8-2023

Evaluation of sensory room education to promote usage in an inpatient psychiatric setting: a quality improvement project.

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Evaluation of Sensory Room Education to Promote Usage in an Inpatient Psychiatric Setting: A Quality Improvement Project

by

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Paper submitted in partial fulfillment of the
requirements for the degree of

Doctor of Nursing Practice

School of Nursing, University of Louisville

July 7, 2023

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Abstract

Seclusion and restraints are intended to be used as a last resort intervention if a patient presents as harmful to themself or others. However, the use of seclusion and restraints in mental health practice has been questioned for several decades. A 26-year study that researched restraint-related fatalities among children and adolescents in the United States from 1993 to 2018 disclosed 79 deaths (Nunno et al., 2022). Seclusion and restraints also restrict autonomy which can cause retraumatization if a patient was previously neglected or abused (Hammer et al., 2011). Many patients presenting to the project site are survivors of neglect and abuse and, therefore, at risk for retraumatization. Distressing long-term effects of seclusion and restraints include self-stigmatization, painful memories, and post-traumatic stress disorder (PTSD) symptoms (Steinert et al., 2013). Nursing staff must implement alternative strategies to seclusion and restraints to reduce the likelihood that children seeking care in acute psychiatric settings will experience these distressing long-term effects. One alternative found in the literature is sensory rooms. The purpose of this project was to increase the staff's knowledge and confidence when implementing a sensory room to promote healing among adolescent patients. Unit staff were provided education regarding sensory room use before the sensory room was implemented by the facility. Pre-questionnaires were utilized before education was offered. The same questionnaires were completed once the sensory room had been implemented and staff began utilizing learned knowledge to determine if there was noted improvement in staff's ratings after education. Seclusion and restraint data was collected on the participating unit. The goal of this evidence-based educational project was to increase staff confidence and knowledge and decrease episodes of restraints and seclusion.

Keywords: mental health, adolescents, retraumatization, sensory room education, seclusion, restraints, quality improvement

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Background

Nursing staff providing care at the project site, an inpatient psychiatric unit in an academic teaching and research hospital located in an urban area in the south, must continuously offer adolescents evidence-based methods to self-regulate to decrease episodes of seclusion and restraints. This in turn can cause patient and staff satisfaction to improve (Perers et al., 2022). Alternative strategies offered by nursing staff may also reduce the possibility that children suffering from anxiety, depression, and PTSD will be further traumatized while seeking support (Perers et al., 2022).

Research suggests that sensory-based approaches are one effective strategy to reduce use of seclusion and restraints, alleviate distress, and empower patients across various healthcare settings. Promoting the use of alternative strategies to encourage patients to self-regulate to prevent emotional and behavioral escalation, reducing the use of seclusion and restraint should be a priority in mental healthcare. However, many psychiatric mental health facilities struggle to find adequate approaches to reach this standard.

The project site is one healthcare facility determined to explore and adopt alternative approaches to seclusion and restraints. One such alternative that has been investigated at the project site is sensory rooms. The possible positive impacts could be improvement of patients' overall experience, increased staff satisfaction, and improvement in therapeutic relationships between staff members and the patient by implementing sensory rooms.

Patients who have a history of neglect or abuse are more likely to display unhealthy coping mechanisms while processing trauma which could lead to seclusion and restraint use (Steinert et al., 2013). Similarly, patients with a history of neglect and abuse are more likely to be triggered by seclusion and restraints (Steinert et al., 2013). Unfortunately, Kentucky holds the

highest rate of child abuse in the nation. For every 1,000 children in Kentucky, there are 20.1 abused and neglected (Kentucky Task Force on Crimes Against Children, 2017). In the project site's county in 2016 to 2017, there were 2,648 confirmed cases of childhood neglect, 311 confirmed cases of physical abuse, and 108 confirmed cases of sexual abuse (Kentucky Task Force on Crimes Against Children, 2017). Most patients seeking care at the project site have a history of physical, sexual, or emotional abuse or sometimes disclose abuse for the first time during their stay.

The primary objective of seclusion and restraints is to de-escalate patients from presenting as a threat of harm to themselves or others (Hammer et al., 2011). Using seclusion and restraints to de-escalate patients with a history of trauma could cause patients to relive their trauma through intrusion symptoms such as unwanted and upsetting memories, flashbacks, emotional distress, and physical reactivity resulting in increased suffering (Hammer et al., 2011). However, all patients are at risk for injury or even death when physical safety holds, or restraints are used.

Recently, a seven-year-old child lost his life at a residential treatment facility in Kentucky (Ali, 2022). Specifics regarding the incident have not been released. Though, the Jefferson County Coroner's Office determined the cause of death to be positional asphyxia (Ali, 2022). Physical safety holds and restraints carry a risk for positional asphyxia, which is a condition that occurs when an individual is in an immobilizing position that prevents normal inhalation and exhalation (Chmieliauskas, 2018). Ali (2022) reports since the incident at the residential treatment facility the agency has increased training on de-escalation techniques and relationship-building strategies that are proven to reduce and prevent the need for physical safety holds.

From July 2021 to June 2022 the project site's quality department collected seclusion and restraint data and provided this information to the project lead. During this period, there was a total of 5,720 incidents of at least one type of restraint. Within the last fiscal year there were 1,442 episodes of seclusion, 1,389 episodes of restraints, and 4,248 physical safety holds within the facility. On the child adolescent unit where this project took place, there was a range of 2.7 to 41.8 restraint episodes per 1,000 patient days each month. Therefore, there is a need for unit staff to execute effective, evidence-based strategies to decrease episodes of seclusion and restraints. Educating unit staff on sensory room implementation could fulfill this need by increasing sensory room usage and creating a secure environment for patients during an inpatient hospitalization.

Literature Review

Many of the studies found in the literature implemented sensory rooms in psychiatric settings to decrease the frequency of seclusion and restraints. More specifically, several of the studies attempted to determine if sensory rooms resulted in a decrease of restraints and seclusion directly or utilized instruments to determine if decreased emotional arousal indirectly led to a decrease in seclusion and restraints. Blair et al. (2017) noted a significant decline in the incidence of seclusion after the implementation of a sensory room in a 120-bed psychiatric facility with adolescent and adult patients ($p < 0.05$) but did not note a significant decline in the incidence of restraints ($p=0.44$). Contrarily, Bobier et al. (2015) decided to utilize the Freemantle acute arousal rating scale to determine if sensory room use affected patient's distress and arousal rating levels. Bobier et al. (2015) reported both staff and patients noted improvement in distress and arousal levels after the sensory room, and consequently a significant decrease in seclusion occurrences.

