

## **Seclusion and Restraint Plan**

### **Southwestern Virginia Mental Health Institute**

**December, 2011**

#### **Introduction**

This update and progress on seclusion and restraint reduction plan is written to be included as part of the SWVMHI Annual Recovery Update and Plan. It also meets the Departmental Instruction 214 requirement for a “Seclusion and Restraint Reduction Plan.”

DI 214 states that:

“Each facility shall establish an annual plan for the development of alternatives to the use of seclusion or restraint. The goal of each plan shall be to significantly reduce the use of restraint and, where applicable, seclusion.

Facilities that have no reported use of seclusion and restraint or only infrequent use shall develop strategies to maintain a seclusion and restraint-free environment.

Individuals and, where applicable, family members must play an active role in the development of strategies for seclusion and restraint reduction and evaluation of the effectiveness of those strategies.”

The Mission, Vision, Values, and Leadership Philosophy of SWVMHI all support an atmosphere of Recovery, respect for all individuals and the use of the least restrictive or coercive interventions. We will stay focused on our Mission, "We promote mental health in southwest Virginia by assisting people in their recovery" by using our facility Values of Communication \* Honesty with Compassion \* Trust \* Teamwork \* Self-initiative \* Leadership \* and Honoring day-to-day tasks to fulfill our Vision, “SWVMHI, in collaboration with Community Service Boards, will always be the region’s center of excellence in the treatment of serious mental illness.”

In addition, SWVMHI has recently developed a Seclusion and Restraint Philosophy.

#### **Seclusion and Restraint Philosophy**

**December 1, 2011**

SWVMHI is committed to creating a trauma informed environment free of violence and coercion based on prevention strategies; assuring a safe environment for individuals receiving services as well as staff; and focusing on the elimination of seclusion and restraint as congruent with the principles of recovery and person-centeredness. This goal is consistent with a facility that treats people with dignity, respect, and mutuality, protects their rights, provides the best care possible, and supports them in the achievement of their personal vision for their lives.

Goals for 2012: This Philosophy statement will be publicized and incorporated into SWVMHI practices and procedures.

In addition, a series of four meetings will be held with the Patient Activity Council/during ward meetings to obtain further input into strategies for reducing seclusion and restraint.

**I. Making the experience safer, better/physical plant.**

**A. New seclusion rooms**

In response to the May 1, 2011, revisions to DI 604, Physical Requirements for State Hospital Seclusion Rooms, SWVMHI made changes to its seclusion rooms. While the existing rooms were grandfathered, it was believed that modifications to the rooms would not only meet the DI but more importantly, increase the safety and comfort of the individuals we serve as well as staff.

In each room the seamed padding was removed and the room was thoroughly cleaned. The removal of the padding not only provided a better environment from an infection control perspective, but it also allowed for natural light in the room. In place of the padding, Gold Medal Safety Padding was installed. Plexi-glass was installed over the window with part of the plexi-glass painted for privacy. The room was painted a pastel color. A clock is on the wall outside of the room and is visible from the room. A mattress is on the floor. All areas of the seclusion room are observable from outside the room. There is a bathroom in the seclusion suite

Goal for 2012: It is noted that the overall blue color of the rooms could benefit from being “broken up” with the addition of another color. The feasibility of this will be explored and if it is determined that the Gold Medal Safety Padding can be painted, this will be done.

**B. Continued use of Comfort Rooms**

The use of Comfort Rooms was implemented during the spring of 2009. There are two on the Acute Admissions Unit (one on Wards AB and one on Wards CD), one on the Geriatric Unit (Wards EF), and three on the Extended Rehabilitation Services Unit (Wards H, I, J). The primary uses of these rooms are to provide individuals with a private area with a variety of sensory aids to encourage successful self-management of difficult emotions. Comfort Rooms give individuals a place to go when feeling distressed, but still in control of their behaviors, and be in an attractive, separate area. The comfort rooms are designed to provide patients with choices that promote therapeutic coping skills.

When not in use, the Comfort Rooms are locked for safety purposes, since the rooms are not visible at all times. If an individual would like to use a room, he or she lets a staff member know, and the room is unlocked. If the individual is on close observation, a staff member will maintain the close observation in the room. If the

individual is not on close observation, the door may be closed and a staff member will check in with the individual approximately each 15 minutes or less. If several individuals want to use the room at the same time, a schedule of 30 minutes each is developed. If no one is waiting to use the room, an individual may use it for a longer period of time.

Comfort rooms are checked and monitored for appropriate use every fifteen minutes by nursing staff making hall rounds. The rooms are also checked for cleanliness and organization. The individuals we serve are directed to wash their hands and use hand sanitizer before and after using sensory items. Upon leaving the room, individuals are asked to complete a brief evaluation/log to provide feedback to measure his or her response to the experience. If an individual is in a behavioral crisis such that it would be destructive or a safety concern to use the comfort room, other options for locations may be offered, such as the bedroom, open quiet room, or possibly an activity room as appropriate. Other interventions would be implemented based on individual assessments and needs.

There are occasions when several individuals want to use a comfort room at the same time. When that happens, an equitable way of scheduling the rooms is implemented, and other alternative coping strategies for individuals are implemented for those who are waiting.

Individual information and encouragement to use the comfort rooms is provided on admission to the ward. Written guidelines are posted on the unit and individualized encouragement is also provided. New nursing staff members are oriented to the concept of comfort rooms within their first month of employment in the classroom. Once on the unit, staff are reminded about promoting use of the rooms through weekly program management meetings and in monthly shift meetings. During these meetings staff members or individuals we serve may provide any recommendations about the comfort rooms and share anecdotes about the use.

Goal for 2012: Continue orientation of new staff members to the usefulness of the Comfort Rooms and remind staff regularly during unit/shift meetings.

## **2011 Comfort Room Utilization**

### **1. Admissions Unit**

- a. Utilization of Admission Unit Comfort Rooms: Admissions Unit comfort rooms have been used for a total of 1619 times in the 11 month period from January 1, 2011, through November 31, 2011.
- b. Feedback on Admissions Unit: The individuals we serve are asked to evaluate their experience in the comfort room when they are finished using it. Of the responses, 2/3 indicated that they were feeling better after leaving the comfort room, and 1/3 indicated they felt the same leaving as they did entering. No

individual reported feeling worse as a result of using the Comfort Room. It is noted that being able to leave the room and complete a survey is evidence that agitated behavior did not escalate. This is considered a success in itself.

Examples of feedback that have resulted in enhancements are requests for more reading material (a bookcase and assortment of books were obtained) and more variety in music selections.

- c. Variables Affecting Comfort Room Usage on Admission Unit: Recently the maintenance department had to turn the power off to the comfort rooms for a period of days due to a need for electrical repairs. During this time, the individuals we serve were allowed to listen to music in the dayroom or in music groups held by staff in the activity rooms. This was a negative variable that reduced the usage of the comfort room, since many individuals go into the comfort room to listen to music. Efforts are made to have the Comfort Rooms accessible at all times.

