

## **Seclusion and Restraint Plan**

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

**2013 - 2014**

#### **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 developed and reviewed a Seclusion and Restraint Philosophy

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

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.

#### **I. Fiscal Year 2013 Annual review of SWVMHI Mission, Vision, Values and Leadership Philosophy**

Completed July 3, 2013, no changes recommended based on the following document:

Excerpts from the Director's Orientation to New Employees (4/19/13 version)

“Hope is one of the principal springs that keeps mankind in motion.”  
~ Thomas Fuller

#### A. Aligning the Mission, Vision, Values & Leadership Philosophy of SWVMHI

In 2006, the Executive Team reviewed facility, national, and state data and information, including information on Mission, Visions, Values, Leadership and Recovery before brainstorming these important aspects to include for SWVMHI. We also conducted a staff survey which focused on understanding our role in the continuum of mental health care and ideas for improvement of services, and a survey focusing on our understanding of recovery principles. These results were considered during a series of Executive Team retreats and study sessions.

#### B. SWVMHI Mission

Definition of Mission Statement:

- What business are we in? And who are our customers?
- Customers are ANYONE who is affected by our work.
- A mission statement should clearly identify our purpose for existing.

We reviewed a variety of Mission Statements as part of our work.

Mission - Department of Behavioral Health and Developmental Services (DBHDS):

“We provide leadership and service to implement and improve Virginia's system of quality treatment and prevention services and supports for individuals and families whose lives are affected by mental health or substance use disorders or by intellectual disability. We seek to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for individuals receiving services.”

~ DBHDS Code of Ethics 4/24/2012

#### **SWVMHI Mission**

**We promote mental health in southwestern Virginia by assisting people in their recovery.  
~ originally promulgated in 2006**

“The future belongs to those who believe in the beauty of their dreams.”  
~ Eleanor Roosevelt

#### C. SWVMHI Vision

Questions to ask about an organization's vision:

- What is and should be the definition of high performance for us? What are we trying to accomplish? What is our desired future role?
- How would we know if we were a high performing organization? How do we define the quality of our services and performance? How do our customers define high quality?
- Is our vision understood and shared by everyone at all levels of our organization? Is there passion to achieve the vision?

“Far away there in the sunshine are my highest aspirations. I may not reach them, but I will look up and see their beauty, believe in them, and try to follow where they lead.”  
~ Louisa May Alcott

Vision - DBHDS:

“Our vision is a system of services and supports driven by individuals receiving services that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of participation by individuals receiving services in all aspects of community life, including work, school, family, and other meaningful relationships. This vision also includes the principles of inclusion, participation, and partnership.”

~ Updated: 07/17/12

The President’s New Freedom Commission on Mental Health Vision Statement:

“We can envision a future when everyone with a mental illness will recover . . . .”

~ President’s New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, final report* (No. Pub. No. SMA-03-3832.). Rockville, MD: U.S. Department of Health and Human Services.

### **SWVMHI Vision**

**Southwestern Virginia Mental Health Institute, in collaboration with the Community Services Boards, will always be the region’s center of excellence in the treatment of serious mental illness.**

~ originally promulgated in 2008

- As a result, the people we serve continue their recovery from mental illness in their chosen communities and in their chosen roles.
- They leave the most restrictive treatment settings within the shortest possible time.
- SWVMHI is the region’s center of excellence for people who are most challenged by serious behavioral health disorders.
- The SWVMHI vision helps to provide structure and guidance in moving toward our goals.

### D. SWVMHI Values

Definition:

- How we want to treat each other, both our co-workers and the individuals we serve.
- What are our underlying ethical standards?
- What is our ultimate or core reason for being – our “Higher Moral Purpose?”
- What values are we going to use to guide the decisions, actions and behaviors of our organization and each of us personally while at work?

DBHDS Values:

“The mission of DBHDS is rooted in a set of core values, which represent the foundation of our work:

- Focus first on the individual receiving the services;
- Be responsive to our external and internal customers;
- Promote partnerships and collaboration;
- Maintain professionalism, integrity, and trust; and
- Be good stewards of our resources.”