Three noted studies allowed patients to self-report their distress level before and after sensory room use utilizing a 10-point Likert rating scale (Novak et al., 2012; Seckman et al., 2017; Wiglesworth & Farnsworth, 2016). Novak et al. (2012) completed a quality improvement study in Australia consisting of both adolescents and adults. Wiglesworth & Farnworth (2016) completed a mixed methods study on an all-female forensic psychiatric unit. Despite differing samples, both studies revealed that patients reported a decrease in stress following sensory room use (Novak et al., 2012; Wiglesworth & Farnworth, 2016). Though, neither quality improvement study revealed a significant decrease in distress levels after sensory room use (Novak et al., 2012; Wiglesworth & Farnworth, 2016). Contrarily, Seckman et al., (2017) noted patients rated level of distress decreased significantly after sensory room implementation on a 20-bed inpatient adolescent unit within a psychiatric hospital in a large academic medical center ($p< 0.05$). One quality improvement study completed on an adolescent psychiatric unit in Australia utilized a distress scale like the other studies but used the Steppingstones questionnaire which added picture faces to clarify distress level (West et al., 2017). The questionnaire was used as an instrument to rank patients' level of distress before and following sensory room use (West et al., 2017). West et al. (2017) noted random effect regression analysis, which was utilized to estimate client-reported and clinician-reported distress levels pre- and post-sensory room use, revealed a reduction in distress after sensory room use.

Researchers have found common themes after the implementation of sensory rooms. Lindberg et al. (2019) completed their study on inpatient psychiatric wards in Sweden noting patients reported a sense of emotional and bodily calm, and empowerment (n=28). Overall, patients expressed enhanced well-being, stating the sensory room made them feel relaxed and

safe (Lindberg et al., 2019). Researchers have since questioned what factors challenge implementation of sensory rooms.

Wright et al. (2020) hoped to gain insight into the barriers and aids that influence the application of sensory modulation in psychiatric inpatient units in Australia. The sample in the study included nurses, occupational therapists, recreation officers, and social workers that worked within inpatient psychiatric units agreeable to participate in sensory awareness training (Wright et al., 2020). Thematic analysis revealed education was crucial for success, unsupportive peers were negative influences, and sensory items were not always accessible when desired (Wright et al., 2020).

Study participants reported that experienced nurses, who did not believe sensory-based methods could be effective, would question why other nurses were implementing the sensory based methods. This questioning discouraged use of the sensory-based methods (Wright et al., 2020). Participants also stated when they felt encouraged that certain sensory items would be helpful in a particular situation, they would be disappointed to find sensory items were typically misplaced or out of stock (Wright et al., 2020). Individuals reported that lack of time and busy workloads were to blame for barriers limiting access to the supplies. However, staff members did report when sensory rooms and carts were stocked and stored appropriately, the intervention successfully reduced agitation and distress in patients with a variety of mental health conditions (Wright et al., 2020).

Through analysis of individual sensory-based approaches across psychiatric facilities, Ma et al. (2021) determined elements that affected sensory-based approaches included culture, personal preference, quietness, the ability of nurses to provide one-to-one support, and patients' independence level. Rather than analyzing sensory interventions individually, Bowers et al.

(2015) attempted to implement a variety of methods simultaneously to reduce conflict, seclusion, and restraints on psychiatric units in London. Bowers et al. (2015) noted implementing ten interventions simultaneously reduced seclusion and restraint occurrences by 26.4% and the rate of conflict events by 14% for shifts that had conflict or required seclusion or restraints (n=564). However, missing data was widespread across the experimental and control group, likely due to the challenging request for staff to implement numerous prevention strategies in a chaotic milieu (Bowers et al., 2015).

Adams- Leask et al. (2018) and Anderson et al. (2017) incorporated individual sensory items into mental healthcare treatment. Adams- Leask et al. (2018) study was completed in a South Australian emergency department where patients were offered sensory modulation therapy while waiting for assessment, discharge preparation, or transition to inpatient. Sensory modulation items included hand fidgets, colored lights, weighted blankets, coconut sand, candy, olfactory items such as lavender, and tactile items such as bubble wrap (Adams- Leask et al., 2018). Adams- Leask et al. (2018) noted a statistically significant decrease in self-reported distress after the use of a sensory modulation ($p < 0.001$) and a statistically significant association between the number of items utilized ($p < 0.05$). Anderson et al. (2017) provided sensory modulation items such as blankets, ball chairs, therapy balls, therapeutic music, and Nintendo Wii sports games in a psychiatric unit. Anderson et al. (2017) reported a significant decrease in restraints when sensory modulation and medication administration occurred as well as a 38% decline in restraint belt use.

Martin and Suane (2012) implemented both a sensory room and sensory cart. Like Bobier et al., this study attempted to determine patients' emotional arousal before and after sensory room use. The authors also attempted to determine if elevated emotional arousal was related to a

decrease in seclusion and restraints but did not note a significant difference. Martin and Suane (2012) did determine staff training on sensory rooms increased the use of sensory rooms which, in turn, significantly and positively impacted patient arousal levels. A study completed by Proterra et al. (2022) discovered didactic training yielded improvement in knowledge or perceived competence of sensory room use, but the combined use of didactic training with techniques of modeling and feedback was the most effective intervention to improve use of sensory rooms. The study mentioned didactic training combined with techniques of modeling and feedback are a part of a known behavioral skills training program which has shown success in educating beginner trainees on important tactics to treat inpatient clients (Proterra et al., 2018).

Research has shown that restrictive measures such as seclusion and restraints impede psychological and physical safety (Seckman et al., 2017). Restraints have and can cause a multitude of issues such as pulmonary disease, skin injury, deep vein thrombosis, nervous system damage, ischemic lesions, sudden death, low self-confidence, severe distress, and recollection of previous sexual abuse (Ye et al., 2019). Despite potentially devastating effects, data suggests the usage of physical restraints has increased in the last decade (Ye et al., 2019). Studies suggest the frequency of physical restraint on inpatient psychiatric settings vary from 3.8% to 51.3% (Ye et al., 2019). The research demonstrates utilizing strategies to help patients self-regulate, such as sensory approaches, decreases the likelihood that patients will experience these harmful effects (Perers et al., 2022).

The overall aim of the sensory-based interventions was to allow agitated, anxious, or distressed patients to self-regulate and avoid restrictive measures by utilizing provided sensory instruments (Anderson et al., 2017; Martin and Suane, 2012; Novak et al., 2012; Perers et al., 2022; Proterra et al., 2022; Seckman et al., 2017; West et al., 2017; Wright et al., 2020). Some

barriers for implementation within studies included the ability of staff to provide or support the sensory-based approaches (Bowers et al., 2015; Wright et al., 2020). For instance, when sensory-based instruments were expected to be provided to patients, it was the staff members' responsibility to provide the instruments. Likewise, it was the staff members' responsibility to suggest the use of the sensory rooms and monitor sensory room use.

Staff members failed to suggest the interventions due to varying reasons. Seckman et al. (2017) and Wright et al. (2020) reported that staff members were worried that sensory instruments were unsafe. Other barriers reported that led to poor follow-through included staffing shortages and a chaotic environment (Bowers et al., 2015). The overall theme in each study included the need for planned staff education and training. The studies that successfully implemented sensory rooms and sensory interventions emphasized education and training prior to implementation (Anderson et al., 2017; Martin and Suane, 2012; Novak et al., 2012; Seckman et al., 2017; Proterra et al., 2022; West et al., 2017). In general, the literature review supports the proposed project by repeatedly showing sensory rooms can yield success when implemented utilizing a supportive approach and providing education for staff members on how and when to use the sensory rooms.