## **2. Geriatric Unit**

- a. Utilization of Geriatric Unit Comfort Room: The Geriatric Unit Comfort Room is referred to as “The Elderberry Comfort Room and Activity Room.” Since the individuals on this unit are less independent and less apt to initiate use of the room in the same manner as the Admissions or ERS unit individuals, it has been set up to use for both individual and group needs.

The Elderberry Room is utilized routinely for Resident Activity Council meetings, Nursing Grooming Group, and 1:1 resident interactions five times per week. It is also utilized for family visits when the visitor room is occupied. On-unit court hearings have occurred in The Elderberry Room on occasion. Independent Evaluations for commitments may be held in The Elderberry Room for a quieter and more comfortable environment for the individuals we serve.

- b. Sensory Options: When an individual would like to participate in activities that are calming or provide diversion, some of the options are:
  - Non-violent Wii games congruent to Geriatric cognitive levels;
  - DVD player with movie and music options;
  - Television;
  - Water fall that can be turned on for audible and visual soothing;
  - Sound machine with options to listen to soothing music, waves or other;
  - Vibrating pillows for physical sensory;
  - Two glider chairs for movement, comfort, and/or physical activity;
  - Reading material of various selections; and
  - Contemplating the attractive wall murals

- c. Monitoring: To ensure safety and appropriate utilization of items in the room, staff members monitor individuals at all times when the room is being utilized.
- d. Feedback: A log is kept of responses after using the room. All comments have been positive, stating “love the comfortable glider chairs,” “enjoyed the quietness of the room,” and “the scenery of the wall mural as well as looking out the window was nice on a cold rainy day” are examples of comments.

### **3. Extended Rehabilitation (ERS) Unit**

- a. Utilization of ERS Unit Comfort Rooms: ERS had three comfort rooms until July 2011, when wards were reconfigured. Individuals served from the previous Ward G were relocated to another ward, and the previously closed Ward accepted some ERS individuals. This recently reopened ward does not have an “official” comfort room yet, although there are quiet areas available for the individuals we serve.

Each ERS comfort room had a special theme reflected in the rooms’ names: The Oasis, Comfort Lodge, and Country Cabin. There were about 300 episodes of comfort room use this year on ERS. Additionally, the rooms may be used for 1:1 individual sessions, assessments, and teaching relaxation techniques.

- b. Feedback on Use of ERS Comfort Rooms: All comments have been positive. Most individuals say they enjoy using the rocking chair and listening to music. Items used most often include: music options, reading materials, stress balls, mood cubes with sounds and lights, comfortable furniture, and rocking chairs.
- c. Variables Affecting Use of ERS Comfort Rooms: In February 2011, all ERS nursing staff members were provided with refresher training regarding the purpose and appropriate use of the comfort room. During that same month, a special education focus was provided to the individuals we serve with updated education and “tours” to promote familiarity with the rooms.

In July 2011, the wards were reconfigured, and what is now Ward H does not have a Comfort Room. Additionally, it is assessed that the reconfiguration of the three wards and initial adjustment period to new environments caused the individuals we serve to use the Comfort Rooms less and to withdraw to their bedrooms more. At this point, individuals have adjusted to their new environments successfully.

### **General Comfort Room Goals for 2012/ Comfort Room Continuing Improvement Plans for 2012**

- Many of the individuals we serve enjoy music for relaxation, so expanding on our music collection would also be part of our future improvement efforts.
- Replacement of sensory items, such as stress balls, coloring sheets, modeling clay, etc. will continue to be ordered and replaced due to extensive use, and damage to some items. Funds are allocated each fiscal year to budget for the purchase of these items to be replaced.
- A literature rack with informational brochures is also routinely re-stocked in the comfort room. Additional education information related to new or prevalent mental health issues in 2012 will be obtained.
- Continued education and communication to staff and the individuals we serve are an integral part of the success for the comfort rooms on the units.
- To increase participation in completing guest surveys, for the comfort room, additional surveys will be placed in the dayroom literature racks and at the nurses' station. Nursing staff will review with the individuals we serve during community meeting groups about the importance of providing feedback on the comfort room surveys and the value of their suggestions.
- Re-create the third Comfort Room on ERS and continue to publicize its usefulness during unit meetings.

### **Comfort Room Conclusion**

The facility is striving to seek new and innovative ways to continue to reduce our use of both seclusion and supine restraints. The implementation of our comfort rooms are part of that effort. Our mission is to assist the individuals we serve on their road to recovery. To that end, we will continue to work towards a seclusion and restraint free environment.

### **C. Additional ward milieu enhancements in 2011 and continuing in 2012**

1. The Geriatric Unit has improved the milieu to be more 'home-like' and utilizing Recovery Principles with activities in the following ways.
  - Hand-painted quilt squares on the wall of the Wards and Dayroom;
  - Bright-colored home-made Quilt hung in the Dayroom;
  - New courtyard furniture (table, chairs, and bench) for comfort and safety;
  - Active Patient Council for planning activities, and special events;

- Weekly piano music;
- Weekly Pet Therapy;
- Grooming group twice weekly for men and women for self-esteem;
- Special snacks/seasonal foods (i.e. bean breaking, fall cupcakes, and Christmas candy making)
- Accommodations made for family picnics;
- Country music band and church groups for evening activities; and
- Special events, including Dandy Don (music and props); Ice Cream Making; St. Patrick Day Celebration; Fall Festival; Bingo (everyone wins a prize); Veteran's Day Celebration; and Birthday celebrations

2. Moves of the individuals we serve to bigger wards on ERS in 2011

The Extended Rehabilitative Services Unit (ERS) made significant environmental changes through utilization of vacant space on Ward H. Beginning on July 13, 2011, each of the three ERS wards was transitioned to different space within the facility. The initial move involved individuals residing on Ward J moving to Ward H. The second transition of individuals residing on Ward I to Ward J was completed on July 27, 2011, and the third move of individuals residing on Ward G moving to Ward I was finalized on August 10, 2011. Each of these moves resulted in an increase in available space, rooming options and overall comfort for the individuals we serve.

The increases in available living space and bedroom options are anticipated to have a positive impact in regard to ongoing reduction in the use of seclusion or restraint by allowing more personal space for individuals in our care as well as increasing options to alter roommate assignments to facilitate more positive interpersonal relationships on the wards. These moves also increased the on-ward activity space to allow for improved programming options within the milieu of the unit. Increases in personal living space are anticipated to reduce interpersonal conflicts and create a calmer, more consumer-friendly environment to facilitate recovery.

3. Ward C/D Milieu Enhancements 2011 including the purchase of the following items to make improvements to the patient-care areas:

- New furniture, including loveseats for each hallway, new stackable chairs for the dayroom area, and tables for the activity rooms.