### **SWVMHI Values**

**We best promote mental health in the people we serve by valuing:**

- **Communication,**

- **Honesty,**
  - **Trust,**
  - **Teamwork,**
  - **Self-initiative,**
  - **Leadership, and**
  - **Honoring day-to-day tasks.**
- ~ Originally promulgated in 2007

1. SWVMHI Value: Communication

Effective communication is an essential component of the successful functioning of SWVMHI. This is true for any fast-paced, complex, healthcare environment. Effective communication flows across units, departments, shifts, and work teams. It flows up and down through the facility, and outside of the organization to families, CSBs, and other community partners.

We must pay special attention to potential communication barriers between groups who might have different priorities and goals, and work to enhance communication.

- Employees at all levels will be engaged in the communication process.
- Communication itself is desired but not all communication is desirable.
- Effective and valued communication is clear, direct, accurate, consistent, concise, timely, inclusive, and relevant.
- The general atmosphere must support valuable communication: *we value hearing about problems for which we do not yet have solutions, as well as possible solutions for problems we do not wish to have.*
- *We strive to minimize loopholes* in communication: in the absence of information, information will be manufactured and will likely be inaccurate.
- *Knowledge is Power*: when valuable information is confined to the few, the whole may suffer, and this may result in organizational weakness.

2. SWVMHI Value: Honesty with Compassion

Honesty with compassion characterizes our interactions with others and is an essential quality of genuine, sincere, and respectful relationships. When there is a balance of respect and understanding between people, frank and open honesty is an expectation with all interactions. However, honesty alone can be cruel and not helpful in furthering the mission and values of the organization. At those times when truth presented by one to another may challenge a belief or understanding of another, it is necessary for honesty to be paired with compassion. Giving support or showing mercy in interactions with others without compromising honesty shows sympathetic concern for the perspective and the feelings of others.

- The platinum rule: *Do unto others as they would have you do unto them.*
- Honest verbal behavior: Avoid duplicity or the appearance of duplicity.
- Go the extra mile to inspire others' confidence in your integrity: Do not have ulterior motives or the appearance of ulterior motives.
- Appearances: *We have to be mindful that in our business, in our region, with our sources of funding, we have to not only be good, we have to look good.*
- Candor, caring, and integrity are required ingredients.
- Honesty with compassion is an important message with our communications.
- Praise Sandwich: Use compliment-feedback-compliment techniques whenever possible.

- Malicious obedience is to be avoided: Obeying feedback to the letter without the application of all relevant values.
- **Elbow Test: Would you exhibit the same behavior if someone were standing at your elbow?**
- *Integrity is shown by doing the right thing even when no one is looking.*

### 3. SWVMHI Value: Trust

**Trust lies at the heart of a functioning, cohesive team.**

Trust is the confidence among team members that our co-worker's intentions are good and that there is no reason to be protective or careful around the group.

In essence, teammates must get comfortable being vulnerable with one another and begin to act without concern for protecting themselves or their turf.

As a result, **they can focus their energy and attention completely on the job at hand**, rather than being worried that their motives might be misinterpreted.

Leaders must encourage the building of trust by demonstrating vulnerability first.

~from Lencioni

- Is deeply intertwined with the other values.
- It is the key to driving out fear in the organization.
- **It is slow to build and quick to destroy.**
- **Link your words to your actions always, always, always.**
- We do not promise more than we can deliver.
- **We sincerely apologize for mistakes.**
- We accept responsibility for outcomes, positive and negative.
- What we say to a person is the same as what we say about that person.
- We do not separate Caring from our Candor.
- We are generous with our benefits of doubt: we do not rush to condemn.

### 4. SWVMHI Value: Teamwork

In order for the work team to attain its goals and objectives, it is imperative that team members work together as a cohesive unit.

The team must share a common picture or vision of what each member is capable of accomplishing.

Teams will function best if there is effective communication, honesty with compassion, and trust with accountability.

- One of the key components in the organizational vision.
- We need to maximize the productivity of our limited human resources.
- Synergy is essential to maximizing productivity.
- Teamwork is essential to synergy.
- There should be a variety of teams working on a variety of problems.
- Evidence of value: team composition, leadership, and quality output.

Teamwork makes us a better facility!

### 5. SWVMHI Value: Self Initiative

We believe that there are multiple paths to recovery based on an individual's unique strengths and resiliencies as well as needs, preferences, and experiences.

In addition to the value of teamwork and working toward team goals, we want to recognize and celebrate individual initiative that meets needs through hard work and creativity.