However, there are notable knowledge gaps in the literature. The literature search did not reveal if staff felt confident implementing sensory room approaches after education was provided nor did it make clear what educational resources are most effective. These knowledge gaps could impact the successful delivery of education and subsequent implementation of a sensory room to decrease episodes of seclusion and restraints.

Rationale

A needs assessment was completed using informal interviews with the quality team director, unit manager, and approximately 15-unit staff members. Informal interviews with the quality team director revealed that the project site must utilize effective strategies to reduce the frequency of restrictive measures. The unit manager stated that the hospital hosting the project site recently started implementing sensory rooms on other child and adolescent units within the hospital.

The unit staff interviewed consisted of licensed nurses, mental health workers, and program coordinators. Unit staff disclosed their adolescent patient population frequently presents with explosive outbursts that involve property destruction, peer-to-peer altercations, and combative behaviors toward staff. Unit staff stated they feel hesitant to employ a sensory room believing it could be dangerous and ineffective for their patient population, but they are willing to implement strategies to decrease the use of physical safety holds, restraints, and seclusion. Therefore, it is apparent that education is needed to show the positive impact sensory rooms have had on acute inpatient mental health populations. It is believed if unit staff are aware of the impact sensory rooms have had on similar patient populations, current hesitant beliefs may change. Feasibility analysis revealed the intervention is reasonable since there is availability of unit nursing staff during monthly meetings, considerable support from the administration, sensory rooms exist throughout the hospital, and the unit this quality improvement took place on recently established a stocked, ready to use sensory room. Additionally, the unit nursing staff are required to attend monthly staff meetings, which makes it likely they will be present during education and data collection.

Conceptual Model

The Donabedian model for quality improvement was established in 1966 and included three elements', structures, processes, and outcomes (Donabedian, 2005). Donabedian (2005) believed the three elements interconnect and build on each other. More specifically, Donabedian believed structure measures affected process measures which led to outcome measures. Howell and Stevens (2020) identified the Donabedian model as the standard approach for assessing quality in healthcare and that is why the model was selected as the framework for a quality improvement sensory room project (see Appendix A). The Donabedian model will serve as a guide when educating and implementing the sensory room.

Purpose and Specific Aims

Research suggests it is vital for mental health facilities to initiate approaches to reduce seclusion and restraints to prevent further trauma and diminished rapport (Buffalo Center for Social Research, 2020). The purpose of this scholarly project was to educate unit staff on the importance of using a sensory room to increase use allowing acute adolescent patients the opportunity to self-regulate when in distress. Many of the patients who leave the hospital from this unit are close to adulthood and have the added burden of trying to navigate adult life. It is not uncommon for the patients on the adolescent unit to have had outbursts that have led to property destruction and physical altercations with peers, resulting in hospital admission. Once reaching adulthood, these same behaviors could result in lifelong consequences such as a prison sentence rather than hospital admission. Therefore, the sensory room must be utilized to help these individuals learn how to self-regulate before harming themselves, their environment, and others. Overall goals for the sensory room project included increasing awareness regarding the need for sensory rooms, noting a change in staff members' decision-making process

implementing the least restrictive measure for the patient first, and improving the therapeutic environment for patients reducing frequency of seclusions and restraints on this unit.

Before the education in-service, a minimum of 75% of nursing staff completed a three-question pre-confidence questionnaire and four-question knowledge test to determine their baseline confidence and knowledge level of sensory room implementation. Immediately after the pre-confidence questionnaire and knowledge test were collected, a minimum of 75% of nursing staff received in-service education regarding sensory room implementation. In-service education intended to increase awareness of why sensory rooms are helpful, increase understanding of when sensory rooms are appropriate, and instill confidence to use the sensory room. After one month of implementation of the sensory room, a minimum of 75% of nursing staff completed the three-question post-confidence questionnaire and four-question knowledge test to determine their confidence and knowledge level of sensory room implementation after education. The goal was to note the total number of sensory and restraint episodes decreased by 10%, post-confidence scores improved, and post-knowledge scores improved compared to the data collected one month before implementation. Outcomes were measurable through the completed questionnaires and provided seclusion and restraint report from the quality department.

Logic Model for Quality Improvement

The logic model provides a visual aid for the quality improvement project discussing the situation, inputs, outputs, outcome goals, assumptions, and external factors (see Appendix B). The inputs consisted of program investments such as time allotted for literature review searches, construction, and staff education. Outputs consisted of activities such as networking with other units, teaching through in-service education, and assessing outcomes as well as participant output from the key stakeholders. Outcomes included increasing knowledge regarding the importance of

sensory room use and, in turn, increasing usage of the sensory room to decrease the risk of retraumatization. The logic model served as a guide to plan, implement education, and review project results.

Methods

Design

The sensory room project was analyzed using a mixed-method approach. This approach was utilized since the DNP project collected both quantitative and qualitative data while monitoring, evaluating, and improving quality and safety outcomes in an inpatient adolescent psychiatric care unit. Quantitative data was collected through chart data reports, confidence questionnaires, and knowledge tests. Qualitative data was collected through the initial poll and comment section of the confidence questionnaire. Collecting both quantitative and qualitative data allowed the researchers to determine if the objectives were met and what revisions were needed for further research.

Setting

The project site was in a fully integrated regional academic health system consisting of seven hospitals, four medical centers, approximately 200 physician practice locations, and over 700 physicians. The psychiatric hospital is one of the hospitals within the large health system's network and is a private, nonprofit mental health hospital located in the midcentral area of an urban area in a midwestern-southern state. The psychiatric hospital provides care to children, adolescents, and adults with various diagnoses.

The facility has five key providers that treat the adolescent population. Key services provided include emotional support, psychiatric disorder care, substance abuse care, specialized treatment for intellectual disabilities, specialized treatment for developmental disabilities,

treatment for cooccurring disorders, and outpatient programming within the 261-bed facility. The mission of the hospital is to serve as an academic health care system, transforming the health of the communities served through compassionate, innovative, patient-centered care. The healthcare system hopes to achieve this vision by striving to provide a culture of exceptional care, develop collaborative relationships with patients, nurture allied healthcare professionals, develop partnerships to advance, and collaborate with the academic partners to educate the next generation of healthcare professionals. The healthcare system strives to promote mental wellness and instill hope to all by identifying health needs and collaborating with organizations to improve access to treatment.

The sensory room project took place on an adolescent unit at the psychiatric hospital affiliate. Unit staffing requirements call for a minimum of one nurse, five mental health workers, and a program coordinator. The adolescent unit can admit males and females with IQs above 70. Patients admitted may have a primary diagnosis of generalized anxiety disorder, major depressive disorder, intermittent explosive disorder, disruptive mood dysregulation disorder, conduct disorder, or post-traumatic stress disorder. The unit was at capacity with a total of 23 patients. All patients on the unit had the ability to use the sensory room, however, the patient's entire treatment team decided together that the individual was able to use the sensory room before use. Patients that had escalated to the point of becoming physically threatening, verbally threatening, or combative were not eligible to utilize the sensory room to self-regulate.

