Therapeutic Communication Techniques to Reduce Physical Restraint and Seclusion in a Psychiatric Inpatient Hospital for Children

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Abstract

Restraints and Seclusions (R/S) occur often in Psychiatric inpatient settings with children being subjected to R/S at higher rates than adults and have a higher risk of injury. Its risks on both the patients and the staff include psychological and physical injuries as well as death. Understanding the use of trauma-informed therapeutic communication (TITC) in the escalation of a patient in crisis can decrease the need for R/S. With current national guideline suggesting the complete elimination of R/S with use only when clinically justified or when a patient's behavior poses a threat of physical harm to themselves and others. In this quality improvement project, the "talk me down" toolkit was implemented on all the wards in an inpatient child and youth psychiatric hospital to reduce the rate of R/S. This toolkit included staff education and use of shift change form and was based on current evidence from literature and studies on the use of the Six Core Strategies to Reduce Seclusion and Restraint. The staff knowledge of TITC was assessed pre and post-implementation using the TIC-OSAT using the paired sample t-test analysis, there was an increase in the overall knowledge scores in all 5 sections of the test when represents an increase in staff understanding of TITC. For the evaluation of the implemented toolkit, a chi-square test was utilized. The result of 43.72% (chi-square = 8.32, df = 1, and p = .004) showed very strong evidence of a relationship between the use of the toolkit and reduction in the rate of R/S. This outcome suggests that the implementation of the "talk me down" toolkit was successful at the creation of short term decline in the rate of restraints and seclusion use and provides the opportunity for a sustainable long term effect on the use of R/S at this facility as well as others inpatient facilities nationwide.

Keywords: Restraint, Seclusion, TIC-OSAT, Trauma Informed Care, Quality Improvement, Talk me down toolkit

Therapeutic Communication Techniques to Reduce Physical Restraint and Seclusion in a Psychiatric Inpatient Hospital for Children

Restraints and seclusions (R/S) are a high-risk procedure that is used as a last resort to maintain both patient and staff safety. The use of R/S has been highly debated in terms of its safety, usefulness, and effectiveness. Research studies have found that R/S are linked to poor psychological and physical patient outcomes and increased mortality rates (Kersting et al., 2019). Trauma-informed care is based on a thorough understanding of social, biological and psychological effects of trauma on children and adolescents and the understanding that R/S interventions can lead to more trauma and should be avoided (Sege et al., 2017). The Six Core Strategies are effective at decreasing the rate of R/S in inpatient settings (Azeem et al., 2017). These strategies include a focus on leadership in organizational culture change, use of data to inform practice, the inclusion of children and their families, workforce development, use of prevention tools (such as risk assessment, trauma assessment, crisis planning) and debriefing (Bryson et al., 2017). This quality improvement project focuses on the core strategy of workforce development using a trauma-informed therapeutic communication toolkit based on the Six Core strategies to reduce the rate of R/S in an inpatient psychiatric hospital.

Background

R/S has been in practice for many centuries, but its effectiveness has always been a debated topic among scholars. Since its acceptance as standard practice in the 1740s, restraints were used with the assumption that they would be beneficial to the people and will cause a change in their unruly behaviors which was not always the case. Over many decades, psychiatrists began to document their observations of patients being abused and assaulted while being restraints by attendants in response to simple gestures of defiance and verbal threats (Masters, 2017).

In the 1960s, the rise in the consumer movement in mental health and the affirmation of several cases regarding the 14th amendment to the US Constitution about the rights of mentally ill patients against incarceration and coercive treatment brought new concerns about the safety and use of R/S to the attention of the public. (Colaizzi, 2005; Masters, 2017). According to Kersting et al (2019), death was noted to be the most frequently reported harm and comprised of cardiac arrest by chest compression, cardiac arrest by strangulation in 9, and pulmonary embolism in 8 studies. Other causes include; venous thromboembolism and injuries. Injuries during physical restraint were reported in 0.8-4% of cases. The Hartford Courant's report in 1998 found that in the past decade a total of 142 patients died as a result of physical and mechanical restraints. The report noted that most of the victims were children who died from asphyxiation (Weiss et al., 1998). The United States General Accounting Office report to Congress in 1999 regarding "Improper Restraint or Seclusion Use Places People at Risk" found that children were subjected to restraint and seclusion at higher rates than adults and were at a greater risk for injury (Huckshorn, 2004). These reports led to efforts by various regulatory bodies such as the Joint Commission and the Center for Medicare and Medicaid Services (CMS), the National Association of Psychiatric Health Systems (NAPHS), the American Psychiatric Association (APA),the American Hospital Association (AHA), the American Psychiatric Nurses Association (APNA), the National Association of State Mental Health Program Directors (NASMHPD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Mental Health Association (NMHA) and the U.S. General Accounting Office (GAO) to establish guidelines for the use of R/S in a bid to curtail its use (Masters, 2017; Rucupero et al., 2011). The CMS based their guidelines on studies that had found that various factors such as the culture of the unit, treatment philosophy, staff attitudes, staff availability, staff training, staff to patient ratio and

location in the United States have a direct effect on the rate of R/S (American Psychiatric Nurses Association, 2018).

In 2007, the State of New York launched a 4-year project called PARS (Positive Alternatives to Restraint and Seclusion) sponsored by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) (Wisdom et al., 2015). PARS was based on The National Association of State Mental Health Program Directors (NASMHPD) “Six Core Strategies to Reduce Seclusion and Restraint Use” program (Masters, 2017). PARS was designed to expand the use of positive alternatives to restraint and seclusion in the Office of Mental Health programs. It emphasizes the reduction of R/S which constitutes a high risk for both patients and staff and runs contrary to the principles of patient-centered, recovery-oriented and trauma-informed care. The project was successful and was noted to reduce the rate of R/S from 50% to 80% over 4 years (Wisdom et al., 2015).

According to the American Psychiatric Nurses Association (APNA) position statement in 2001, nurses as leaders must maintain the safety of both patients and staff while providing a therapeutic milieu. This environment must help the patient to effectively manage potentially dangerous behaviors by limiting the circumstances that could lead to the use of R/S. R/S contribute to the cycle of workplace violence, which consumes about 23% to 50% of staff time, leads to 50% of staff injury, and increases the risk of staff and patient injury by 60% causing an increase in the length of patients’ hospitalization (Mental Health America, 2020). It is the mandate of organizational leadership in any healthcare facility serving different ages and populations to implement a facility individualized R/S reduction policy (Mann-Poll et al., 2018). Supporting additional staff training on trauma-informed care, implementing prevention-oriented

alternatives, and enhancing the environment of care can reduce, the cost of daily care, the rate of liability-related costs, sick time, staff turnover, hiring, and replacement costs.