All persons have the ability to demonstrate a recovery orientation and a positive approach through creative thinking and hard work.

- Counterbalances the value of Teamwork.
- Staff do the right things for the right reasons and ask questions or offer opinions when in doubt.
- Not knowing is less of an issue than not asking.
- Staff self-initiate but do so with personal, professional, and organizational respect for what might have already transpired.
- This requires trust/trustworthiness, passion, communication, and unselfishness.
- The bull in the china shop: check with others to see how ideas, projects, etc. might impact those around you.
- Recognize the value of your contribution and the cost of your absence.
- Desire to be accountable and seek supervisory feedback.

6. SWVMHI Value: Leadership

SWVMHI believes that creativity and the ability to lead are not limited to a few, but reside within each of us.

Given the opportunity, people at all levels can be leaders.

Each member of our staff can seize the initiative to make creative changes that benefit the people that we serve, every day.

- It is closely intertwined with the values of Teamwork and Self-Initiative.
- Leadership behavior includes being a good follower.
- It is expected but supporting our leaders is also expected.
- It is not just a function of expertise or position: **leadership can be demonstrated by fulfilling your own role.**
- Staff should be ready to identify and support leaders.
- Staff are encouraged to identify impediments to achieving our mission and work collaboratively to make improvements.

7. SWVMHI Value:

Honoring Day to Day Tasks

We want to honor those day-to-day tasks and interactions that collectively promote recovery. We all strive to treat everyone with decency, dignity, and directness. In a psychiatric hospital these qualities actually become the core of therapy and of change.

These qualities must be more than just what we do, they must be what we are.

When we live these qualities day to day, we model them as ways of being that others might follow our lead. In the most mundane or trivial interaction, we still transmit our way of being, even if in seemingly insignificant quantities.

**Atoms may be small, but no molecule can do without them; and the universe cannot do without molecules. So day-to-day tasks are the building blocks of excellence at SWVMHI.**

- This value captures concepts such as politeness, neighborliness, optimism, good manners, and leading by example.
- These fundamental tasks are the building blocks of excellence.
- We treat everyone as valued participants and every interaction as a moment of truth.
- Us vs. Them: There is no “them,” only “us.” Charting should reflect this value just like our daily interactions.

- Teachable moments: Supervisors should “catch” staff engaging in this value to provide positive feedback.
- Not engaging in this value offers opportunity for instruction and modeling.

## 8. Making It Happen!

**It is important for SWVMHI and its employees to have a clear understanding of the values we wish to drive throughout the organization.**

The SWVMHI Executive Team is SWVMHI’s ultimate champion of our Mission, Vision and values.

However, it must not begin and end at this level.

**All SWVMHI staff must learn, live, and lead the values of SWVMHI.**

### E. SWVMHI Leadership Philosophy

The Southwestern Virginia Mental Health Institute leadership philosophy promotes creativity, teamwork, and shared leadership by expecting all employees to learn, live, and lead the Values. We believe leadership can and should be demonstrated by all staff in their individual and collective roles. This leadership philosophy enables SWVMHI to fulfill its Mission of assisting people in their Recovery.

#### SWVMHI Elements of Leadership

Leaders:

- see the big picture,
- define outcomes and expectations,
- set the course,
- inspire,
- are visionary,
- serve as catalysts, and
- they are role models.

The “All Hands Work of Leadership”

- A person is a leader when he or she is functioning in the interest of values that are not local to the person, but are of some greater force of which the person is a vehicle.
- Leaders keep both the vision and the mission in mind. They hold a well crafted picture of the desired ends, referencing those ends to daily actions.
- Leaders maintain a creative tension between current realities and a preferred future.

## II. Making the experience safer, better/physical plant.

### A. Seclusion Room Modification

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. 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. 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.

It was noted that the overall blue color of the rooms could benefit from being “broken up” with the addition of another color. Painting was completed in early 2013 so that there is a clear ground and a clear wall.

#### 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 stressed, 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.

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.

New staff are oriented to this option as part of their onboarding on the units. 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.

Goal: Staff renovated and purchased equipment and supplies to refurbish the third Comfort Room on the Extended Rehabilitative Services Unit. The unit will continue to publicize their usefulness during unit meetings.

