on the following rationale: 1. ☐ The proposed project does not involve research that obtains information about living individuals [45 CFR 46.102(f)]. 2. ☐ The proposed project does not involve intervention or interaction with individuals OR does not use identifiable private information [45 CFR 46.102(f) (1), (2)]. 3. ☐ The proposed project does not meet the definition of human subject research under federal regulations [45 CFR 46.102(d)]	**Human Subjects Research** **Review Type:** **Category:** 1. ☐ Full Board _____ 2. ☐ Expedited _____ 3. ☐ Exempt _____
☐ **University of Massachusetts, Amherst (UMA) Faculty/staff/students NOT engaged in Human Subjects Research.** Determination based on all criteria below being met: - UMass Amherst faculty/staff/students will not be involved in a direct intervention or interaction with human subjects of research. - UMass Amherst faculty/staff/students will not obtain identifiable private information for the research. - UMass Amherst faculty/staff/students will not be involved in the consent process. - All data will either be de-identified (no-one is able to link the information back to identifiers) OR coded (key linking participant data/specimen exists but the key to the code will never be released to UMass Amherst Faculty/Staff).	**NOTES:**

Appendix E

Restraint Reduction Utilizing Tidal Model Concepts Questionnaire

Please answer the following question using a ratings scale of 1-5, with the following rating assignments:

1 – Strongly Disagree

2 – Disagree

3 – Neutral

4 – Agree

5 – Strongly Agree

1. **I found the Tidal Model and the key concepts it covers to be helpful. _____**
2. **The material presented was helpful in providing information on how to reduce restraint use. _____**
3. **I think that the material presented would be helpful to other mental health facilities. _____**
4. **I feel the methods mentioned, including interviews, individualized counseling sessions, and journaling were good options to collect information in an attempt to reduce restraint use. _____**
5. **I was able to implement at least one change in my practice that reduced restraint use. _____**

Please answer the following question Yes or No

Do you feel that learning more about Tidal Model concepts in the future would be beneficial to your practice? _____

Comments:

(Not all utilized the comments section, those that did have their comments listed here)

I found the presentation to be interesting and informative. I look forward to reading more about this topic soon.

I think that sadly restraint use is necessary in many instances, but trying to use new ways to work with our clients to try and reduce their use is an interesting topic. I hope that we can actually make some improvements.

Thanks for the information. I look forward to trying some of these things out soon.