Problem Statement

The use of R/S constitutes a high risk and can cause problems for both the patients and staff and should be avoided whenever possible because restraining them can cause physical struggling, chest pressure, and other breathing interruptions (United States General Accounting Office, 1999). Ethically, the use of R/S is very questionable as it affects the patient's autonomy (defined as self-rule that is free from both controlling interference by others and from limitations) and dignity and hinders their personal integrity (Darwall, 2006; Hoffmann et al., 2015). R/S should only be used in the face of imminent danger and when unavoidable. Reducing restraints is very important to nursing leadership because once a nurse is present at any R/S, they are held accountable for the safety of both staff and patients which can be very stressful for many nurses (American Psychiatric Nurses Association, 2014; Lai, 2017; Ye et al., 2019). Positive Alternatives to Restraint and Seclusion (PARS) has been implemented in all Urban/Suburban psychiatric Centers in the State of New York for children, however, various obstacles continue to hinder its use. This includes power struggle between staff and patients, paternalistic attitudes, lack of resources such as adequate staffing and limited staff knowledge in the use of trauma-informed therapeutic communication in de-escalating patients in crisis and averting the need for R/S (Carlson & Hall, 2014; Huckshorn, 2014). The Centers for Medicare & Medicaid Services (CMS) Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program developed an optional R/S tool called Hospital-Based Inpatient Psychiatric Services (HBIPS) Event Tracking Log tool used for tracking the rates of R/S. This tool calculates the rate of physical restraint by the rate of patient hours in restraint per 1,000 inpatient hours (HBIPS-2) and rate of seclusion by rate of patient

hours in seclusion per 1,000 inpatient hours (HBIPS-3) (Centers for Medicare & Medicaid Services (CMS), 2020). With increased focus in the reduction of the rate of R/S, it should be noted that there has been a significant decrease in the rate of R/S within the last decade. At the host site, the rate decreased from 0.33 to 0.06 between 2009 and 2018 (Mulder, 2010; Data.Medicare.gov, 2019). This decrease is very impressive but more work is needed as the goal of the National Association of State Mental Health Program Directors (NASMHPD) is to eliminate the use of R/S completely because its use should be seen as a facility failure (National Association of State Mental Health Program Directors (NASMHPD), 2001; 2008). The PICOT framework was utilized to form the questions that guided the literature search for this project. In a psychiatric inpatient hospital for children (P), what will be the effect of increased promotion and education of staff in the culture of trauma-informed therapeutic communication (I), compared to current practice (C) to significantly reduce the rate of Restraints and Seclusion (O) over five weeks (T)?

Purpose Statement

The primary purpose of this quality improvement project is to promote and evaluate the effectiveness of the six core strategies of trauma-informed care, particularly trauma-informed therapeutic communication in the reduction of R/S. This project aims to reduce the rate of R/S in the inpatient children's psychiatric hospital by using the "Talk me down" toolkit which consists of staff training, consistent communication, supervision, mentoring and follow up to ensure staff receives adequate knowledge of trauma-informed therapeutic communication.

Project Question

In children in a psychiatric inpatient hospital, how effective will the use of trauma-informed therapeutic communication toolkit "Talk me down" compared to current practice be in

decreasing the rate of restraints and seclusion?

Project Objectives

The objectives of this DNP project are that in the timeframe of this DNP project, the host site will;

1. Implement and promote the use of trauma-informed therapeutic communication toolkit "Talk me down" which encompasses the evidence-based practice guideline of Six core strategies of trauma informed care to reduce the rates of R/S
2. Administer an education seminar for the multi-disciplinary team to train on the use of the "Talk me down" communication toolkit to reduce the rate of R/S
3. Reduce the rate of R/S by 50% using the "Talk me down" toolkit

Significance

Current national guidelines by The Substance Abuse and Mental Health Services Administration (SAMHSA), the National Association of State Mental Health Program Directors (NASMHPD), and multiple state health departments including the State of New York have initiated a policy that requires the use of R/S to be highly monitored and regulated. The consensus from all these organizations is the need to reduce or /and eliminate the use of R/S except when there is an imminent danger for the patient or staff and when all alternative methods have been ineffective. The use of R/S has been shown by studies to negatively affect a patient's overall outcome and safety as it can affect therapeutic relationships between the patients and staff as the patient can perceive R/S as a coercive. It can also lead the patient to relive past trauma while creating new ones (Timbo et al., 2015). R/S can also lead to unintended consequences such as blunt trauma, blood clots, restricted breathing, and death. In the children population, studies have

found that children are secluded or restrained at a rate 6 times higher than adults. A study by Nunno et al in 2006 found 45 deaths recorded in children's residential facilities between 1993 and 2003 were due to physical or mechanical restraints. Children are secluded or restrained at a rate 6 times higher than adults and can affect the inpatient milieu (Furre et al., 2017). In the state of New York, the use of the six core strategies based on trauma-informed care has been efficiently utilized in reducing the rates of R/S from 50% to 80% over 4 years in inpatient and residential programs for children (Masters & Huckshorn, 2020). The success of these strategies is very motivating but due to the universally accepted negative effects of R/S, the quest for all facilities will be the total elimination of its use. However, the power struggle between staff and patients, paternalistic attitudes by staff, inadequate staffing and limited staff knowledge in the use of trauma-informed therapeutic communication in de-escalating patients continues to be a leading cause for R/S in inpatient psychiatric facilities. Therefore, to continue to significantly decrease the need to use R/S requires increased promotion and education of staff in the culture of trauma-informed therapeutic communication.