### **III. Recruitment and Retention of Qualified Medical Professional Staff**

In 2013, with the addition of three fulltime psychiatry staff, SWVMHI has now filled all medical professional slots. Now all eight treatment teams are staffed with psychiatrists, in addition to one fulltime Medical Director, two internists and two fulltime MOD. In addition, four psychiatrists applied for and were granted VDOH loan repayment funds which were matched by the facility. The facility has a medical

professional on site 24 hours per day, seven days per week for admission and other medical emergencies/urgent needs. Active peer review is conducted and meetings are held (almost) weekly. The Facility Director and others also attend these meetings to assure effective communication.

#### **IV. Staff Development & Training, Recognizing Best Practices**

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

SWVMHI staff attended training 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: 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

Goal: Continue to implement an excellent Road Trip Orientation.

#### 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 in 2010 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) have completed a six- hour course of training. All of this training has involved practical application of the skills under observation in addition to instruction.

Goal: Continue to Train staff in Level I and Level II Motivations Interviewing, assuring that implementation of MI is noted in Employee Work Profiles.

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: 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. 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 began in February 2012. We anticipate that all 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. More than 70% of SWVMHI DSAs have completed Level I and \_\_\_% have completed Level II.

#### F. Health Promotion/Training in Tai Chi

Health promotion activities that benefit SWVMHI employees also benefit the individuals we serve 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: 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

- 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: A Tai Chi demonstration and class was held for employees on September 19, 2013 at the 21<sup>st</sup> annual Family Day. Continue to enhance the Tai Chi Program at SWVMHI.

## V. 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 include the implementation of changes to enable the admissions process to be carried out in a more welcoming manner. Due to other priorities, such as being placed in the Electronic Health Record pilot program in June, 2013, this was put on hold.

### 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 two Peer Support Specialists, one fulltime and one part-time, working with the individuals we serve to develop WRAP Plans.

Goal: It is our intention to increase the number of completed WRAP plans.

### **VI. Monitoring of Individual Situations and aggregate data; Intervention in 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 delay, 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 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.

#### D. In Depth Analysis of Seclusion and Supine Restraint Episodes (CY 2012)

##### 1. Overall Data

- a. In CY 2012, 97 patients had one or more episode of Seclusion or Supine Restraint. There were 318 episodes.
- b. Note: The analysis below does not include episodes of Physical Restraint , Ambulatory Restraint, or Humane Blanket.
  - i. In the calendar year, there were 6 episodes of Human Blanket use, with 6 patients (4 episodes on Admissions: 3 on Ward A and 1 on Ward B; 2 episodes on ERS with 2 patients, one each on Wards H and J).
  - ii. There were 8 episodes of Ambulatory Restraints with 7 patients (3 episodes with 3 patients on ERS Ward J; 5 episodes on Admissions: 2 patients on Ward A with 2 episodes and 3 episodes on Ward B with 4 patients).
  - iii. Two patients (one on Ward A and One on Ward B) had episodes of both Ambulatory Restraints and Humane Blanket, for a total of 11 unique patients out of 13. Of these 11 patients, 9 also had episodes of Seclusion and/or Supine Restraint. One individual required the use of the Humane Blanket in the Admissions Suite, but did not require further intervention once he arrived on the unit.
  - iv. It is interesting to note that Admissions Wards C & D and Geriatrics E & F had no episodes of Ambulatory Restraints or Humane Blanket use.
  - v. There were 129 episodes of Physical Restraint. These episodes were often, but not always associated, with Seclusion or Supine Restraint use.

##### 2. New Admissions

- a. Of the 97 patients who had an episode of Seclusion or Supine Restraint, 30 had an episode within 48 hours of being admitted and 40 had an episode within their first week on admission.
- b. These 40 patients had a total of 149 episodes of Seclusion and/or Supine Restraints throughout their admission(s) in CY 2012.