- New exam tables in the examination rooms with step stools along with a new emergency equipment cart. Emergency equipment supplies were updated, including new suction machines, digital scales, Ambu-bags, vital sign equipment / supplies and wheelchair oxygen tank holders.
- Communication boards to facilitate communication skills with the individuals we serve who may have communication issues, such as speech / hearing impairments or other disabilities.
- New linen hampers for each hallway and the tub room.
- A new shower chair for the ward.
- Vinyl bed wedges for elevation of the head of beds as ordered by medical professionals.
- Television screen protectors were installed on each hallway.
- For improvements to the comfort room, a bookcase was added. Sensory kits and sensory items were purchased to stock the comfort chest. These items included: stress balls, cross-word puzzles, sensory balls, and game sets, etc.
- Bed and wheelchair alarms for fall prevention.
- Outside games along with storage containers for these.
- New chart racks for each team room.
- 24- hour Clocks
- Storage cabinet for Activity Room C-105 for craft / art / group supplies
- New Equipment Purchases for Medication Rooms and for Medication Safety, including :
  - 2011 Nursing Drug Handbooks for all Wards
  - Nine New Medication Carts: Two for Ward AB; two for Ward CD; two for Ward EF, and three for Wards I, J, and H
  - Electric Pill Crusher for Ward EF
  - Digital Thermometers for the Medication Room Refrigerators (All)
  - New Refrigerators for the Medication Rooms (All)
  - Anti-fatigue Mats for all Medication Rooms (Admissions and ERS)
  - Insulin Bins with High Alert Stickers for all Medication Rooms (All)
  - New Glove Racks for all Medication Rooms

- Double Lock Narcotic boxes for refrigerators in all medication rooms

## **II. Staff Development & Training.**

### **A. Enhancements to TOVA Training**

SWVMHI staff attended training primarily to meet the biannual recertification requirement for instructors. Listed below are three items that are enhancements or possible program strengths that are somewhat specific to our facility:

1. The SWVMHI TOVA program incorporates data collected from the *SWVMHI After Code Processing Forms* to continuously monitor and improve the effectiveness of interactions between staff and the individuals we serve during behavioral crises. Class discussions focus on therapeutic practices and interventions that have resulted in positive outcomes as well as developing trends or issues where improvement is indicated.
2. Specialized TOVA training was implemented for medical and pharmacy staff. Part one of the training is an online course that emphasizes the core concepts of the TOVA program and the facility's commitment to reducing the use of seclusion and restraint. Part two is an instructor-led session that includes a demonstration of the physical skills/hands-on restraints, a written test on the core concepts of the program and an opportunity for discussion.
3. The SWVMHI TOVA instructional team consists of eleven active instructors: eight direct care staff on all three shifts and three staff development coordinators. This team actively promotes the use of therapeutic, non-physical interventions to manage behavioral crises. This therapeutic approach includes at a minimum, using the least restrictive intervention possible and reserving the use of seclusion and restraint exclusively for emergency situations where less restrictive options are non-viable for keeping everyone safe and unharmed.

Goal for 2012: Continue to implement an excellent TOVA program, emphasizing Seclusion and Restraint reduction and Trauma-Informed Care.

### **B. Road Trip Training (revitalized in 2011)**

SWVMHI's Road Trip Training was based on SAMHSA's 2003 plan entitled "Road Map to Seclusion and Restraint-Free Mental Health Services," written to assist facilities to reduce and ultimately eliminate the use of seclusion and restraint in behavioral health care settings. Select information from the SAMSHA plan has been used as the foundation for SWVMHI Road Trip and additional information was added specific to the challenges of providing services in southwest Virginia and according to the Mission and Values of SWVMHI.

This training was initiated in 2007, with revision/update in 2008. Leadership personnel in each of the four residential units of SWVMHI were initially trained in the content and presentation methods this curriculum. In 2007 and 2008, all three shifts on each unit participated in a one day training session, resulting in a total of 261 staff trained. In the spring of 2010 and summer of 2011, the curriculum was revisited and the curriculum was added as a component to the new employee orientation so that every employee hired is exposed to these concepts. Since that time, an additional 370 staff have attended the new employee orientation version of the Road Trip.

The presentation aims to increasing the knowledge and skills of service providers, administrators and consumers on alternatives to the use of seclusion and restraint. It is a tool to assist everyone to understand and perform competently in our system transformation so we may create and implement systems and services that support and facilitate recovery, promote resilience while eliminating seclusion and restraint. Through the following content, this information is intended to build bridges between the individuals we serve and providers. The curriculum is written to include the perspective of the individuals we serve to assist providers to work from a consumer- based philosophy and to recognize recovery and wellness are essential in providing alternatives to the use of seclusion and restraint.

#### Curriculum Content:

- Working by the Mission and Values
- Recovery and Resilience
- Incorporating Personal Experiences: Seclusion and Restraint Issues and Assumptions
- Recognizing Our Strengths
- Our Culture and Our Staff
- TOVA
- Communication Skills
- College of Direct Support
- Supervision and Coaching
- Recognizing the Impact of Trauma
- New Sensory Strategies
- Key Elements of Debriefing

#### **Helpful suggestions on how to help avoid the Use of Seclusion and Restraint Presented by Jim Lundy Unit Nurse Coordinator during “Working by the Mission and Values” Section of Road Trip Training.**

1. **Avoid getting into a power struggle with an individual se serve.** We can tend to have an, I’m in Charge or I’m the Boss mindset. This creates an automatic us vs. them situation. In a power struggle everyone feels they must win. The individual will do everything to assure they will win no matter what. It is very important that we recognize when a power struggle is occurring and

stop it early. If you as a staff member become entangled in a verbal back and forth, recognize it and remove yourself as soon as it is safe. Remember it takes two to be in a power struggle. If you sense a power struggle is occurring be willing to step aside or come to the assistance of your co-workers.

2. **Don't take the job or the individual's behavior personally.** It is easy to become very emotionally engaged (angry), frustrated and lose our perspective. It is important to remember why we are here and why the individuals we serve are here. The individual is here for inappropriate behavior in some form. We all must work hard not to take the individual's behavior personally. If the individual we serve realizes that the behavior they are engaged in is being taken personally by staff, expect them to provide more of the behavior.
3. **If you become the focus of the individual's agitation or aggression, it is imperative that you realize this and step away.** If you feel that an individual in crisis is focused on you either verbally or physically, at the earliest safe opportunity leave the general area. \*\*If you are working with someone and note they are the focus of the individual's agitation, quickly and quietly ask them to consider stepping away. It takes a stronger person and professional to walk away, than to remain in the situation and have the individual continue to escalate.
4. **Be calm yourself.** The more emotionally upset you appear to be, the more emotionally upset the individual we serve will become. Be what you want to see.
5. **Be aware of your tone of voice.** Use the lowest possible tone that can be understood, and clearly heard. If you use a loud, harsh or abrasive tone of voice, you can expect the individual we serve to match you every time.
6. **Be alert to slight changes in behavior.** Pacing, fists clenched, cursing, small altercations which are out of the ordinary, becoming argumentative, facial expression etc. You are a very important part in noting early signs of agitation. Report these behaviors to the Team or Charge Nurse as soon as possible. Ask the medication nurse if they have a PRN medication. The sooner the individual receives a PRN, the better.
7. **Use your active listening skills.** Remember violence is the voice of the unheard. If the individual we serve feels they are not being heard they will assume you do not care or not worth your time. The individual will act in a manner that will get your attention so you will hear them.
8. **If a Contingency Plan is in place, follow it to the letter as much as humanly possible. Be consistent.** If you feel that a part of the Contingency Plan is not working, be sure to let the team know. A Contingency Plan is

considered to be a living document and can be changed and updated using all of the staff's input.