Search Terms

For the literature review, inclusion and exclusion criteria were developed for this project. Various aspects of the literature were considered, such as publication date, peer review, articles relevance to project topic and the articles reported outcomes. The studies that were included had to have a direct relation to the research question regarding the reduction of R/S using trauma-informed care in an inpatient psychiatric facility and the research outcome answering the project research question. The search was done on health-related databases which included ProQuest Central, Embase, APA Psycinfo, CINAHL Plus, PubMed and Google Scholar. The search terms utilized for the identification of important articles include “restraints and seclusion, six-core

strategies in children inpatient psychiatric center, trauma-informed care to decrease restraint and seclusion in children, ethical effects of restraint and seclusion". The inclusion criteria requirement was that articles focused on children's inpatient population for all the above search terms except for "ethical effects of restraints and seclusion" which included all inpatient age populations. Publications from 2015-2020 were considered. Studies that included restraints and seclusions in children in an outpatient setting, adults in an inpatient setting and published before 2015 were excluded. The search resulted in 482 articles and based on the exclusion criteria; it was decreased to 151 studies that were closely related to the topic and research question were selected after further review of the abstracts, topics, and data. The host site had an intranet page with resources on R/S and facility polices which was also reviewed.

Review of Literature

A literature review was conducted to identify the most significant current literature on the staff-related issues that increase the rate of R/S and the use of therapeutic communication based on trauma-informed care to reduce the rate of R/S in inpatient psychiatric facilities. The literature review also provides information from both the staff and patient perspectives on the use of R/S and problems that it can lead to especially ethical challenges. The literature highlights the six core strategies of trauma-informed care which has been proven to be effective for the reduction of R/S based on its many successes in various clinical inpatient and residential programs (Masters & Huckshorn, 2020). These core strategies form the basis for the "Talk me down" Toolkit for the reduction of R/S and its efficiency will be evaluated in this project.

Ethical Challenge of Restraint and Seclusion

The clinical use of R/S has been shown to reduce injury caused by disruptive and

aggressive patient behavior. However, it is also important to assess the ethical and emotional considerations of R/S as well. R/S has been shown to cause emotional burdens such as negative experience, depression, panic, traumatic experience to both staff and clinical staff (Zheng et al., 2020). Haugom et al (2019) examined the ethical challenges faced by clinical staff regarding patient seclusion in inpatient psychiatry settings in Norway. The study was aimed at exploring how staff members describe, assess, and perceive the ethical challenges that they encounter during coercion, including seclusion. The study was based on detailed written descriptions of 149 episodes of seclusion from inpatient 57 psychiatric wards including adolescent populations. The study utilized an exploratory and descriptive approach and data was analyzed using qualitative content analysis. The authors created a semi-structured form with an ethical aspect section based on four core ethical principles of autonomy (self-rule), beneficence (doing good), non-maleficence (do no harm), and justice (fairness in all). The form was used by clinical staff including psychiatrists, psychologists, psychiatric nurses, social workers and social educators, who were personally involved in the seclusions to provide written descriptions of various aspects of the seclusion episodes. The study found that most of the staff noted several ethical challenges between control and treatment during seclusions. With most staff struggling to balance the desire to provide a therapeutic milieu and the necessity of seclusion due to the patient's behavior. The study also showed that these ethical challenges can be burdensome for most the staff and can result in psychosocial strain. Some of the staff reported becoming tired, mentally exhausted and being afraid of the close proximity and required follow ups necessary for monitoring a patient after R/S. Staff also reported feelings of loneliness and lack of personnel resources as there were fewer people to ask questions. Haugom et al (2019) concluded that clinical staff deal with ethical challenges during seclusions which could lead to psychosocial stress.

As the professional and social debate regarding the use of R/S in psychiatric patients continues to be a challenge as its use can be used as an acceptable form of therapeutic intervention or a tool for submission and control or an emergency measure. Spinzy et al study in 2018 focused on assessing the subjective experience and attitudes of previously restrained or secluded patients in an inpatient psychiatric hospital. A total of 40 patients with psychiatric disorders were interviewed for 30minutes each, using a semi-structured four-segment questionnaire. The four sections included demographic data, subjective experience during restraint, perception of the restriction concept and assessing the influence of environmental factors in the restriction experience. The study found that 77.5% of the patients reported that the restraint evoked a feeling of loneliness; loss of freedom was reported at 82.5%. 73.6% of the patients felt that staff visits during R/S were helpful and two-thirds of patients felt the R/S was justified to the patient's dangerous behavior and another two-third felt R/S was the most unpleasant experience of the hospitalization. The study concluded that it would be beneficial for Clinical staff to listen to patients' perspectives on R/S to provide a better evaluation of the procedure (Spinzy et al., 2018).

Use of the Trauma Informed therapeutic Communication to Reduce rates of R/S

The use of the Six Core strategies of trauma-informed care (6CSTIC) in the reduction of R/S has been shown by many studies to be efficient in reducing the rate of R/S. This strategy was developed by a project sponsored by the National Association of State Mental Health Program Directors (NASMHPD). Their goal was to foster a culture of resilience, wellbeing, and recovery in all psychiatric health care facilities. The 6CSTIC was developed to reduce the rates of R/S because of its traumatic effect on the patients. The NASMHPD developed a planning tool which was designed for use as a checklist or template that guides the design of a R/S reduction plan that

incorporates the use of a prevention approach, includes the 6CSTIC strategies to reduce the use of R/S. This tool is also important as a monitoring tool to supervise the implementation of a reduction plan and identify problems, issues, barriers, and successes. The first strategy is "leadership towards organizational change" with a goal to decrease the rate of R/S by redefining and clarifying the organizational mission, care philosophy, guiding values. This guidance, participation, and ongoing review of the R/S project is the duty of the executive leadership of the organization. The second strategy involves the "use of data to inform practice" which involves using data in an empirical, non-punitive, manner. It also utilizes data to analyze the characteristics of facility usage by unit, shift day, and staff member. Other data analyzed include; identifying facility baseline; setting improvement goals and comparatively monitoring use over time in all care areas and units. The third strategy is "workforce Development" which involves the creation of a therapeutic milieu where policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on patients and the prevalence of these experiences in persons who receive mental health services and the experiences of the staff. The fourth strategy involves the "use of R/S reduction tools" and assessments to identify risk factors for violence and R/S history; use of a trauma assessment; tools to identify persons with risk factors for death and injury; the use of de-escalation or safety surveys and contracts; and environmental changes to include comfort and sensory rooms and other meaningful clinical interventions that assist patients in emotional self-management. The fifth strategy is the "consumer roles in inpatient settings" which encourages the full and formal inclusion of all patients (including past patients in recovery) in a variety of roles in the organization to assist in the reduction of R/S. The last strategy is "debriefing techniques" which are used to reduce rates of R/S by using the knowledge gained from the thorough analysis

of past R/S events and using the information gained to inform policy, procedures, and practices to avoid future repeats. It is also used to help both patients and staff and witnesses process and identify any potential traumatizing effects of the R/S (Huckshorn, 2004).