Sample

Full-time nursing, part-time nursing, and full-time therapy staff received education on the sensory room. These team members included the registered nurses, program coordinators, mental health workers, licensed practical nurse, unit therapist, and unit caseworker employed on the

unit. The unit roster consists of four part-time registered nurses, six full-time registered nurses, one licensed practice nurse, seven part-time mental health workers, nine full-time mental health workers, three full-time program coordinators, one licensed therapist, and one caseworker. The potential sample size for this project was 32 individuals.

Context

The mission and vision of the healthcare system is patient-focused and focused on providing superior care. To continuously evolve and surpass standards of care, quality improvement projects are completed. Quality improvement ideas are encouraged, given that the institution is an academic teaching facility. There was great support for this quality improvement project. Support was voiced by the manager of the adolescent unit, educator of the adolescent pod, and quality improvement department.

The individuals who received education and encouraged sensory room use were known as facilitators. The facilitators were the registered nurses, licensed practical nurses, program coordinators, and mental health workers that work on the adolescent unit. Prior to implementation of the project, facilitators who are capable of driving change were not using evidence-based strategies to avoid seclusion and restraints. Unit facilitators were polled before education to determine the root cause of increased seclusion and restraint usage and beliefs regarding the sensory room. Responsibilities for the key facilitators for this project included being available for educational opportunities, remaining open to change, and taking the initiative to implement the sensory room during appropriate instances. The director of nursing and the Interdisciplinary Research Oversight Council (IROC) for the hospital supported the project before IRB approval was granted. A letter of support was provided from the director of nursing and IROC (see Appendix C and Appendix D).

Barriers to Project Implementation

Staff members served as facilitators and may have potentially been reluctant to implement the sensory room due to safety concerns. However, this barrier was addressed through education. High patient-to-staff ratios could also potentially have impeded the facilitator's ability to implement the sensory room. Though, this barrier was addressed by educating dayshift nursing staff, nightshift nursing staff, program coordinators, and unit therapists to increase the likelihood of sensory room utilization.

Procedure

Intervention Implementation

This quality improvement project focused on the education of the facilitators. Unit facilitators were polled one week before the education in-service. The poll requested that staff write why they believe the incidence of seclusion and restraints is rising and current opinions on sensory rooms (see Appendix E). In turn, the project leader used the poll to note staff opinions and staff concerns. One week after facilitators completed the poll, they completed a knowledge test (see Appendix F) and confidence questionnaire (see Appendix H) to collect baseline data before receiving sensory room education.

The project leader read the sensory room protocol (see Appendix J), showed staff members the location of the sensory room, showed staff members how to use the sensory room items, allowed staff members to demonstrate using the sensory room items, reviewed the sensory room log, and reviewed the sensory room feedback form immediately after the provided test and questionnaire were collected in March of 2023. The facilitators were then brought back to the nurse's station to discuss the created educational handout (see Appendix K) for sensory room use.

The educational handout briefly highlighted the purpose, guidelines for safety, expectations, and a quote explaining why sensory rooms are needed. The educational in-service concluded by addressing concerns mentioned in the unit poll and answering additional questions. Then, the protocol and educational handout were posted in the nurses' station for staff to reference while implementing the sensory room. One month after the education in-service in April of 2023, facilitators completed the same knowledge test (see Appendix G) and confidence questionnaire (see Appendix I) during a unit staff meeting.

Process Measures

The impact of sensory room education on facilitator confidence and knowledge were measured by comparing pre-questionnaires and pre-knowledge tests to post-questionnaires and post-knowledge tests. The general aim was to determine if education would increase confidence in facilitators' ability to use the sensory room and knowledge regarding the purpose of and how to implement sensory rooms. Sensory room implementation would be deemed effective if rates of seclusion and restraints decreased after implementation of the education.

Outcome Measurements

The primary outcome measure for this quality improvement project was to decrease episodes of restraints and seclusion by increasing facilitator confidence in and knowledge of sensory room use. Ideally, this would have occurred as patients were offered tools to self-regulate when emotionally dysregulated and sensory overstimulated.

Data regarding frequency of restraints and seclusion were gathered via chart reports completed by the quality department. The quality team completed chart audits to determine the number of seclusion and restraint episodes that occurred and summarized the data into reports. The numerical restraint and seclusion data reports before education were compared to the

numerical data collected one month after education by the quality team, unit manager, and project leader.

Data Collection

Data collection before implementation included pre-questionnaire and pre-knowledge tests for staff. After one month of implementation, staff were asked to complete the post-questionnaire and post-knowledge test. The instruments were completed and collected during unit staff meetings. Individuals that collected data included the unit manager and quality improvement leader. The survey data was secured by the nurse manager and remained at the facility in the unit manager's locked office. The survey results were only accessed by the nurse manager, quality team, and project leader. The seclusion and restrain frequency was gathered via a facility report. The facility report provided from the quality leader stated the number of seclusion and restraint episodes that occurred on the unit each month. The report indicated if there had been a noticeable change in seclusion and restraint episodes one month after sensory room education was provided on the adolescent unit. The facility report did not include patient identifiable data.

Ethical Considerations/Permissions

The evidence-based practice coordinator was contacted before implementing the quality improvement project at the hospital. Permission was granted to reach out to additional leaders for improvement once the evidence-based practice coordinator at the office of professional practice confirmed the project idea was feasible for the hospital. Management and the quality team at the site voiced approval as well. Finally, a proposal was provided to the evidence-based practice coordinator for research council review. The research review council notified the individual leading the quality improvement project once approval was granted. The proposal was also

submitted to the University of Louisville IRB for approval. After the research council accepted the project idea and IRB approval was granted, the individual leading the quality improvement project began collecting pre-education data.

Patient confidentiality and anonymity was addressed by reviewing data collected by the quality team that did not contain patient identifiers. The quality team ensured data safety was maintained by using numerical data rather than identifying data in accordance with-HIPPA regulations. Staff confidentiality and anonymity were upheld by instructing all staff members to submit confidence questionnaires and knowledge tests without any identifying information. Instead, staff members were instructed to create a six-digit identification code. The six-digit identification code was written on each form to allow comparison of data before and after education. Staff members were advised to create the six-digit code by writing down the last four digits of their significant others or family members' phone number followed by their favorite two-digit number. Staff members were asked to provide their honest and unbiased opinions while completing questionnaires and surveys, to obtain accurate results.

Measures

Several instruments were employed to evaluate the effectiveness of the sensory room. To note changes in staff knowledge, a brief knowledge test (see Appendix F and Appendix G) focusing on key topics discussed during education was administered. Facility reports determined if the incidents of seclusion and restraints decreased. Finally, a short confidence questionnaire (see Appendix H and Appendix I) was also provided to staff members to determine if staff members felt more confident implementing sensory rooms after scheduled in-services and to allow staff members to note their concerns. Staff members were asked to rate their level of confidence on the following: I feel confident justifying why the sensory room should be used,

implementing the sensory room according to the sensory room protocol, and recognizing individuals that are appropriate to use the sensory room. The rating scale was a Likert like rating scale ranging from one to five with one being strongly disagree and five being strongly agree.