**Seclusion & Supine Restraint Among New Admissions – CY 2012**

<b>Team</b>	<b>No. Patients with episodes within 48 hours of admission</b>	<b>No. Episodes within 48 hours of admission</b>	<b>No. Patients with episodes within 7 days of admission</b>	<b>No. Episodes within 7 days of admission</b>	<b>Total Episodes for these patients</b>
<b>Total</b>	30	47	40	99	149
<b>Admissions A</b>	8	13	11	37	50 1 Pt. had 16 eps.
<b>Admissions B</b>	4	9	5	18	19
<b>Admissions C</b>	9	15	13	31	40
<b>Admissions D</b>	7	8	9	11	38 1 pt. had 28 eps.
<b>Admissions Total</b>	28	45	38	97	147
<b>Geriatrics E/F</b>	2	2	2	2	2
<b>ERS Total</b>	0	0	0	0	0

3. Seclusion & Supine Restraint by Team – CY 2012

- a. Recall that in CY 2012, 97 patients had one or more episode of Seclusion or Supine Restraint. There were 318 episodes.
- b. SWVMHI Table:

<b>Team</b>	<b>No. Patients with episodes of Seclusion and/or Supine Restraint</b>	<b>No. of episodes</b>	<b>Range of No. of episodes</b>
<b>Total</b>	97	318	1 - 31
<b>Admissions A</b>	15	57	1 - 16
<b>Admissions B</b>	10	29	1 - 10
<b>Admissions C</b>	27	56	1 - 8
	1 pt. had 5 episodes on C then was transferred to E/F & had 2 more episodes – data <u>not</u> included here on C; A 2 <sup>nd</sup> pt. had 7 episodes on C then was transferred to ERS H &	1 pt. had 5 episodes on C then was transferred to E/F & had 2 more episodes – data <u>not</u> included here on C; A 2 <sup>nd</sup> pt. had 7 episodes on C then was transferred to ERS H &	

	had 3 more episodes – data <u>not</u> included here on C, including those 2 patients would bring the total to 29	had 3 more episodes – data <u>not</u> included here on C, including those 12 episodes would bring the total to 68	
<b>Admissions D</b>	17	58	1 - 28
<b>Admissions Total</b>	69	200	1 - 28
<b>Geriatrics E/F</b>	9 1 pt. had 5 episodes on C then was transferred to E/F and had 2 more episodes – data included here on E/F	26 1 pt. had 5 episodes on C then was transferred to E/F and had 2 more episodes – data included here on E/F	1 - 10
<b>ERS H</b>	11 1 pt. had 7 episodes on C then was transferred to ERS H & had 3 more episodes – data included here on H; 1 pt. had 1 episode on H then was transferred to J & had 1 more episode, data <u>not</u> included on H, including that pt. would bring the total to 12	70 1 pt. had 7 episodes on C then was transferred to ERS H & had 3 more episodes – data included here on H; 1 pt. had 1 episode on H then was transferred to J & had 1 more episode, data <u>not</u> included on H, including that episode would bring the total to 71	1 - 31
<b>ERS J</b>	8 1 pt. had 1 episode on H then was transferred to J & had 1 more episode, both episodes included here	22 1 pt. had 1 episode on H then was transferred to J & had 1 more episode, both episodes included here	1 - 9
<b>ERS Total</b>	19	92	1 - 31

#### 4. Comparison with National Data

a. Physical Restraint



**HBIPS COMPARATIVE STATISTICS REPORT (HAP AND BHC)**

Behavioral Healthcare Performance Measurement System

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**Southwestern Virginia Mental Health Institute (VA03)**

**Physical Restraint Overall**

NRI ID: 835 TJC ID: 14835

Measure Description: Number of hours clients spent in physical restraint for every 1000 inpatient hours, overall population.

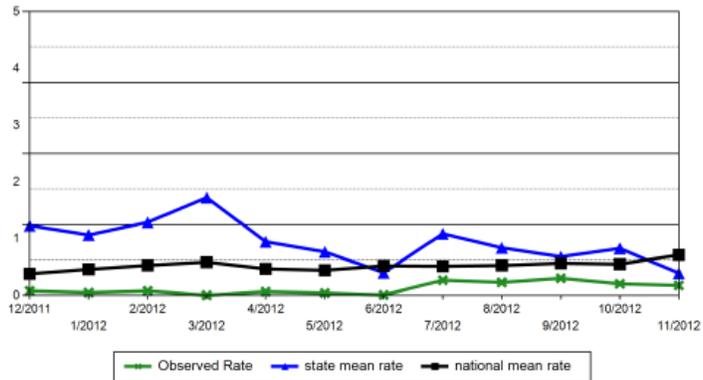
\*\*\*Means include both HAP and BHC programs