A study published in 2017 by Azeem et al. was aimed at determining the effectiveness of the 6CSTIC in reducing the use of restraints and seclusions (R/S) in hospitalized youths. In March of 2005, the staff was trained on the principles of trauma-informed care such as recovery-oriented care such as person-centered care, dignity, respect, partnership and self-management in reducing R/S as well as the avoidance of the use of judgmental terms in describing patients. The medical record was collected and analyzed from July 2004 and March 2007 based on age, gender, psychiatric diagnosis, prior admissions, ethnicity, type of admission, length of stay and number of seclusion and restraints. The study found that within the last 6 months of the study, there were only 31 R/S compared to 91 episodes found 6 months before the training. This study concluded that the implementation of the 6CSTIC in an inpatient youth in a psychiatric hospital was effective in decreasing the rate of R/S by over 50%. This article shows that the principles of trauma-informed care such as recovery-oriented care such as person-centered care, dignity, respect, partnership and self-management in reducing restraints and seclusion. It also trained staff in the avoidance of the use of judgmental terms in describing patients. This is especially relevant to this project as facility administration have expressed concerns regarding patient and family perceptions of paternalistic attitudes demonstrated by staff leading to increased patient aggressive behavior which ultimately leads to the R/S of patient.

Another study conducted by Bryson et al in 2017 was to evaluate the features that lead to a successful implementation of a trauma-informed care program, especially in child and adolescent inpatient psychiatric and residential settings. Using a modified five-stage realist system review of

peer-reviewed trauma-informed care studies. The authors examined the following interventions; Attachment, Self-Regulation, and Competency Framework; Six Core Strategies; Collaborative Problem Solving; Sanctuary Model; Risking Connection; and the Fairy Tale Model. They found that senior leadership commitment, enough staff support, amplifying the voices of patients and families, aligning policy and programming with trauma-informed principles, and using data to help motivate change were instrumental in implementing trauma-informed care across the facilities. The study concluded that the reduction or complete elimination of R/S was achievable by using specifically targeting R/S measuring in training and program policy modifications as well as by implementing broader therapeutic models.

In the state of New York, the use of the 6CSTIC has been successful in decreasing the rate of R/S since its implementation in 2007. A study by Wisdom et al. in 2015 was initiated by the New York State Office of Mental Health (OMH) called the Positive Alternatives to Restraint and Seclusion (PARS) project. It was implemented to use alternatives to restraint and seclusion within state-operated and licensed inpatient and residential treatment programs serving children with severe emotional disturbances. The project was focused on children's facilities because previous statistics had shown that pediatric patients in OMH facilities were five times more likely to be placed in R/S than adult patients. The project incorporated the standards set by the Joint Commission (TJC), The Center for Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD), which all promote a reduction in the use of restraint and seclusion in programs for people in mental health programs. It was aimed at the elimination of the use of restrictive interventions throughout the state's mental health system of care by creating coercion- and violence-free treatment environments governed by a philosophy of

recovery, resiliency, and wellness. Three OMH facilities with the highest rate of R/S were recruited for the study. The data provided by the facilities through the New York State Incident Management and Reporting System (NIMRS) was analyzed using linear regressions which were measured the rate of R/S episodes per 1,000 client-days against time (2007–2011) in order to find out if there was a decrease during the PARS implemented period. The study also collected qualitative data from notes from facility consultations, steering committee reviews, site visits and conference calls with OMH, and site reports. Basin qualitative theme analysis methods were also used to identify lessons learned from the project. The program involved setting up committees for leadership oversight, the training, implementation, and engagement of facility staff using the 6CSTIC to Reduce the Use of Seclusion and Restraint. The study showed significant decreases in restraint and seclusion episodes as well as improved communication between management and staff and staff and patients.

Controversies

The use of R/S continues to be controversial as some have argued that not using R/S will result in an unsafe environment for the patient or others in a facility setting. However, the process of retraining or secluding a patient can also cause injury to staff and patients as the patient and the staff may not agree on what the patient's needs (Al-Maraira & Hayajneh, 2018). In children inpatient psychiatric facilities, it is used as a last resort as it sometimes is unavoidable due to increased aggressive behavior and risk of imminent danger. It is a practice that studies have shown to affect both patient and staff. For the nursing profession, it a practice that affects the core ethical principles that we stand for and causes ethical challenges for nursing staff as they are responsible for both auxiliary staff and the patients.

Current Recommendations

It is essential to provide staff with the training and tools needed to provide care to patients in a safe and therapeutic environment. The use of Trauma-informed communication based on the 6CSTIC has been proven to be effective in decreasing the rate of R/S in the children's psychiatric population. Modifications of the same strategies have also been proven to significantly reduce the rates of R/S as well but in the adult population. The study by Bryson et al in 2017 recommended the modification of the core strategies to fit each facility's patients and staff needs. A non-randomized study by Duxbury et al in 2019 in England, utilized facility modified version of the 6CSTIC called " REsTRAIN YOURSELF" to reduce the rate of R/S in 7 adult acute psychiatric wards by an average of 22% with some wards having as much as 80% reduction (Duxbury et al., 2019). It is important to assess and identify specific activities that have been noted by staff to be effective in facilitating an open and respectful therapeutic communication between staff and patients. Involving staff in policy decision making leads to their empowerment and commitment to the policy. Therefore, this project hypothesizes that training and providing staff with necessary therapeutic communication "Talk me down" tool kit will help in reducing the rate of R/S by 50% at the host site. Achieving this goal will lead to improved patient and staff satisfaction with care provided, reduction in injuries, decreased medication use, shorter admission periods, reduced staff turnovers and absenteeism (Duxbury et al., 2019).