Independent variables included the sensory room, nursing staff, and patient population. Dependent variables included a change in staff confidence level regarding sensory room implementation, shift in staff knowledge level, and effect on the incidence of restraint and seclusion.

Data Analysis

Statistical analysis was performed to determine if there were statistically significant changes in the average knowledge score and the average confidence level of nurses before and after sensory room education. Each correct response on the knowledge test received a value of one and total scores were tabulated for each knowledge test. Similarly, average confidence scores were tabulated from the completed Likert scales. Paired t-tests were conducted through the computer program Jamovi Statistics to determine if mean values changed significantly, in any of these categories, after education was provided. For the change of the mean value to be considered significant, the p-value for the independent sample t-tests needed to be less than 0.05. Frequency of incidence of seclusion and restraints one month before were compared to frequency of incidence of seclusion and restraints one month after implementation.

Staff members were also able to provide comments at the end of the post-confidence survey. The comments left at the end of the survey were analyzed through thematic analysis to determine how staff members' educational experience can be improved in the future.

Results

Demographic Survey

Prior to education, unit staff were asked to complete a demographic survey to collect data on the sample. The demographic survey specifically questioned the number of years each staff member had worked in healthcare and the number of years each staff member had worked in a mental health setting. To maintain anonymity, the demographic survey included multiple choice questions with a range of years for each response. A frequency table showing the number of staff members with corresponding years worked in healthcare is represented (see Table 1). A frequency table showing the number of staff members with corresponding years worked in a mental health setting is represented as well (see Table 2). Data was collected from a total of 25 participants. At the conclusion of the project, 13 of the 25 participants were included in the data analysis due to 12 participants providing incomplete and inaccurate identification numbers.

Table 1

Frequencies of # of Years in Healthcare

# of Years in Healthcare	Counts	% of Total	Cumulative %
Less than a year	1	7.7 %	7.7 %
1-5 years	6	46.2 %	53.8 %
6-10 years	3	23.1 %	76.9 %
Over 11 Years	3	23.1 %	100.0 %

Table 2

Frequencies of Years Worked in Mental Health

Years Worked in Mental Health	Counts	% of Total	Cumulative %
Less than a year	1	7.7 %	7.7 %
1-5 years	7	53.8 %	61.5 %
6-10 years	3	23.1 %	84.6 %

Frequencies of Years Worked in Mental Health

Years Worked in Mental Health	Counts	% of Total	Cumulative %
Over 11 years	2	15.4 %	100.0 %

Pre-intervention Unit Poll

A unit poll was also utilized to identify why staff believe the incidence of seclusion and restraints are rising and opinions on sensory rooms before education. Thematic analysis revealed staff believe the incidence of seclusion and restraints are rising due to staffing shortages, lengthier admissions at acute facilities, increase in admissions with patients presenting primarily with aggression, increased acuity overall, decrease in parental involvement, and lack of resources for mental healthcare. Thematic analysis revealed staff's opinions on sensory rooms before education included that sensory rooms may be dangerous for kids with an aggression history, not as helpful for patients with average IQ, helpful for appropriate patients with adequate supervision, be hindered by lack of staffing, potentially helpful for self-regulation, and increase risk for contraband.

Descriptive Statistics

Descriptive analysis was utilized using Jamovi Statistics to note if there was variation between the mean scores of pre-education and post-education survey results. Descriptive analysis results for the provided knowledge tests (see Table 3) and the provided confidence questionnaires (see Table 4) for the project sample (n=13) are shown.

Table 3

Descriptives

	N	Mean	Median	SD	SE
Pre-Knowledge Test	13	2.15	2	0.899	0.249

Descriptives

	N	Mean	Median	SD	SE
Post-Knowledge Test	13	2.69	3	0.855	0.237

Table 4

Descriptives

	N	Mean	Median	SD	SE
Pre-Confidence Questionnaire	13	11.1	12	3.17	0.880
Post-Confidence Questionnaire	13	12.0	12	3.46	0.961

Matched Pre-Intervention and Post-Intervention Data

To evaluate the effectiveness of the education of facilitators, paired sample t-tests were completed using Jamovi Statistics. The paired sample t-tests determined if the mean score of the pre-intervention and post-intervention knowledge tests and confidence questionnaire scores were significantly significant. Pre-education and post-education data sets were matched through staff's anonymous, six-digit identification number on each survey completed. The paired t-test results for the knowledge test (see Table 5) and the paired t-test results for the confidence questionnaire (see Table 6) are noted for the sample (n=13).

Table 5

Paired Samples T-Test

								95% Confidence Interval			
			statistic	df	p	Mean difference	SE difference	Lower	Upper		Effect Size
Pre-Knowledge Test	Post-Knowledge Test	Student's t	-2.01	12.0	0.068	-0.538	0.268	-1.12	0.0461	Cohen's d	-0.557

Note. H_a $\mu_{\text{Measure 1 - Measure 2}} \neq 0$

Table 6

Paired Samples T-Test

								95% Confidence Interval			
			statistic	df	p	Mean difference	SE difference	Lower	Upper		Effect Size
Pre-Confidence Questionnaire	Post-Confidence Questionnaire	Student's t	-2.14	12.0	0.053	-0.923	0.431	-1.86	0.0151	Cohen's d	-0.595

Note. H_a $\mu_{\text{Measure 1 - Measure 2}} \neq 0$

Chart Analysis

A facility report composed by the quality department was utilized to evaluate patient outcomes on the unit the intervention was provided before and after staff were educated. The report states the number of seclusion and restraint episodes that occurred for the entire month per 1,000 patient days. Data collected from February and April was compared since education was provided throughout the month of March. The data offered from the quality department is shown below (see Table 7).

Table 7

Intervention	February 2023	April 2023
Seclusion per 1000 pt days	0	0
Restraints per 1000 pt days	14.5	25.8

Discussion

In mental health settings, seclusion and restraints can be utilized if a patient presents as a danger to themselves or others after all other means to deescalate have failed. Though, the use of seclusion and restraints is questionable due to the risk of injury, death, and retraumatization. Sensory rooms have proven to decrease the likelihood seclusion and restraints will be necessary in mental health settings across the literature. The purpose of this scholarly project was to educate unit staff on the importance of using a sensory room to increase usage and allow acute adolescent patients the opportunity to self-regulate when in distress. The aim was to note staff

knowledge increased, staff confidence increased, and the use of seclusion and restraints decreased after education was provided. The aims were analyzed utilizing pre-and post-education knowledge tests, pre-and post-education confidence questionnaires, and chart data reports one month before and one month after education.