9. **It is a firm expectation that we treat everyone, (staff and the individuals we serve) with dignity, respect, and courtesy at all times.** The individuals we serve will mirror what they see and many times will give what they get.
10. **When dealing with the individuals we serve, remember to keep your word, do what you say you will do.** If you promise something or tell them you will speak to them in a minute, do it. Never promise what you cannot or are not sure you can deliver. If they ask for something that is not possible or you are not sure about, ask the Charge Nurse. Always strive to be kind, honest, and use empathy.
11. **Be aware of your non-verbal communication.** Example: facial expression, body language / positioning.
12. **Always call a Code Response / Alert sooner rather than later.** It is better to have staff come and not need them, than to need them and not have them.
13. **If you have a mentality that we are here to police or punish the individuals we serve, then you are in the wrong field of work and you will be out of step with where the facility is going.** If you begin to think that an individual needs to be punished for his or her behavior and needs to be placed in restraints, then you need to step away and leave the area.
14. **We must not be impatient with the individuals we serve in crisis.** It may take quite some time for them to calm down. Give them plenty of time and space as long as everyone is safe. We sometimes feel rushed to resolve an issue so other unit's staff can return, but we must all not be in a rush when it comes to crisis intervention.
15. **Limit the amount of talking / laughing among code responders.** Especially outside of the individual's room or the seclusion room while waiting. It is understood that generally staff are trying to relieve a stressful situation by talking or joking around. Keep in mind that in many cases the individual we serve will escalate in behavior when paranoid or agitated if they feel staff are talking about them or laughing at them.
16. **Any use of mechanical restraints and seclusion should absolutely be considered as a last resort.** Everything else should be considered or attempted before implementing seclusion and or restraints.

**Some reasons why we want to avoid a seclusion or restraint situation, if at all possible:**

1. Up to 80 percent of the individuals we serve have experienced some form of sexual abuse in their life time.
2. Up to 90 percent of the individuals we serve have experienced some form of physical abuse in their life time.
3. All of the individuals we serve have experienced some form of trauma in their life time.
4. The incidence of injury to both the individuals we serve as well as to staff are greatly increased during a hands on seclusion or restraint episode.
5. When we use hands on to control an individual, we are creating a situation that can cause them to relive a past traumatic sexual and/or physical abuse event.

All staff must change their mindset related to the use of seclusion and restraint. The use of mechanical restraints should not be considered as a treatment option for any individual, as their use represents treatment failure.

Every episode of seclusion and restraint is reviewed by the Special Management Committee.

We must be proactive and think outside of the box. We must think of new ways to work with the individuals we serve in crisis. The facility's goal is to work proactively towards eliminating the use of mechanical restraints and seclusion. With instituting these 16 concepts we will begin a journey to success.

Goal for 2012: Continue to implement an excellent Road Trip Orientation in 2012. Before the end of the year, meet together with the Instructors to assess the need for further modifications/changes to the program.

### C. Motivational Interviewing Training

Motivational Interviewing is a mental health best practice aimed at helping persons to find their own motivation for making behavioral changes to enhance their likelihood of success. The approach has the associated advantage of increasing an individual's recognition that they are the most important partner in the healing alliance and consequently reducing the perception of individuals that they are being coerced. Staff persons trained in this approach are better able to avoid or resolve conflicts with the individuals we serve through verbal interaction, and consequently we believed it would help us to reduce the use of seclusion and restraint if all of our staff could apply this approach in interactions with patients.

We began a process one and a half years ago of training our staff in this approach beginning with obtaining funding to have an outside trainer train a core group of about 40 clinicians and supervisors in clinical and supervisory Motivational Interviewing skills. Subsequently that group has worked on developing training programs adapted to this setting and the types of interventions various professionals have with the individuals we serve. Approximately 150 Clinical

professionals (registered nurses, psychologists, social workers, psychiatrists, and rehabilitation staff) completed training in the use of these skills in clinical interventions and recovery services planning. The remaining staff persons who have routine interactions with the individuals we serve (Licensed Professional nurses, psychiatric aides, and admission clerks) are halfway through a six- hour course of training. All of this training has involved practical application of the skills under observation in addition to instruction.

Goal for 2012: Continue to Train staff in Level I and Level II Motivations Interviewing, assuring that implementation of MI is noted in Employee Work Profiles. Before the end of the year, meet together with the Instructors to assess the need for further modifications/changes to the program and to set additional goals.

D. Recognizing Best Practices, Recovery Heroes: Positive recognition for effective staff interactions that prevent seclusion and/or restraint

Recognition of “Recovery Heroes” began in October, 2010, with the monthly SWVMHI Employee Newsletter. This regular article gives positive recognition to a featured employee who worked on a patient-care unit and who demonstrated therapeutic interventions to successfully manage a difficult situation without the use of seclusion or restraint. A description of the event as well as a summary of the effective techniques used, along with the employee’s picture, offers employees administrative acknowledgement and appreciation. It also communicates particularly effective techniques to all employees and helps reinforce their continued use.

The Coordinator for Nursing Staff Development is the author of the articles. She seeks input from staff members and managers on the units, from the 24-hour Nursing Report, and from Significant Event Reports. She then interviews the employee as to what particular recovery concept or skill he/she intentionally used and obtains a more detailed description of the outcome as it affected the individual(s) we serve. Employees who have been recognized are excited when the employee newsletter comes out and they see they are the Hero for the month. They stop her in the hallway or call her on the phone to express thanks for the feature. Many have stated that they shared the article with their friends and families and are proud that their success was highlighted.

Recovery Hero articles have given renewed passion to the employees on the units by providing acknowledgement for the compassionate, often times stressful, work that they do. It also promotes actions to decrease seclusion or restraint by being person-centered.

Goal for 2012: Continue to run Recovery Heroes articles monthly recognizing exceptional performance of staff.

E. The Value of the Direct Service Professional Career Pathway Curriculum

The Direct Service Professional (DSP) Career Pathway has provided a mechanism in which our Direct Service Associates (DSA) have gained a rich learning environment, skill development, and gained increased competence in assisting the individuals we serve in their recovery.

Successful completion at each level in the pathway requires the DSA to demonstrate and maintain proficiency in eight competencies (Advocacy and Individual Empowerment; Communication; Community Living Skills and Support; Crisis Intervention; Documentation; Facilitation of Services; Information Gathering; and Organization Participation). These competencies are observable and measurable behaviors and have distinct progression to each level which is validated by supervisors and managers. These competencies are directly tied to excellence on the job.