Theoretical Framework

For this quality improvement project, the Kevin Lewin's change management theory (1951) will be utilized. Kurt Lewin is recognized as a pioneer in group dynamics and organizational studies (Craig & Hollingshead, 2016; Papanek, 1973). He developed his change theory to identify and evaluate factors and forces that can impact a situation. He encourages the rejection of old knowledge and replacing it with new information (Burnes, 2004). Lewin's model

of change theory is comprised of 3 stages (unfreezing for the assessment and ensuring need for change; change/Moving for the implementation of the change and refreezing for the sustenance of the change (See Appendix A) (Cummings et al., 2015). He used this model to identify and examine the factors and forces that influence a situation (Wagner, 2018). The theory requires leaders to reject prior knowledge and replace it with new data. He believed that if the potency of forces could be identified and determined, then it becomes easier to know the forces that should be lessened or reinforced to realize change (Burnes, 2004; Wagner, 2018).

Historical Development of the Lewin Theory of Change.

Kurt Lewin (1890 to 1947) is widely regarded by change management scholars as a great asset and irreplaceable contributor to the field of change theory (Schein, 1988; Sonenshein, 2010). He is widely recognized as the intellectual founder of the contemporary theories of behavioral science, planned change, and action research (Burnes, 2004). Lewin's focus on concept and importance of change stemmed from his wider social concerns for social conflict resolution. He theorized that learning was the fundamental element for resolving social conflicts, such as those noted during World War I. He felt learning would enable people to change their views through fresh understanding, thus facilitating a resolution (Burnes, 2004; McGarry et al., 2012).

Lewin's work is composite, his change theory is made up of 4 conceptual theories under the comprehensive notion of a “planned change” even though currently the fourth theory (Three-step model of change) is widely discussed as a standalone theory. Lewin felt that these theories were interrelated and essential parts to any change agenda at any level including personal, group, organizational, or national (Szabla et al., 2017; Wright et al., 2017). These theories include: the field theory (the 1930s) which deals with individuals, their surroundings and situations that affect

them; the group dynamics (1944) which states that the dynamics of any group is a determining factor in how they respond to certain forces and how the manipulation of these forces could result in desired changed group behavior; action research theory (1946) which stated that for a change to be effective, it must be a result of both collaboration and participation processes within the group level and three-Step model of change (TSC) (1947) which discussed social change (Burnes & Seel, 2012; McGarry et al., 2012; Stivers & Wheelan, 2012). Lewin hypothesized that social change was a force field change and recommended that the change agent thinks in terms of how the current force field level can be turned into the desired state. He stressed that a planned change occurs when the force field equilibrium at Level L1 was replaced by a new equilibrium at the desired Level L2 (Burnes & Bargal, 2017). Lewin's hypothesis suggests that individually or in a group, people are impacted by limiting powers, or hindrances that counter driving forces aimed at maintaining equilibrium, and the driving force, or a positive force for change that push in the direction that makes change occur. He theorized that the tension between the driving and restraining force maintains equilibrium (Stouten et al., 2018). He stated that for an organization to change the status quo in order to effect a planned change, it was important to use his three-step model which consisted of; unfreezing (creating problem awareness), Changing/moving(seeking alternative) and Refreezing (integrating and stabilizing a new system equilibrium) (Burnes, 2004 ;Wojciechowski et al., 2016)

Applicability of Theory to Current Practice

Quality improvement in patient care can be difficult to implement, especially, if the proposed change requires complex modifications in clinical routines, change in patient's behavior, improved collaboration among disciplines and change in an organization's practice culture (Grol, Bosch, Hulscher, Eccles, & Wensing, 2007). Lewin's TSC has been shown by many research

studies to be very effective and commonly used change theory for the various quality improvement clinical nursing projects. His theory identifies a complete framework processes for change application and he stressed that each level must be successfully addressed prior to moving to the next process (Wojciechowski, Pearsall, Murphy, & French, 2016).

Lewin's TSC has been used in social sciences and organizational development. A review of the literature also shows that this theory has been successfully using in clinical nursing practice, nursing research, nursing education, health care operations, and educational administration. Lewin’s TSC structure and processes (framework) have been found to be effective in the avoidance of common pitfalls that prevent the successful implementation of a planned change thus can be effectively utilized as a change guide (Shirey, 2013).

Vejar, Makic, & Kotthoff-Burrell (2015) utilized Lewin’s TSC as a framework for their quality improvement project on improving medication management in a geriatric primary care practice to reduce the risk of adverse drug events in this population. Utilization of the theory framework including provider, staff, and patient education led to improved medication management which significantly improved patient safety and the care quality in the clinic. Tappen et al. in 2017, also utilized the Lewin’s TSC in the successful implementation of the Interventions to Reduce Acute Care Transfers (INTERACT) in 71 nursing homes to improve acute change management, reduce unnecessary Emergency Room visits and hospitalization of nursing home patients.

Lewin’s TCS is important in the understanding of the shaping and growth of an organization in response to a new behavior such as a change in policy based on evidence-based practice of individuals who work or live in these organizations (Burnes, 2004).

Kurt Lewin's Three -Step model of change

Lewin's TSC consists of 3 steps. These steps include**;** (a) unfreezing (when change is needed), (b) Moving (when change is initiated) and (c) refreezing (when equilibrium is established) (Mitchell, 2013).

Unfreezing Stage

In the TSC first stage involves the "unfreezing" of the present culture or habits. Lewin suggested that to achieve this, that it was important to break open the self-righteousness and complacency shell. He stated that to change behavior and attitude, one needed to be stirred up emotionally and experience repressed emotions (agitate the status quo or equilibrium state). This stage is very important if resistance is to be overcome and adherence achieved (Ana, Hawkes, Ancc, & Hendricks-Jackson, 2015; Burnes & Bargal, 2017). There are 3 methods that can be used to achieve unfreezing. The first method involves increasing the driving force that directs the behavior away from the existing equilibrium or status quo. The second method involves decreasing the restraining forces that negatively impacts the movement from the existing status quo. The third method includes a combination of the first 2 methods. Some activities that can assist in the unfreezing step include; motivate participants by preparing them for change, build trust and recognition for the need to change, and actively participate in recognizing problems and brainstorming solutions within a group (Kritsonis & Hills, 2005; Stowell, West, & Howell, 2012).

Change/Moving Stage

According to Lewin, once change/ movement has begun, trial and error are permitted by the organization around the new practice and people become guided by the new social norm as more people are seen performing carrying out the practice. This leads to more acceptance of the practice and resistance fades or declines (Manchester et al., 2014). In this stage of TSC, it is

important to attain a new level of equilibrium by moving the target system. Some steps that can help in this step include: employee persuasion to realize that current status quo was of no benefit to them and encourage then to analyze the problem from a new point of view, encouraging team effort on the quest for new and relevant data and finally connecting the views of the group to powerful and well-respected leaders that are in support of the change (Kritsonis & Hills, 2005; Stowell, West, & Howell, 2012).