Reporting Period	Facility		State			National			
	Denom	Result	Mean	*STD	*N	+Mean	*STD	**N	++ Weighted Mean
12/2011	109344	0.08	1.23	1.81	8	0.38	0.77	184	0.46
1/2012	109680	0.05	1.07	2.10	8	0.46	0.99	177	0.61
2/2012	104664	0.08	1.29	2.34	8	0.53	1.44	177	0.70
3/2012	112032	0.00	1.73	3.20	8	0.59	1.77	177	0.73
4/2012	105912	0.07	0.95	1.65	8	0.47	1.14	177	0.61
5/2012	110016	0.04	0.77	1.40	8	0.44	0.95	176	0.62
6/2012	105168	0.01	0.40	0.56	8	0.52	1.17	175	0.68
7/2012	106752	0.27	1.09	2.02	8	0.51	1.19	172	0.77
8/2012	109704	0.23	0.84	1.33	8	0.53	1.42	166	0.69
9/2012	106392	0.30	0.68	1.10	8	0.57	1.41	165	0.75
10/2012	113208	0.20	0.83	1.33	8	0.55	1.38	138	0.69
11/2012	106768	0.17	0.39	0.61	4	0.71	1.86	93	0.74

Non-State Facilities will list a blank in state data fields.

\*STD = Standard Deviation \*\*N = Number of HCOs selecting measure +Mean is the averaged value of HCO rates.

++Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators.



b. Seclusion



**HBIPS COMPARATIVE STATISTICS REPORT (HAP AND BHC)**  
Behavioral Healthcare Performance Measurement System  
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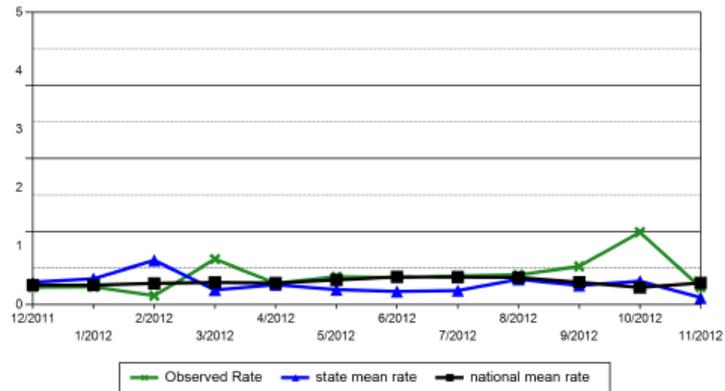
**Southwestern Virginia Mental Health Institute (VA03)**

Seclusion Overall NRI ID: 840 TJC ID: 14840  
Measure Description: Number of hours clients spent in seclusion for every 1000 inpatient hours, overall population.

\*\*\*Means include both HAP and BHC programs

Reporting Period	Facility		State			National			
	Denom	Result	Mean	STD	N	+Mean	STD	N	++ Weighted Mean
12/2011	109344	0.29	0.38	0.54	8	0.33	1.17	182	0.40
1/2012	109680	0.30	0.44	0.69	8	0.33	1.24	175	0.48
2/2012	104664	0.15	0.76	1.58	8	0.36	1.44	175	0.46
3/2012	112032	0.78	0.25	0.28	8	0.38	1.32	175	0.49
4/2012	105912	0.36	0.34	0.48	8	0.37	1.29	175	0.44
5/2012	110016	0.48	0.25	0.28	8	0.42	1.61	174	0.49
6/2012	105168	0.46	0.22	0.27	8	0.47	1.82	173	0.54
7/2012	106752	0.49	0.24	0.29	8	0.47	1.82	170	0.62
8/2012	109704	0.51	0.43	0.68	8	0.46	1.68	164	0.58
9/2012	106392	0.65	0.33	0.40	8	0.38	1.60	163	0.50
10/2012	113208	1.24	0.40	0.50	8	0.29	1.26	137	0.41
11/2012	108768	0.29	0.12	0.12	4	0.37	1.51	93	0.52

Non-State Facilities will list a blank in state data fields.  
STD = Standard Deviation    N = Number of HCOs selecting measure    +Mean is the averaged value of HCO rates.  
++Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators..



E. Internal Review Committee 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.

## F. 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.

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*.

## G. 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.

## **VII. 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. The Seclusion and Restraint Reduction Work Group made 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. Completed.