One hundred and two (70 percent) of our current DSA staff have successfully completed Level I. Of the one hundred and two DSA staff, 30 percent are currently pursuing Level II, which includes taking on-line college classes. By January 2012, SWVMHI will have 18 DSAs who will have successfully completed 12 hours of college credit and competency validation. They will receive a Career Studies Certificate in Behavioral Health.

The on-line college courses for Level II include:

- **Becoming a Helper** – Concentration on effective helping relationships in assisting the individuals we serve with their recovery.
- **Contemporary Behavior Therapy** – Learning about Cognitive Behavior Therapy: coping skills; acceptance and mindfulness based on interventions, self-control, and reinforcement.
- **Looking Out/Looking In** – Learning to communicate in a principled manner. Presents communication not as a collection of techniques, but as a process to engage the individuals we serve.
- **Abnormal Psychology and Life** – Focused on a dimensional and integrative perspective toward mental disorders with emphases on reducing stigma (using clinical cases and personal narratives).

Some interesting comments from staff completing Level II that validates a paradigm shift in the culture of assisting the individuals we serve in their recovery:

*“I have a better understanding of what our clients are dealing with; we have fewer codes, more listening, and generally a calmer, more therapeutic*

*atmosphere.”*

*“I have observed staff having more patience with clients, listening and trying lots of techniques we have learned to have fewer codes.”*

*“Clients are like us, just with more problems in the end, we all are working toward recovery. I have observed staff talking with clients more, interacting more, and offering the client more choices.”*

*“I look at the individuals I serve in a different light. They are inspiring to me and make myself want to be more helpful to them. We are all different in some shape or form and we all have problems, but we must get beyond our problems in order to help the individuals we serve.”*

On- line classes for Level III will begin February 2012. We anticipate that all 18 who will complete DSP Level II will participate in Level III classes:

- **Psych 195- Topics in Pharmacology and Drug Abuse** – Provides an opportunity to explore topical areas of interest to or needed by students.
- **Introduction to Behavior Modification** – Studies the history of behaviorism and the principles and applications of behavior modification. Emphasizes observation and application of behavior modification principles.
- **Mental Health Skill Training I** –Develops skill necessary to function as a mental health worker, with emphasis on guided practice in counseling skills as well as improved self-awareness. Includes training in problem-solving, goal-setting, and implementation of appropriate strategies and evaluation techniques relating to interaction involving a variety of individual needs.
- **Intellectual Disabilities Skill Training I** –Explores current problems and social, cultural and legal issues involved in therapeutic interventions for understanding and programs relating to individuals with intellectual disabilities.
- **Human Relations** – Introduces the theory and practice of effective human relations. Increases understanding of self and others and interpersonal skills needed to be a competent and cooperative communicator.
- **Developmental Psychology** – Studies the development of the individual from conception to death. Follows a life-span perspective on the development of the person’s physical, cognitive, and psychosocial growth.

When the students graduate from Level III, they will have 36 college credit hours towards an Associate’s Degree in Human Services.

Goals for 2012: Continue to promote Levels I, II and III for staff, thus expanding the education and skills of DSA staff.

F. Health Promotion/Training in Tai Chi

Health promotion activities that benefit SWVMHI employees also benefit the individuals we serve in terms of fall reduction, pressure wound avoidance, and effective coping skills. With this in mind, an interdisciplinary workgroup from the Accident Review Committee sponsored an open house event for employees to drop in and participate in learning and applying techniques to promote a SAFETY CULTURE at work and related to patient care. This was held on September 22, 2011, and titled: “We’ve Got Your Back.”

The Open-house promoted an employee and patient safety culture by associating:

- Tai Chi education and demonstration with physical and mental health benefits,
- Stress management and nutrition application promoting injury prevention, and
- Lifting and positioning techniques through proper body mechanics and use of equipment.

Specifically relating to Tai Chi as an effective coping skill method as well as health promotion, there were demonstrations throughout the day by two certified Tai Chi instructors, Bill and Linda Pickett from Knoxville, Tennessee. Tai Chi is a slow, deliberate, flowing movement of the body. It works through improving balance, movement, breathing, muscular strength, and state of mind. Numerous positive physical and mental health aspects are promoted by Tai Chi, including fall prevention, diabetes and arthritis treatment, and building self confidence.

Other activities related to the health-care giver being more person-centered and incorporating the concepts of recovery include individualizing the use of lifting and transfer techniques, physical comfort in positioning, stress management using biofeedback and aroma therapy, and nutrition.

Almost 100 employees participated and almost 85 percent of these participants responded that they gained new information for health/safety promotions in the workplace at an “above average” ranking. The success of this event is supportive of our recovery initiatives, culture of safety, and injury prevention.

#### Incorporating Tai Chi into SWVMHI Programs

The use of Tai Chi has been proven to be effective in the reduction of stress. The practice of Tai Chi enables individuals to live in the moment and focus on moving ahead. This is a totally new approach in our facility and has captured the enthusiasm of the individuals we serve as well as staff alike. For the individual, the process of learning and practicing Tai Chi offers the opportunity for very positive and exciting interaction with instructors and other students.

Slow, rhythmic movements strengthen muscles, improve balance, and help to develop core strength and focus. Blood pressure is lowered. Improved concentration and a sense of accomplishment encourage positive interactions that will reduce the use of seclusion and restraint by allowing the individual to better process and respond more positively to difficult situations.

Goals for 2012: Plans are underway to transform two therapy groups into Tai Chi classes in January. These will be initially led by occupational therapy staff who will also provide ongoing training for other interested staff from any department.

- G. Making Medication Practices Better and Safer: Implement recommendations in approved revision of DI regarding Seclusion/ Restraint implications of administering IM medications and assess for effectiveness.
- A workgroup was formed in September 2011 that consisted of the Director of Quality/Risk Management and the Unit Nurse Coordinators to review the DI, policies, and forms related to the DI.
  - Training was developed by this workgroup and education was conducted by the Unit Nurse Coordinators with the Head Nurses and the Psychiatric Lead Aides on September 29, 2011, in a “Train the Trainer Session.”
  - All Nursing Staff were trained regarding the DI during the month of October 2011.
  - The Seclusion or Restraint Initiation and Monitoring Form Parts I and II were revised to include the section related to medications.
  - The Physician’s Seclusion or Restraint Order Form was also revised at that time.
  - Policy #3033, Emergency Use of Seclusion or Restraint, was also revised to reflect the changes as well.

### **III. Patient Welcoming & Early Intervention**

- A. Plan to re-do the Admissions Suite area

Much preliminary work has been completed by a workgroup led by Jim Lundy.

Goals for 2012 include the implementation of changes to enable the admissions process to be carried out in a more welcoming manner.

- B. Welcome Kits

Newly admitted individuals are given “Welcome Kits” that have been prepared by the ERS Community Roles group. This group stresses the importance of volunteering and gives participants the opportunity to work together, learn new

skills, and explore possibilities for volunteering once they return to their communities.