Refreezing Stage

At this stage of TSC, the new practice has caused a change in the organizational setting, coercing it to accommodate socially and procedurally. This point is very crucial as the continued reinforcement for the new practice increases the chances of sustaining it. The organization could revert to the previous status quo found at the beginning of the project if it fails to acknowledge the new practice normalcy (Manchester et al., 2014). The refreezing process helps in the stabilization of the new equilibrium attained through the change, thus creating a balance between the driving and restraining forces. Continues reinforcement and institutionalization of the new practice through formal and informal mechanisms such as policies and procedures (Kritsonis & Hills, 2005; Stowell, West, & Howell, 2012).

Theory Application to the DNP Project

For this project, the unfreezing stage will be achieved by the destabilization of the normal culture which currently is the use of the New York State Restraint and seclusion reduction program Positive Alternatives to Restraint and Seclusion (PARS). Through assessment, it has been identified that this program though proven to be effective, was not being correctly utilized during patient crisis or behavior escalation. Lewin's disequilibrium was achieved by discussions with the project stakeholders and pointing out the improper practice culture noted during episodes

of R& S, especially the lack of use of trauma-informed communication and the noted power struggle, and paternalistic attitude of the staff. To initiate change the stakeholders will be educated on the importance of trauma-informed care and their understanding of its use will be evaluated. Stakeholders will be provided information on current practices at the host site in comparison to best practice guidelines. Charge nurses will be bought in to reinforce the use of the importance of trauma-informed communication skills found in the “Talk me down” toolkit. The promotion of the driving force will create momentum, which can be met by resistance by stakeholders that questions its importance or value. Through open communication and analysis based on evidence-based practices, the “Talk me Down” tool kit will be accepted by stakeholders as it can help achieve the desired goal of the facility which is reduced rates of R/S.

For the Change/Moving stage of this project, the “Talk me down” toolkit use will be implemented to reduce the R/S with staff encouraged to utilize trauma-informed communication during behavioral escalations to avoid R/S. At this stage, there will be continued enforcement of the use of the “Talk me down” toolkit as modeled by the charge nurses. There will be allowances for trial and error by the host site and staff will begin to accept the tool kit as a new norm and continue to use it more often. As the positive effects are noted with continuous use, the staff will become more invested in its use, and resistance will decline.

In the final stage of Refreezing for this project, the use of the “Talk me down” toolkit, will positively have affected the rate of R/S at the host site and through the trials and error noted in the last stage, adjustments will been made and accepted by staff which creates a new equilibrium. The Refreezing stage will be attained with the R/S policy modification at the host site. Charge nurses will continue to reinforce the practice to avoid reverting to old practices. There will be refresher educational classes provided for continued promotion of its use.

Setting

The project site is Children and Youth inpatient psychiatric Hospital located in Ogdensburg, New York and is part of the State-owned health system which was established in 1890. The site is a 27-bed psychiatric inpatient hospital. The patient population is made up of children only with ages ranging from 4 years to 17 years. Approximately 25 patients are admitted monthly and a total of about 285 patients admitted yearly. This facility uses an electronic health record program called MHARS.

Population of Interest

The population of interest for this project is the medical staff at the host site. They include six registered nurses and twelve Mental Health Therapy Aides (MHTA). The above-mentioned staff all work full time at the hospital. The inclusion criteria are all direct patient care medical staff at the facility. Medical and nursing students were excluded from participating in the project because of not being employees of the hospital.

The indirect population of interest are the patients admitted to thus 27-bed psychiatric inpatient hospital and the treatment team which consists of the treatment team leader, providers (psychiatrist, NP, and PA), social workers, social worker assistants, recreational therapy aides, psychologist and teachers. The treatment team provides support to nurses and the MHTA during a code and will benefit in training on the therapeutic tools too.

Stakeholders

The main stakeholders for this project are the management team of the facility. The management treatment team includes the deputy director, clinical director, and nurse administrators, who will help in the promotion and support of the implementation to ensure

success. The nurse administrators will also continue to be champions for the program and approve the change of shift form that will be in the “talk me down” tool kit. The management team will help with continuous promotion and support during the project implementation phase and policy update approval if the project is successful (Aarons, Ehrhart, Moullin, Torres, & Green, 2017). These tasks are essential as leadership in organizational change is the first strategy of the 6CSTIC and requires organizational leaders to take an active and visible role in the implementation process (Andrassy, 2016; Black et al., 2020; Riahi, Dawe, Stuckey, & Klassen, 2016). Studies have shown that many organizations have been successful at reducing the use of R/S with strong leadership commitment (Wieman, Camacho-Gonsalves, Huckshorn, & Leff, 2014). The management team has given permission for this project to be carried out at this inpatient hospital.

In addition to the management team, all medical staff especially nurses and MHTAs’ who provide direct patient care are also important stakeholders. These staff actions will have a direct effect on the success of this project; therefore, it will be essential to develop a good rapport before the implementation of the project by consulting with staff on this project topic and getting their feedback on the intended change and implementation (Jones & Van de Ven, 2016; Kaufman, 2011; Mdletye, Coetzee, & Ukpere, 2014). Staff engagement has been validated by many studies as an effective way to reduce resistance to change at the early stages of the change initiative and leads to implementation success (Jones & Van de Ven, 2016). This will be achieved by the project leader's presence at the site to build rapport with all stakeholders by answering questions, providing education, clarifying directions, attending meetings, and providing support as needed. The nurses will use, promote, and enforce the use of therapeutic tools. The MHTA will utilize the therapeutic tools in their interactions with patients to deescalate behaviors by identifying pre-warning signs and triggers.

Intervention

This DNP project has a 5-week implementation timeframe and will be conducted in a children and youth psychiatric inpatient Hospital. Approval for this project at this host site was received from the facility clinical director (Appendix B). The project intervention will start with the chart review of 27 patient charts 5 weeks before the first day of implementations of the "talk me down" toolkit. The data will be collected from the facility Treatment Team leader and the information will not contain any patient personal information or identifiers. This review will be to determine the number of patient restraints and seclusions within that past 5 weeks. In the first week of the implemented of the project, the project Lead will educate and train staff using PowerPoint presentations and flyers at the Facility conference room on the "talk me down" toolkit which consists of education on trauma-informed therapeutic communication and use of a shift change form (developed by the project Lead and approved by the nursing administration department) to assist staff in identifying each patient trauma history as well as triggers and de-escalation techniques that have worked in the past. Staff current understanding and utilization of trauma-informed therapeutic communication will be assessed using a pre-implementation Trauma-Informed Organizational Self-Assessment (TIC-OSAT).