In addition, in March 2011, all employees were required to complete cultural competency training and education and annually thereafter. This training provides 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.

- 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. Goals 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.

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*

### **VIII. Court Hearing Site Change and Procedures Effective 4/12/13**

The present process in place for conducting court hearings at SWVMHI in the Henderson Building has presented some significant challenges though the years. However, the reconfiguration of space we have been working on for the last year has allowed us to relocate the hearings to the suite of rooms that once housed the school personnel associated with the Adolescent Unit (now designated the "L Hallway Conference Area") and to reengineer our court process to provide the following benefits:

- A shorter distance between treatment areas and the new courtroom space.
- Patients and staff will no longer be required to move between buildings, exposing themselves to weather related discomforts and potentially unsafe conditions.
- To conduct hearings inside the locked perimeter, providing for better safety and security of patients, courtroom personnel, visitors, and staff.

The new space, most recently occupied by the Adolescent School, has been remodeled and is comprised of:

- The L Hallway Conference Room, which will serve as the new courtroom

- Two patient/visitor waiting rooms
- One meeting room for the attorney to meet with the individual.

**IX. Trauma Informed Care Initiatives in 2012**

As part of the SWVMHI 125<sup>th</sup> anniversary celebration in the spring of 2012, SWVMHI hosted a one day conference on Trauma Informed Care. National recognized speakers included Brian Sims, M.D., Joan Gillece, Ph.D. and trauma survivor William Killebrew IV. More than 100 staff attended this presentation.

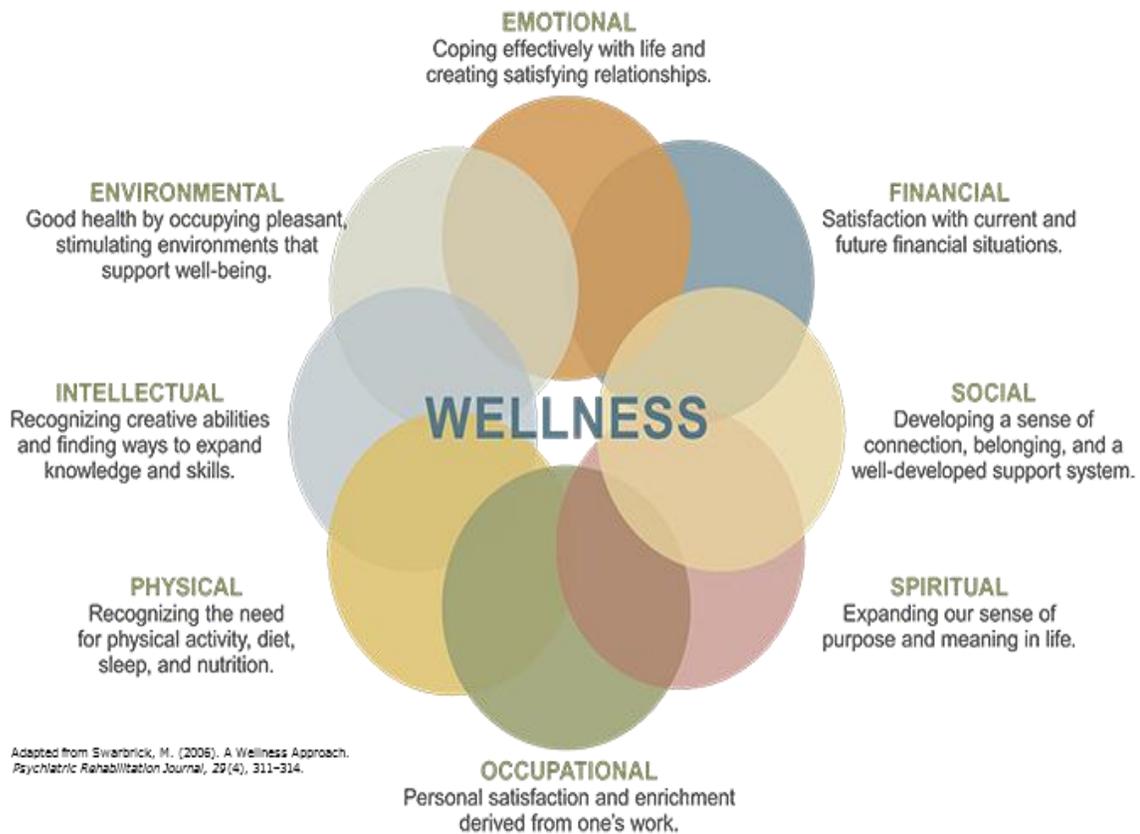
In addition, SWVMHI has obtained a number of DVDs that will be helpful in achieving this goal including those mentioned above, the SAMSA presentation "Leaving the Door Open" and a DBHDS DVD on recovery.