“Welcome Kits” include basic hygiene items (toothbrush, tooth paste, comb, and deodorant). They also have a stress ball, puzzle pages, and Stress Relief Tips and Strategies. There is a paper insert with a message from the Community Roles participants: *“This bag contains a few items we hope will make you feel welcome and let you know we’re here for you. We have experienced some of the same feelings you may be having now.”*

#### C. Use of Personal Safety Tool

The Personal Safety Tool was designed to be used as soon after admission as possible to give the staff an opportunity to sit one-to-one with a newly admitted individual and begin to develop a joint plan to use when and if a crisis occurs.

The components of the tool (triggers, warning signs, and crisis prevention strategies) provide a personal plan that can be implemented early on to prevent or at least lessen the severity of a crisis. The process of reviewing these areas is an early way of letting the individual know the staff is supportive and keenly interested in assisting them to avoid negative experiences. The individual identifies situations that may initiate digressing behavior and then they share the warning signs that will alert staff to begin offering alternative strategies. The strategies are specific to the individual and identify what works for them. The person may choose from the strategies listed and they may also write down other tactics that are unique to themselves.

The remaining two areas of the Tool are “Seclusion and Restraint” and “Trauma History.” These are left to the end of the Safety Tool because they may denote intensely negative experiences. This information sheds valuable light upon the past and gives staff insight as to the person’s feelings and coping ability relative to past trauma. Seclusion and/or restraint may simulate past distress and should be avoided to prevent re-traumatization.

The Patient Safety Tool is a document completed by a member of the Team within 72 hours of admission. The form prompts the individuals we serve to discuss any history of seclusion or restraints. The form also gathers information as to what might trigger an individual to be agitated and what interventions would assist in calming them down. Upon completion, the original is placed in the individual’s chart and a copy is maintained in a three ringed notebook at the Nurse’s Station for staff to access and review. It is hoped that the Patient Safety Tool will assist the individual and staff to be aware of the individualized triggers. The form also will assist staff to know what the individual’s preferences in de-escalation are, in an effort to calm them down before the crisis escalates.

#### D. Wellness Recovery Action Plans

WRAP (Wellness Recovery Action Plan) is being used across the nation as a way to help people with psychiatric disabilities to work towards and reach their goals. The WRAP is tool that uses self help strategies that compliment other treatment methods. WRAP, developed and networked by the Copeland Center for Wellness and Recovery, is the tool chosen by peer specialist in the Commonwealth of Virginia to assist the individuals we serve to meet their recovery goals.

Over the past year SWVMHI had one Peer Support Specialist working part-time with the individuals we serve to develop WRAP Plans. Last year a total of 23 WRAP plans were completed by individuals during their stay at the facility. Due to individuals, at times, being discharged prior to completion of their WRAP plans, efforts are made by our Peer Support Specialist to provide them with information upon discharge about the WRAP plans and to work to complete the more critical parts of the plan. A total of 16 individuals left with the wellness toolbox section and information to complete on their own, and a total of 31 individuals left with information on various sections of the WRAP plan such as: preventing relapse, WRAP for work and how to become a peer specialist.

Goal for 2012: Our Peer Support Specialist is now employed with us in a full-time capacity; therefore, it is our intention to increase the number of completed WRAP plans for 2012.

#### **IV. Monitoring of Individual Situations and aggregate data; and Intervention on Individual cases.**

- A. Regular participation of leadership staff at Codes, serving as role models and monitors.

It is an expectation that clinical leadership staff including nurse coordinators, programs directors and others respond to patient crises. In this manner can best practices be promoted, even in the midst of a behavioral crisis.

- B. Regular review of difficult patient situations.

Each Monday, Wednesday and Friday, leadership staff including Executive Team members and other clinical leadership review patient events. This provides an almost real-time opportunity for consultation and feedback by highly skilled individuals. Events, even if they don't result in seclusion or restraint are discussed for opportunities for improvement and safer, better patient care. Frequently leaders then meet with Treatment Team staff to discuss any concerns or difficult situations.

- C. Review of monthly data in Quality/Risk Management Committee

Seclusion and Restraint events can be traumatic to both the individuals we serve and staff. As such they are reviewed as high risk events and all S&R event data at

SWVMHI is reviewed on a monthly basis at the facility's Quality/Risk Management Committee meeting. This committee consists of facility leadership including the Facility Director, Medical Director, Clinical Services Director, Chief Nurse Executive, Director of Quality/Risk Management, and the Assistant Director for Administration.

S&R data is collected from forms completed by staff at the time of the event. Staff in the Quality/Risk Management office enters this data into the DBHDS S&R database where it is aggregated and then submitted by Central Office staff to NASMHPD Research Institute (NRI) for use as one of the indicators in the CORE Measures program. NRI then compiles the submitted data and returns to SWVMHI a report that benchmarks the facility's S&R data against both state and national data. These CORE Measures reports are reviewed at the monthly Quality/ Risk Management Committee meetings. Since July 2009 when SWVMHI first began to participate in CORE Measures data has indicated that, in the absence of any special cause variation, the facility's S&R data has been within one standard deviation of both the National and State means. In the case of restraint SWVMHI is often below the benchmark data.

Processing data in CORE measures can be time consuming and the resulting data can be 60-90 days old when reviewed by the committee. Due to this dealu, SWVMHI also reviews S&R data gathered from the previous month at each Quality/Risk Management Committee meeting. In doing this we are able to able to review data for specific individuals who may be experiencing seclusion or restraint. We are also able to analyze our supine restraint data over time by using Control Charts that display the current year's events with those of the previous two years. We then also review our S&R data on an ongoing rolling 12 month basis that displays data on a facility wide basis, and each unit. We see these data displayed in terms of S&R episodes, number of individuals who experience an S&R event, as well as the number of hours each experience. We are then able to discuss trends or other changes in the data. For example we are able to see that when we compare supine restraint use YTD in 2011 to 2010 we have seen a 50.5 percent reduction in 2011. We also then can see that in the most recent 6 months of the rolling 12 month data we have seen a 13.5 percent decrease in the use of all types of restraint and a 41 percent decrease in the use of seclusion.

D. IRC Review of Individuals having difficulty

A clinical case review is available from the Internal Review Committee (IRC) (Facility Director, Medical Director, Chief Nurse Executive, and Clinical Director with consultation with Director of Psychology) at the request of the treatment team, Unit Programs Director, Nurse Coordinator, or Executive Team member. Such consultation is recommended if there is a pattern of behavior suggesting heightened risk for adverse events, if the individual's Recovery Services Plan is not effective, or if there is a substantial disagreement among members of the individual's treatment team, including the individual that we serve, family, and/or

Community Service Board staff about some aspect of the individual's treatment or discharge planning.

E. Contingency Plans

The use of Contingency Plans has been part of our initiatives to reduce the use of seclusion and restraint for a number of years. Contingency plans are written guidelines and strategies for working with patients to prevent and manage endangering behaviors that could result in seclusion or restraint. We define contingency plans in the following manner:

**Contingency Plans:** A plan developed by the Treatment Team for patients who have demonstrated a potential for significant aggression, self injury, and/or property damage, including those whose behaviors have resulted in the use of seclusion or restraint. These plans identify the patterns of behavior that are of concern, possible triggers or predictors (antecedents) of such behaviors, and strategies for prevention and intervention to reduce the high risk behaviors, and to intervene in a manner that reduces the risk of injury to the individuals we serve as well as staff.