In the second week, the Project Lead will monitor staff utilization of "talk me down tool" by: reviewing the nurses and MHTA's 24-hour logbooks to ensure shift change form proper use per shift; by daily leadership walk around on the wards and observing staff interactions with the patient and provide teaching and encouragement if needed. This week activity will also include reviewing the daily implementation process report and receiving debriefing report from the nurses on the wards as well as providing retraining if needed. The Project lead will also attend weekly huddle meetings with all staff to discuss the implementation progress and retrain staff as needed.

The third week will comprise of improvement workshop, huddles, mentoring, and coaching for both nurses and staff and review of daily report and debriefing of nurses on the ward. The fourth week will include the performance challenge of staff without training or mentoring; however, the Project Lead will continue leadership walk around to observe staff compliance with the use of “talk me down” toolkit. This will allow the Project Lead the opportunity to observe staff utilization of the “talk me down” toolkit.

Finally, in the fifth week, the post-implementation Trauma-Informed Organizational Self-Assessment (TIC-OSAT) will be administered to staff. Data will also be collected on the number of R/S within the 5-week implementation period. All collected data will be analyzed during week 5.

Tools/Instrumentation

This project will utilize the Trauma-Informed Organizational Self-Assessment (TIC-OSAT) (Appendix C), St. Lawrence Psychiatric Center Clinical Services Policy & Procedure Manual “Restraint/Seclusion Policy (Appendix D), the “talk me down” toolkit (Appendix E and F) for implementation and the “talk me down” project chart review forms (Appendix G).

Trauma-Informed Organizational Self-Assessment (TIC-OSAT)

Trauma-Informed Organizational Self-Assessment (TIC-OSAT) (Appendix C) is an organizational assessment tool that allows organizations to assess their progress in implementing practice change initiatives and it is based on the SAMHSA’s principles of trauma-informed care. The TIC-OSAT has shown the strongest internal consistency reliability for the overall tool (0.86) and 0.84 for the knowledge section, 0.74 for the attitude section, and 0.78 for the practice section (King, Chen, & Chokshi, 2019). This tool was validated through a trauma expert review by the New York State Trauma-Informed Network and the Coordinated Care Services, Inc. (CCSI)

(Conover, Sharp, & Salerno, 2015; Kinoglu, Nelson-Dusek, & Skrypek, 2017; Unick, Bassuk, Richard, & Paquette, 2019). The tool was developed by New York Coordinated Care Services Inc. (CCSI) and is free with no permission required for use. The TIC-OSAT uses a Likert type response format ranging from (strongly disagree), (disagree), (Do not know), (not applicable), (agree), and (strongly agree). It will be utilized to assess staff understanding of Trauma-informed therapeutic communication pre and post-implementation.

Restraint/Seclusion Policy

The St. Lawrence Psychiatric Center Clinical Services Policy & Procedure Manual "Restraint/Seclusion Policy" was developed by the New York State Office of Mental Health (Appendix D) and is based on the Six Core strategies of trauma-informed care (6CSTIC). The 6CSTIC is reliable and has been validated by several studies (Bryson et al., 2017; Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2017; Muskett, 2013). The reliability of the 6CSTICS was established by the National Association of State Mental Health Program Directors (NASMHPD) with a pilot project (eight studies across the country) in 2004 using the Inventory of Seclusion and Restraint Reduction Intervention (ISRRI) tool. The studies found a 79% reduction in seclusion and restraint hours, and a 62% reduction in the number of service users requiring seclusion and restraint (Huckshorn, 2004). An inter-rater reliability study by Wieman, et al, in 2014 using the ISRRI tool in 43 faculties across the country found a 17% ($p=.002$) in the rate of patients secluded and seclusion hours also reduced by 19% ($p=.001$). The rate of restraints reduced by 30% ($p=.03$) and reduction in restraint hours by 55%. The National Registry of Effective Programs and Practices in 2012 approved the 6CSTICS as an evidence-based practice framework that guides efforts toward preventing R/S based on the results of a five-year, eight-state research project (National Association of State Mental Health Program Directors, 2014). This tool does not require

permission to use and the OMH website allows free use of its tools for OMH employees.

“Talk Me Down” Tool Kit

The “Talk me down” toolkit consists of a Shift change form (Appendix E) and educational PowerPoint presentation/printed PowerPoint handouts (Appendix F) and will be utilized by staff to reduce the use of R/S. The shift change form was developed by the Project Lead with approval from the Nursing Administration department. The educational PowerPoint/printed PowerPoint handouts were created by the Project Lead and includes information on trauma informed care from the free R/S resources from the OMH website. These tools were reviewed and approved for content relevance by the stakeholders at the host site and by the project team.

“Talk me down” Project Chart Review Forms

The “Talk me down” project chart review forms are used to organize the project chart reviews to show a clear path to data collection for the analysis of the pre/post-implementation survey and the number of R/S 5 weeks before and the 5 weeks during implementation. These forms were reviewed and approved for use by the project team.

Study of Interventions/Data Collection

The project lead will collect retrospective data on the rate of R/S in the past 5 weeks pre-implementation of the “talk me down” toolkit as well as 5 weeks post implementation. This data will be collected from the facility Treatment Team leader, who complies this data weekly as part of the State of New York mandated monitoring of the rate of R/S at each state-owned facility. This data will not contain any patient information or identifiers. This review will be to determine the number of patients that were restrained or secluded 5 weeks before and 5 weeks after implementation of the “talk me down” toolkit. Staff will also complete the Trauma-Informed Organizational Self-Assessment (TIC-OSAT) pre and post implementation of the project. This is

to assess staff current understanding of trauma informed therapeutic communication and current practice culture at the hospital. This will also identify any areas of resistance or difficulties staff might have, such as limited staffing and lack of organizational support that might be a hinderance to the successful implementation of the "talk me down "toolkit. Privacy for staff participants will be maintained as no identifying information will be collected. The project lead developed an audit tool called the "Talk me down" Project Chart Review Forms (Appendix G) which will be used for the analysis of the collected data. Each participant will be given a random code known by them and the project leader only. This will guarantee confidentiality when participants complete the pre and post TIC-OSAT.