**X. Attachments**

- A. DBHDS DI 201
- B. SWVMHI Policy 3033
- C. SWVMHI Policy 8000
- D. Family Day handout 2013

## D. Family Day handout 2013

### The Eight Dimensions of Wellness



**Take the Pledge for Wellness to Learn More!**

Go to <http://www.promoteacceptance.samhsa.gov/10by10/dimensions.aspx>

**for more information**

### **A Holistic Guide to Whole-Person Wellness**

For people with mental health and substance use conditions, wellness is not the absence of disease, illness or stress, but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness.

Wellness means overall well-being. It incorporates the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life. Each aspect of wellness can affect overall quality of life, so it is important to consider all aspects of health. This is especially important for people with mental health and substance use conditions because wellness directly relates to the quality and longevity of your life.

That's why SAMHSA's Wellness Initiative encourages you to incorporate the Eight Dimensions of Wellness in your life.

**In Our Own Words:**



## Balance

### 1. Emotional Wellness

- I am a positive person most of the time.
- I find healthy ways to cope with stress (exercise, relaxation, social support).
- I function independently, but I know when I need to ask for help.
- I take responsibility for my own behavior.
- I know my opinions and values and can talk about them.



## iCare

### 2. Environmental Consciousness

- I spend time outdoors enjoying nature.
- I work to surround myself with others who are positive.
- I walk, bike, use public transportation, or carpool.
- I recycle, reduce and reuse.



## iLearn

### 3. Intellectual Inquiry

- I like to learn from books, television, and/or newspapers.
- I enjoy learning in my groups from staff and from my peers.
- I take advantage of opportunities to learn from the experience of others.
- I seek out ways to apply what I learn to my own life and I learn from my own experiences.
- I enjoy being creative and exploring new ways to show my talents.



## iMove

### 4. Physical Wellness

- I exercise regularly and try new types of exercise including machines, tai chi and walking.
- I eat at least 5 servings of fruit and vegetables a day and keep snacking to a minimum.
- I get 6-8 hours of sleep on average/night.
- I practice moderation in all areas of my life.
- I see a health care practitioner if I can't solve a health concern on my own.
- I manage my weight in healthy ways.



## 5. Finding Meaningful Occupation

- I manage my time effectively.
- I work effectively with others.
- I am developing the necessary skills to achieve my career goals.
- I have confidence in my job search skills (resume writing, interviewing, etc.).
- I spend a portion of my time doing volunteer or service work.
- I have a sense of purpose in my life.
- I am motivated to learn more about what my interests and abilities are.
- It is easy for me to make long-range goals about my future.



## 6. Spiritual Awareness

- I have a belief system (e.g., spiritual, atheist, religious).
- Do my decisions reflect my personal values and ethics?
- I take time for spiritual growth and development.
- I am open to experiencing new things.
- I have a good understanding of where I fit into the world.
- I use resources to improve my well-being.



## 7. Social Intelligence

- I like myself as a person.
- I interact easily with people of different ages, backgrounds, races and lifestyles.
- I connect well with others and foster healthy friendships.
- I communicate my feelings effectively.
- I maintain a network of supportive friends/family/social contacts.
- I accept of the diversity of others (i.e., race, ethnicity, religion, gender, ability, or sexual orientation).
- I give priority to my own needs by saying 'no' to others' requests of me when I need to take care of myself.



## 8. Financial Wellbeing

- I budget my funds so I do not run out of money
- I know my total amount of debt.
- I understand my sources of income and am interested in learning more.
- I know how to access help and low cost sources of clothing and assistance.

**([www.uwrf.edu/StudentHealthAndCounseling/Wellness/DimensionsOfWellness.cfm](http://www.uwrf.edu/StudentHealthAndCounseling/Wellness/DimensionsOfWellness.cfm))**