**Strategy and Procedures:** Contingency Plans are designed to aid all staff members in interacting effectively, safely, and therapeutically with the individuals we serve. Contingency Plans will, generally, be completed on any individual who requires seclusion or restraint, and in other circumstances at the discretion of the Treatment Team. However, in the uncommon circumstance where the Team finds that a Contingency Plan is not indicated for an individual with a previous episode of seclusion or restraint, the Team Psychologist shall discuss this finding with his or her supervisor or designee. The resulting consultation shall review the issues carefully and arrive at a plan of action designed to reduce or eliminate the need for seclusion or restraint over the remainder of the episode of care. Such a plan may include behavioral treatment interventions. Any restrictions of rights must be in accord with the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation, and Substance Abuse Services.*

F. Staff Processing after each Code

SWVMHI Policy 8000, *Behavioral Crises and Behavioral Emergencies* states that because the TOVA program places much emphasis on using a team approach in dealing with aggressive individuals, it is important to "process" with staff members involved after an event. One intent of this is to identify and reinforce what went well, so that it will be reinforced in ongoing interventions. Another intent is to identify, for that particular patient and situation, what was not successful and/or what could be improved, and to implement actions to successfully prevent or diffuse similar situations without hands-on interventions.

The Charge Nurse oversees the staff processing after the event and completes the form. This documentation is then reviewed by the Unit Nurse Coordinator and the Unit Program Director. During 2011, full implementation of a revised form took place. It condensed a two-page form into one, and added more “check-box” options so that data gathered was more consistent to aggregate and analyze. Also, the individual’s Treatment Team was added as being a recipient of this form to aid in better “real time” communication to the team of feedback from staff members involved with the event.

Data shows that a majority of high risk behavioral codes occur without resulting in seclusion or restraint. Effectiveness of codes (managing the situation without injury, seclusion or restraint) is attributed to factors such as quick intervention, a clear team leader, communication skills, and utilizing the individual’s identified coping preferences. The Admissions Unit has the highest percent of behavioral codes, which is expected, since the individuals we serve are most acutely symptomatic on this unit, compared to the other two units of individuals we serve who have most often been stabilized. A number of suggestions for individuals are implemented based on feedback from the staff processing; for example, revising a contingency plan, obtaining prn medications to be available sooner at individual request, and ensuring consistency in staff approaches.

Information from the staff processing after codes is shared at the Quality Management/Risk Management Committee. As well, the Facility TOVA Coordinator receives aggregate data from the Code Processing, from which she incorporates input to improve the TOVA training. This may be to use real-life examples, reinforce specific TOVA techniques, and/or to proactively identify problem areas and teach TOVA students how to avoid such.

Additionally, in the 24-Hour Nursing Report that is reviewed daily by Facility Administration and Nursing Management, the charge nurse enters as a “significant event” the details about any behavioral code and/or any incident that led to use of seclusion or restraint. On Mondays, Wednesdays, and Fridays, at the interdisciplinary meetings of Special Management, each incident is reviewed and assessed for further interventions or preventative techniques.

## **V. Nursing Initiatives**

### **A. Seclusion and Restraint Reduction Workgroup**

1. Members of the Seclusion and Restraint Reduction Work Group include: Jim Lundy, chair person; Diann Marshall, RN MSN, SNC; Cheryl Smith, BSN RNCB; Elaine Davis, RNCA; Gerry Moore, RNCA; Heather Shepherd, RN; Adam Anderson, LPN; and Lynn Henderson, PA.
2. The Seclusion and Restraint Reduction Work Group began meeting in October 2010. The first meeting convened on October 4, 2010, and met weekly for eight

weeks. In these initial meetings the group reviewed in detail each seclusion and restraint episode from January 1, 2010, to current day events.

Details that were discussed and evaluated were:

- unit involved,
  - specific individual served
  - specific information related to the individual's course of treatment while at the facility,
  - precipitating behaviors leading up to the seclusion and/or restraint event,
  - staff interactions before and after the event.
  - the number of episodes each individual had
  - the time of day and day of the week the event occurred,
  - staffing numbers on the shifts of the events.
  - Medications regimes and use of PRN medications prior to seclusion and restraint events
3. The group identified four areas to be addressed. These areas are:
- Improvement in communication between the individual's Team and front line staff, especially on second and third shifts.
  - Provide more intensive education for the current and new hire staff in order to begin a change in the culture and mindset of staff.
  - Provide for a quicker intervention for the individuals we serve who have repetitive seclusion and or restraint events.
  - Lastly, a thorough review of the medication ordering practices of Medical Officers of the Day and with short term contract Physicians.
4. After the initial eight weeks in December 2010, the group met bi-weekly for one month. During this period the group was divided into smaller sub-work groups. Each sub-group was assigned to assess how best to address each area identified. On January 10, 2011, the group as a whole met and recommendations by the sub-work groups were reviewed. The Seclusion and Restraint Reduction Work Group would like to make the following recommendations.
- a. Provide simple yet intensive Seclusion and Restraint reduction education to new hire employees during the Road Trip Training. It is also recommended this education be provided to all current nursing staff. The education should emphasize the use of seclusion and restraints are considered a failure in treatment. The Facility's Mission, Vision, and Values, of a restraint free environment as well as easy to recall percentages of the numbers of the individuals we serve who are admitted that have experienced sexual and or physical abuse will be discussed. The desire is to begin a cultural and mindset change among the front line staff. In the Road Trip 'Training, seclusion and

restraint reduction education was begun in the month of January, 2011, for all new hires and continues to be taught monthly. The Nursing Department leadership also provided competency training for all licensed nurses at the facility. During that training, Jim Lundy presented the seclusion and restraint reduction education to all who attended.

The Nurse Practice Committee meeting had breakout sessions with the Psychiatric Lead Aides and Head Nurses providing educational material and lecture on Seclusion and Restraint Reduction. In that same committee in September 2011, Sue Eller, LEAP/WRAP facilitator and Peer Support Specialist, presented information on the topic of Recovery from the individual's perspective entitled, "In Our Own Voice."

In March 2011, all employees were required to complete cultural competency training and education. This training provided staff with a broader understanding of cultural considerations as well as how to effectively communicate / interact with the individuals we serve.

- b. The group recommends the development of a small, rapid response team to assess an individual's plan of care who have had a seclusion and/or restraint episode. The rapid response team would consult with the Team early before the incidents of seclusion and restraint episodes rise. The group noted that between eight and ten of the individuals we serve had 67 percent of the overall number of events. It was felt that if a small, rapid response team would consult early with the treatment team before the numbers of seclusion and restraint episodes rise, it is possible many seclusion and or restraint events could be avoided.