Key Findings

The paired sample t-tests for the pre-intervention and post-intervention knowledge tests revealed p=0.068. The paired sample t-tests for the pre-intervention and post-intervention confidence questionnaire scores revealed p=0.053. Therefore, the paired sample t-tests determined the mean scores of the pre-intervention and post-intervention knowledge tests and confidence questionnaire scores of the sample (n=13) were not significantly significant. Although comparison of the matched groups were not statistically significant, comparison of the pre-post intervention values revealed an increase in mean score when descriptive analysis was utilized. Specifically, the mean value of pre-post intervention knowledge test increased from 2.15 (SD=0.899) to 2.69 (SD=0.855) and the mean value of pre-post intervention confidence questionnaire increased from 11.1 (SD=3.17) to 12.0 (SD=3.46). Chart data reports one month before and one month after education revealed episodes of restraints increased, but seclusion was not utilized throughout either month. Unit staff reported the number of restraints likely increased due to a rise in new admissions presenting with a history of aggression and a primary diagnosis of either conduct disorder or intermittent explosive disorder.

Bowers et al. (2015) reported staffing shortages and a chaotic milieu led to inability to follow-through on sensory room use. Coincidentally, Wright et al. (2020) stated that sensory interventions were not provided due to individuals report of lack of time and busy workloads in their quality improvement projects. Similarly, this quality improvement project revealed nursing

staff believed a sensory room could be helpful for appropriate patients with adequate supervision but would be hindered by lack of staffing. Nurses then expressed concerns that the sensory room could increase risk for contraband and may be dangerous for kids with an aggressive history. Seckman et al. (2017) and Wright et al. (2020) indicated sensory instruments would not be implemented as frequently if staff members were concerned that sensory instruments were unsafe. The education was provided to relieve anxiety and show sensory rooms could potentially promote the safety of staff and patients. However, education was provided on the unit during scheduled staff meetings, but nursing staff were still on shift and needed to tend to patient needs, answer phone calls, and collaborate with the treatment team. Therefore, several members of the nursing team were preoccupied and distracted during education which may have impacted learning.

Limitations

This quality improvement project had several limitations. The sample size (n=13) was small and convenience sampling was utilized. If all members of the nursing team had participated in the study, the sample size would have reached 32 individuals. Though, there were 12 data sets that could not be analyzed due to inability to match pre and post intervention surveys. Staff members were told to write down or note their chosen identification number, but because post-intervention data was collected one month later, individuals stated they were unable to find where they had previously noted their identification number. The overall sample size was also reduced as time elapsed and staff members transitioned to new positions, scheduled vacations, and arranged paternity/maternity leave. Therefore, the attrition rate reached approximately 35%.

Staff members were also made aware by the nurse manager that the sensory room camera was not functioning throughout March while education was provided. The unit manager explained, per the risk department, one staff member must remain within eye view while a patient is in the sensory room when the camera is operational. However, if the camera is not operational, one staff member must remain within eye view while a patient is in the sensory room and an additional staff member must be present to ensure an allegation cannot be made against the staff member monitoring the patient. Due to the unit typically operating at minimal staffing ratios because of staffing shortages, taking two staff members away from the milieu to monitor one patient was likely not feasible, which hindered the ability to utilize the sensory room during appropriate instances.

Implications to Nursing

Nursing staff have a unique opportunity to empower patients throughout sensory rooms due to their current direct patient care role. Nursing staff must continue to be educated on the benefits of sensory rooms to increase usage and educated on the sensory room protocol for patient safety. The unit charge nurses must also persistently advocate for the use of sensory rooms throughout treatment team meetings to gain treatment team approval and advocate for patients previously approved to utilize the sensory room throughout their shift.

Conclusion

Pre-post data did not reach statistical significance, but this QI project did show an increase in the mean score of knowledge tests and confidence questionnaires after education was provided. Unit staff were also allowed to provide feedback and voice concerns through questionnaires and throughout unit staff meetings. Unit staff expressed that the quality improvement project was useful as it increased their overall knowledge and confidence to

implement the sensory room. Though, unit staff emphasized it was challenging to implement the sensory room due to acuity of patients, the malfunctioning sensory room camera, and staffing shortages. Therefore, currently, the sensory room cannot be sustained due to these mentioned barriers. Next steps should include evaluation of the project feedback with the unit manager and unit educator to determine how to address these barriers in the future.

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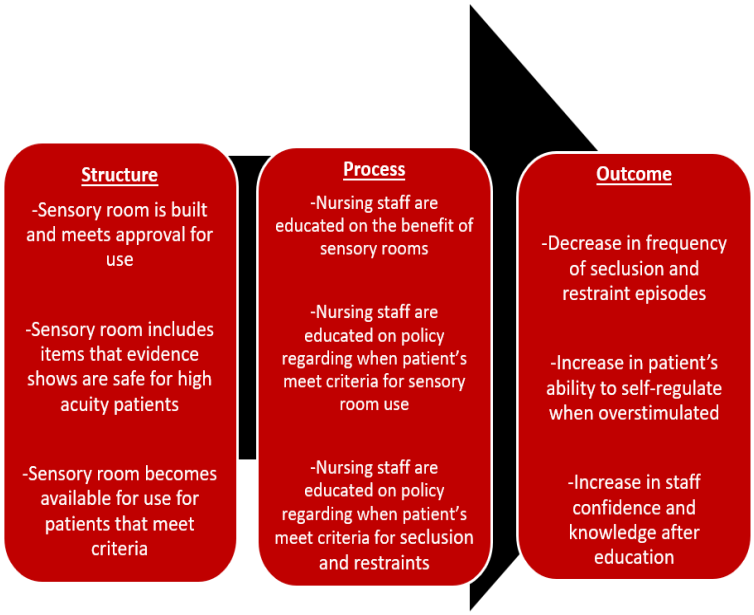
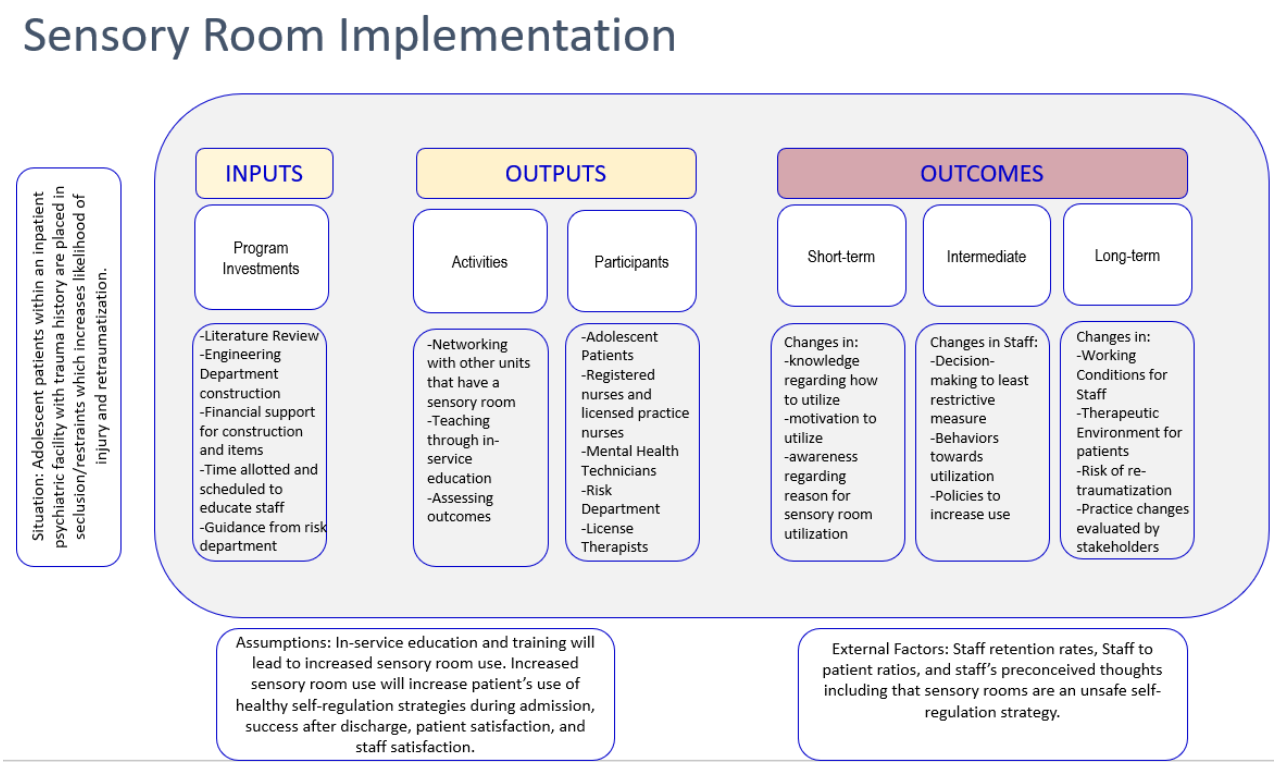
Appendix A
Conceptual Model