The Internal Review Committee (IRC) was reinstated in response to this recommendation. The IRC is comprised of the Facility Director, Medical Director, Clinical Director, Chief Nurse Executive, Assistant Nurse Executive, Psychology Director, and Quality/Risk Management Director. The IRC is convened at the request either the IRC or the Treatment Teams when individuals demonstrate aggressive behavior and/or are placed in seclusion and restraints, or are not making sufficient progress in their plan of care. The IRC explores medication regimen, contingency plans, complicating factors in treatment, and discharge planning.

- c. A communication notebook should be created for staff to write questions, observations, and recommendations related to an individual's plan of care. Emphasis should also be placed on the exchange of information in the change of shift report as well as in the Team report to assure this information is

reviewed and addressed by the team. For future consideration, assign team members to rotate, altering their schedule and either come in early or stay later in order to answer questions and provide real time assistance. It is also recommended, while on duty, Treatment Team Members should make every attempt to respond to behavioral codes and when individuals on their assigned ward are in crisis.

In response to this recommendation, the Chief Nurse Executive fully implemented the SBAR method of communicating during shift report. SBAR (Situation-Background-Assessment-and Recommendation) is a nationally recognized method of enhancing communication between caregivers. SBAR was taught to all Registered Nursing staff to assure quality information is passed along accurately in shift report.

Another initiative to reduce Seclusion and Restraints via improving communication was to revise our After Code Processing form. These forms are completed immediately after a behavioral code is called. Staff are asked to complete an assessment of the event, which involves asking what went correctly and what did not. Recommendations for the Team are documented on the form by the frontline staff. These After Code Processing Forms are then routed to the Unit Nurse Coordinator, Treatment Team, Program Director, and lastly to the Chief Nurse Executive. Key findings from the forms are then presented to the Quality Management Committee.

- d. Provide for a more thorough orientation for the Medical Officers of the Day and Contract Physicians. In that brief orientation period, discuss the facility's medication administration practices and expectations for providing PRN medications when necessary. Jim Lundy has already discussed the negative impact of rapid cycling of contract Physicians on the Teams with the Medical Director and his staff to work towards contracting Physicians who will remain for longer periods. This will reduce the amount of medication changes and instability of the individuals we serve.
- e. Possible goals for 2012 include: Continue the cultural change through education and training. Improve the process of transportation of forensic individuals to medically necessary appointments and treatments outside of the facility. Implementing and expanding upon the facility's current trauma-informed care training. Incorporate Motivational Interviewing training with new employees.

#### B. Nurse Practice Committee

Nurse Practice Committee consists of Nursing Administration, Nurse Managers, Head Nurses, and Psychiatric Aides. With this key leadership, meetings include specific topics and issues related to implementation of recovery concepts as well as

promoting the facility goal of decreasing seclusion/restraint. Examples of such topics are the following:

**Nurse Practice Committee Meeting January 18, 2011**

- **Co-morbidity: Addiction and Mental Illness**

Sandy Harless, RNCA, gave a presentation based on training that she and five others attended in Roanoke, Virginia. The physiology of addiction was discussed along with references to various medications used to treat mental illness. An informative handout was distributed.

- **Caring: The Essence of Mental Health Nursing**

Robin Coleman, Psych Lead Aide, reviewed points regarding the importance of displaying “caring” with the individuals we serve with whom nurses and aides interact. She shared personal anecdotes that were inspirational.

**Nurse Practice Committee Meeting April 19, 2011**

- **Seclusion and Restraint**

Jim Lundy presented interventions to de-escalate the individuals we serve.

**Nurse Practice Committee Meeting/Psychiatric Nursign Conference May 12, 2011, Achieving Recovery in Mental Health**

- Alicia Alvarado presented Spiritual Revival for the Nursing Caregiver Assisting with Mental Health Recovery.

**Nurse Practice Committee Meeting September 29, 2011**

- **Seclusion/Restraint**

The Unit Nurse Coordinators gave a power point presentation on revision to the Seclusion and Restraint guidelines. The new DI 214, Use of Seclusion and Restraint in State Facilities, and DI 215, Use of Restraint for Secure Transport, were reviewed. Discussion was held regarding documentation, need for RN assessment, and various situations that arise. An attendance roster was signed, and the Head Nurses/Lead Aides will be Train the Trainers for this material with their workgroups.

- **In Our Own Voice**

Sue Eller, a LEAP/WRAP facilitator and Peer Support Specialist, along with

Sandy Herbert, Chair of the Regional Consumer Empowerment Recovery Council (RCERC), presented, “In Our Own Voice.” A film was shown and then each discussed their personal experience with mental illness through the stages from acute illness to recovery. These speakers were well prepared as they told their stories from the heart. It was a very emotional but eye opening presentation. We had 32 employees attend and they gave very positive remarks on the presentation.

- **Cognitive Impairments**

Night Shift Lead Aides, Lisa Sheets, Connie Surber, Janice Morris, and Terri Buchanan, with the assistance of Staffing Nurse Coordinator, Jean Powers, prepared and presented important information regarding cognitive disabilities and the difficulty individuals we serve with cognitive/learning disabilities face with solving problems. The challenges were “brought home” by an applied exercise.

C. Other Nursing Initiatives

1. The following information was ordered and received from SAMHSA:

- *Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual and Workbook*
- *A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*
- *Definition and Terms Relating to Co-Occurring Disorders – Overview Paper 1*
- *Advisory on Tobacco Use Cessation During Substance Abuse Treatment Counseling*
- *Advisory on Clients with Substance Use and Eating Disorders*

2. During the year the following information was communicated among the Nurse Managers:

- *You Let Them Do What? Decision-Making Capacity and the Exercise of Patient Autonomy in LTC*
- *Safety Culture Creates Better Care for Patients*
- *Combating Disruptive Behaviors: Strategies to Promote a Healthy Work Environment*
- *Understanding Eating Disorders and Cutting*

- *Understand the signs for suicidality*
  - *Behavior Health and Social Media- how to use social media in effective recovery plans*
  - *Two diseases, one approach? Substance Abuse and Mental Illness*
3. In July, SWVMHI admitted a transgendered individual and needed to make emergency arrangements by converting an empty office on the unit back into a patient room to accommodate the individual's need for private/personal space. Staff interacted with the individual with sensitivity.
  4. Also, during the year, a brochure was created for the ward information racks that included:
    - *Wellness*
    - *Autism Spectrum Disorder*
    - *Bipolar Disorder*
    - *Post Traumatic Stress Disorder*
    - *Dealing with Depression*

## **VI. Trauma Informed Care Initiatives in 2012**

Goals for 2012: SWVMHI plans an emphasis to become a trauma informed organization in 2012. We have applied for a SAMHSA grant for technical assistance with this process and hope to learn of our acceptance early in 2012. Regardless, staff training events will focus on this topic through grand rounds, a revision of SWVMHI practices during the admission process and a redesigned admissions space.

In addition, SWVMHI has obtained a number of DVDs that will be helpful in achieving this goal including those mentioned above, the SAMSA presentation "Leaving the Door Open" and a DBHDS DVD on recovery.

## **VII. Attachments**

- A. DBHDS DI 201
- B. SWVMHI Policy 3033
- C. SWVMHI Policy 8000