Appendix B
Logic Model



Appendix C
Director of Nursing Letter of Support

UL Health Peace Hospital
2020 Newburg Road, Louisville, KY 40205 P: 502-451-3330

9-14-2022

To Whom it May Concern,

As the Director of Nursing for 2 Lourdes and Breanna Sherrard, I support and approve her project. The project involves educating nursing staff on the effects of sensory rooms to increase usage. This project aligns with Peace's mission and vision for our patients.

Thank you,

Kristina Koeppl MSN RN NEA-BC

Director of Nursing Inpatient Child and Adolescent Units

Appendix D
IROC Letter of Support

UofL Health

January 26, 2023

Re: Evaluation of sensory room education to promote usage in an inpatient psychiatric setting: A quality improvement project

Dear Ms. Sherrard,

On January 26, 2023, the Interdisciplinary Research Oversight Council (IROC) completed a scientific review of your proposed study. The committee members determined that there were no threats to internal and external validity of the study, and that the study had the potential to advance scientific knowledge in the field. In addition, the study does not appear to have an adverse operational or financial impact on any nursing unit. As a means of follow-up, the IROC would appreciate an update on your progress the last month of each quarter at their monthly business meeting.

The next step in the project approval process is submission to the Human Subjects Protection Program (HSPP) at the University of Louisville (UofL) for review by their Institutional Review Board (IRB). Applications are made using the iRIS system, which requires a sponsored account through UofL. The request form is located on the UofL HSPP website at https://louisville.edu/research/humansubjects. You can contact the IRB at hsppofc@louisville.edu or (502) 852-5188.

You may access the iRIS system online at the following web address: https://iris.louisville.edu:444 or contact the UofL Health Research Office (ULHRO) for assistance at umcresearch@ulh.org. If you complete the submission process in iRIS, please select UofL Health as a Department, include UofL Health Research office as a contact, and select UofL Hospital as a study site. All study specific correspondence should be sent to the ULHRO via their service account.

Once the iRIS submission is complete, your proposal will be received and reviewed by the IRB and the ULHRO. Note that both offices will issue an approval letter upon review completion.

Please note that data collection at UofL Health cannot begin until all approvals have been received.

Thank you for advancing the nursing research enterprise at UofL Health.

Sincerely,

K. Robinson

Kathryn L. Robinson, MSN, RN, NPD-BC, OCN, EBP-C
Chair, Interdisciplinary Research Oversight Council
Evidence Based Practice Coordinator
University of Louisville Hospital
(502) 541-9770
kathryn.robinson@uofhealth.org

cc: research@uoflhealth.org, Kathy Wohlschlegel

Appendix E
Pre-education Unit Poll

Instructions:
Please write out responses to the following questions.
Do **NOT** list your name, position, or employee number anywhere on this poll.

Why do you believe the incidence of seclusion and restraints is rising?

What are your current opinions on sensory rooms?

Appendix F
Pre-education Knowledge Test

Instructions:
Please select the answer that is most correct.
Do **NOT** list your name, position, or employee number anywhere on this questionnaire.

What can sensory rooms promote:

A) Feeling of security
B) Improved patient and staff rapport
C) Self-regulation
D) All of the above

Which patient meets criteria for the sensory room:

A) Patient initially admitted with self-injurious precautions that is requesting to take a break and the treatment team has approved sensory room use.
B) Patient that is threatening to hit a peer.
C) Patient that had a poor family session with self-injurious precautions that will be supervised by a therapist.
D) Patient that has a history of aggression and recently had an explosive outburst.

Sensory rooms are implemented to:

A) Meet JCAHO (Joint Commission on Accreditation of Healthcare Organizations) standards
B) Decrease retraumatization related to seclusion and restraints
C) Improve satisfaction scores
D) All of the above

What is necessary before a patient utilizes the sensory room?

A) Guardian permission
B) Treatment team approval
C) Signed Consent
D) All of the above

Appendix G
Post-education Knowledge Test

Instructions:
Please select the answer that is most correct.
Do **NOT** list your name, position, or employee number anywhere on this questionnaire.

What can sensory rooms promote:

E) Feeling of security
F) Improved patient and staff rapport
G) Self-regulation
H) All of the above

Which patient meets criteria for the sensory room:

E) Patient initially admitted with self-injurious precautions that is requesting to take a break and the treatment team has approved sensory room use.
F) Patient that is threatening to hit a peer.
G) Patient that had a poor family session with self-injurious precautions that will be supervised by a therapist.
H) Patient that has a history of aggression and recently had an explosive outburst.

Sensory rooms are implemented to:

A) Meet JCAHO (Joint Commission on Accreditation of Healthcare Organizations) standards
B) Decrease retraumatization related to seclusion and restraints
C) Improve satisfaction scores
D) All of the above

What is necessary before a patient utilizes the sensory room?

A) Guardian permission
B) Treatment team approval
C) Signed Consent
D) All of the above

Appendix H
Pre-education Confidence Questionnaire

Instructions:
Please rate your agreeability with the following statements below. Please provide your honest and unbiased opinions, to obtain accurate results.
Do **NOT** list your name, position, or employee number anywhere on this questionnaire.

I feel confident implementing the sensory room according to the sensory room protocol.

(1) Strongly Disagree
(2) Disagree
(3) Neither Agree or Disagree
(4) Agree
(5) Strongly Agree

I feel confident recognizing patients that are appropriate to use the sensory room.

(1) Strongly Disagree
(2) Disagree
(3) Neither Agree or Disagree
(4) Agree
(5) Strongly Agree

I feel confident justifying why the sensory room should be used to my coworkers.

(1) Strongly Disagree
(2) Disagree
(3) Neither Agree or Disagree
(4) Agree
(5) Strongly Agree

Additional Comments or Concerns: _____

_____

_____

_____

Appendix I
Post-education Confidence Questionnaire

Instructions:
Please rate your agreeability with the following statements below. Please provide your honest and unbiased opinions, to obtain accurate results.
Do NOT list your name, position, or employee number anywhere on this questionnaire.

I feel confident implementing the sensory room according to the sensory room protocol.

(1) Strongly Disagree
(2) Disagree
(3) Neither Agree or Disagree
(4) Agree
(5) Strongly Agree

I feel confident recognizing patients that are appropriate to use the sensory room.

(1) Strongly Disagree
(2) Disagree
(3) Neither Agree or Disagree
(4) Agree
(5) Strongly Agree

I feel confident justifying why the sensory room should be used to my coworkers.

(1) Strongly Disagree
(2) Disagree
(3) Neither Agree or Disagree
(4) Agree
(5) Strongly Agree

Additional Comments or Concerns: _____

_____

_____

_____

Appendix J
Sensory Room Protocol

Comfort Room- A Peaceful Place

A. Purpose

A comfort room is a space designed to calm one's senses by exposing them to physically comfortable and pleasing visual, auditory, olfactory, and tactile stimuli. The goal of the comfort room is to teach individuals calming techniques to decrease agitation, decrease anxiety, and develop self-regulation skills that can be used in the hospital and maintained after being discharged.

B. **Guidelines**

The comfort room is a tool used to help individuals manage their feelings and behavior and ultimately prevent the use of seclusion, restraint, and other restrictive interventions.

a. The comfort room will be used at will and will not be forced upon individuals.
b. The comfort room will be used to avoid escalation - not as a reward for good behavior or a privilege that is taken away.
c. The comfort room will be used before aggressive or out of control behavior occurs.
d. The comfort room will be used when an individual is able to use the room safely, not after someone has already lost control of their behavior.
e. The comfort room is not a seclusion room or a time out room, a punishment, or a reward.
f. The user may choose to leave the room at any time.

C. Participants

a. Any team member may identify a patient who could benefit from use of the comfort room. After identification and before use, the patient's entire treatment team will discuss and agree upon parameters. Risks and benefits will be discussed.
b. Use of the comfort room will be added to the individual's treatment plan, behavior plan and/or quick reference guide.
c. If a patient has a history of property destruction, self-injurious behavior, or ingesting nonfood items, potentially dangerous items should be removed and/or locked before the individual enters the room.

D. Maintenance and Cleaning

a. Before allowing any individual to enter the comfort room, the trained facilitator assigned to monitor the patient should check the room for any broken or misplaced items and remove or add items as needed.
b. Prior to entering the room, all individuals should wash their hands or use hand sanitizer.
c. After use, an assigned team member will wipe the used surfaces with a cleaning wipe.

d. Routine cleaning will occur daily by assigned environmental services team members.
e. At least once weekly, an assigned team member will inspect the room, clean any surface visibly in need of cleaning, remove broken or damaged items and put in any necessary work orders. Assigned team member will document on cleaning/maintenance log.

E. Use of Comfort Room

a. Patients approved to use the comfort room may request to use the room when therapeutically appropriate. Initially, the patient could use the comfort room every time the individual asks, regardless of current assigned activity. Criteria will be outlined in the patient's individual treatment plan, behavior plan or quick reference guide. If the comfort room cannot be used safely due to current unit staffing or acuity of the milieu, the comfort room will not be utilized.
b. Team members may suggest the use of the comfort room to an approved patient as coping skill.

F. Monitoring/Safety

a. The comfort room will only be used under the supervision of trained facilitators.
b. Patients may use the room for up to 30 minutes at a time.
c. One patient will use the room at a time.
d. Before a patient enters the comfort room, the trained facilitator will complete the inventory sheet.
e. The camera room must be notified before a patient enters the comfort room. Camera room staff must be instructed to turn on the dining room camera and the comfort room camera on 2 Lourdes. If the comfort room camera is not operational, the treatment team must be aware before a patient utilizes the comfort room.
f. While the patient is utilizing the comfort room, the trained facilitator will sit or stand in a marked area within camera view.
g. The patient must remain within line of sight of the trained facilitator at all times while using the comfort room.
h. Trained facilitators are not allowed to utilize electronics while monitoring patients using the comfort room. Therefore, cell phones and headphones are prohibited.
i. If a patient begins to become upset or agitated while in the room or attempts to break/damage items, the use of specific items or the entire room will be discontinued until the treatment team approves use again. Notify RN and all necessary treatment team members of the patients' behaviors and actions while utilizing the room.
j. The door will remain locked when not in use and unlocked while in use.

G. After Use

a. Turn off all equipment and lights.

b. The trained facilitator will return all items to their original location and complete the inventory sheet. The trained facilitator will ensure that each item accounted for before comfort room use is accounted for after use.
c. Comfort Room use will be documented on a log kept at the Nurses Station.
d. When possible, patients and team members will be asked to complete a Comfort Room Feedback Form.

H. Team Member Training

a. Any team member supervising a patient in the comfort room must first be trained on the use of the room by the Occupational Therapist, Nurse Manager, Behavior Analyst, or Intervention Specialist.
b. Training will consist of the following:
    1. Review *Comfort Room Protocol*
    2. Review *Comfort Room Log*
    3. Review *Comfort Room Inventory Sheet*
    4. Review *Comfort Room Feedback Form*
    5. Observe trainer utilizing equipment
    6. Demonstrate ability to use equipment
    7. Knowledge Test, Confidence Form, and Demographic Questionnaire

Appendix K
Sensory Room Handout

The Sensory Room Educational Handout

Expectations

- The comfort room will be used when an individual is able to use the room safely, not after someone has already lost control of their behavior
- The comfort room will be used to avoid escalation - not as a reward for good behavior or a privilege that is taken away

"Using restrictive measures to de-escalate patients with a history of trauma could cause patients to relive their trauma through intrusion symptoms such as upsetting memories, flashbacks, emotional distress, and physical reactivity resulting in increased suffering."

-Hammer et al., 2011

Purpose of Comfort Room

- Promote feeling of security
- Improve ability to self-regulate
- Decrease risk for retraumatization by preventing the use of seclusion, restraint, and other restrictive interventions
- Improve patient and staff rapport
- Decrease anxiety and agitation overall

Guidelines for Use

- The **treatment team** must approve a patient to use the comfort room **BEFORE** a patient is allowed to use the comfort room.
- Only **TRAINED** staff are allowed to let patients use the comfort room, **one** patient at a time.
- The camera room must be notified to turn on the dining room camera and the comfort room camera **BEFORE** a patient enters the comfort room.
- The patient must remain within **LINE OF SIGHT** of the trained facilitator and the trained facilitator must sit or stand in a **marked area** within camera view.
- Staff **CANNOT** use electronics while monitoring
- The door will remain **LOCKED** when not in use.

Facility Protocol Reminders