Ethics/Human Subjects Protection

The "talk me down" toolkit project is a quality improvement (QI) project and does not require IRB oversight according to the Touro University Nevada Institutional Review Board (IRB) determination form. For the host facility, a determination form was sent to the New York State Nathan Kline Institute/Rockland Psychiatric Center Institutional Review Board, which determined to be a "Not Human subjects Research" and no IRB permission was required. However, the Collaborative Institutional Training Initiative (CITI) program modules were completed by the Project Lead before the commencement of the project. Attendance for the educational training for the TIC-OSAT questionnaires were not conditional for continued employment. No monetary compensation will be provided to participants. To maintain patient and staff confidentiality, no identifying data will be collected. Health Insurance Portability and Accountability Act (HIPPA) laws and regulations will be observed in the security and privacy of patients' health information. Data will be analyzed and reported only in the aggregate. All data will be stored in a secured file cabinet and a flash drive with only the project lead will have

access. This data will be destroyed three years after the project completion.

Measures/Plan for Analysis

This quality improvement project will utilize inferential statistical analysis for the evaluation of the effectiveness of the use of the "talk me down" toolkit in the reduction of the rate of R/S in an inpatient psychiatric hospital. The Statistical Package for the Social Sciences (SPSS) version 27 will be used for data analysis. The first assumption is to assess if there is a change in the level of understanding of staff in the use of therapeutic communication techniques to reduce the rate of restraints and seclusions. This will be assessed by administering the pre and post-implementation TIC-OSAT (Appendix C). The data will be collected using the "Talk me down" Project Chart Review Forms (Appendix G) and results will be measured and compared utilizing a paired samples t-test. This is because paired samples t-test is used when there is a need to differentiate between two variables for the same subject and the two variables are separated by time (Howell, 2017). The difference in the scores from both the pre and post-implementation TIC-OSAT will show the increase in knowledge and understanding of the staff on trauma-informed therapeutic communication and current practice culture at the hospital.

The efficacy of the educational interventions and the use of the "talk me down" toolkit will be evaluated using the Chi-square test to assess the rate of R/S in the 5 weeks before the implementation of the intervention compared to the percentage at week 5 of the implementation. The data will be collected using the "talk me down Review form. The assumption is that the rate of R/S will be reduced by at least 50%. A chi-square is effective in testing whether the observed proportions for a categorical variable differ from hypothesized proportion (Gau, 2019). The assumption for the Chi-square test is that the difference between the expected rate of R/S and the observed rate of R/S will show that there is a significant relationship between the reduction in the

rate of R/S post-implementation and the use of the “talk me down” toolkit (Sun & Yu, 2016). This will confirm the effectiveness of the “talk me down” toolkit in reducing the rates of R/S.

Analysis of Results

This DNP project developed a “Talk me down” toolkit which was based on evidence-based guidelines of the 6CSTIC to reduce the rate of R/S. The clinical question that this project aimed to answer was: “In children in a psychiatric inpatient hospital, how effective will the use of trauma-informed therapeutic communication toolkit “Talk me down” compared to current practice be in decreasing the rate of restraints and seclusion? The “talk me down” toolkit consists of a Shift change form (Appendix E) and educational PowerPoint presentation/printed PowerPoint handouts (Appendix F) on trauma-informed therapeutic communication (TITC). The project consisted of 2 assumptions; firstly, to assess for the change in staff knowledge and understanding of the use of TITC to reduce the rate of restraints and seclusions based on the efficacy of educational training intervention. This was assessed using the TIC-OSAT (See Appendix C) and the reduction in the rate of R/S by at least 50% post implementation of “talk me down “toolkit.

TIC-OSAT Pre and Post Implementation Test Knowledge Scores

To assess for efficacy of the educational training, the TIC-OSAT was administered to 18 nursing staff members (8 registered nurses and 8 mental health therapy aides) twice during the implementation period. First assessment was before the educational training (Pre-implementation) and then the last week of implementation (Post Implementation). The TIC-OSAT consists of five sections. Section I “Supporting Staff Development” is made up of 29 questions about staff's current understanding of Trauma and Trauma-informed care. Section II, “Creating a Safe and supportive Environment” is made up of 51 questions on the safe physical environment, creating a supportive environment, cultural competence, patient privacy and confidentiality, safety and crisis prevention planning written crisis prevention plans, communication techniques, and consistency

and predictability. Section III “Assessing and Planning Service” is made up of 36 questions on Patient intake assessment, treatment goals, and planning and offering trauma specific interventions and services. Section IV consists of “Involving Consumers” which is made up of 9 questions about involving current and former consumers in programming and finally, Section V “Adopting Policies” which has 10 questions creation and review of policies. The TIC-OSAT uses a Likert type response format with scores ranging from (strongly disagree=2 points), (disagree=3 points), (do not know=1 point), (not applicable= 0 points) (agree=4 points), and (strongly agree=5 points). Data collected from both tests were used to create a *tic-osat.sav* spreadsheet with scores of each section analyzed separately. The difference in means of the 10 variables in *tic-osat.sav (pre_test1,pre_testII, pre_testIII, pre_testIV, pre_testV* and *post_testI, post_testII, post_testIII, post_testIV and post_testV)* measuring pre-education and post-education total scores of each of the 5 sections were analyzed using a paired samples t-test. The results of the pre- and post-implementation TIC-OSAT is found below in Table 1.

Table 1
Paired sample t-test results for tic-osat.sav data

Test Section	Difference in Mean	t (Test Statistic)	df (degree of freedom	two-tailed P-Value	Significance Level

pre_test1 and post_testI	-12.92778	-6.798	17	.000	Significant
pre_testII and post_testII	-6.26667	-1.825	17	.086	Not significant
pre_testIII and post_testIII	-11.48889	-7.753	17	.000	Significant
pre_testIV and post_testIV	-2.52778	-1.643	17	.119	Not Significant
pre_testV and post_testV	-5.16111	-4.741	17	.000	Significant

Note: Total number of staff = 18

An illustration of TIC-OSAT Scores pre and Post Training and education is provided in Figure 1.

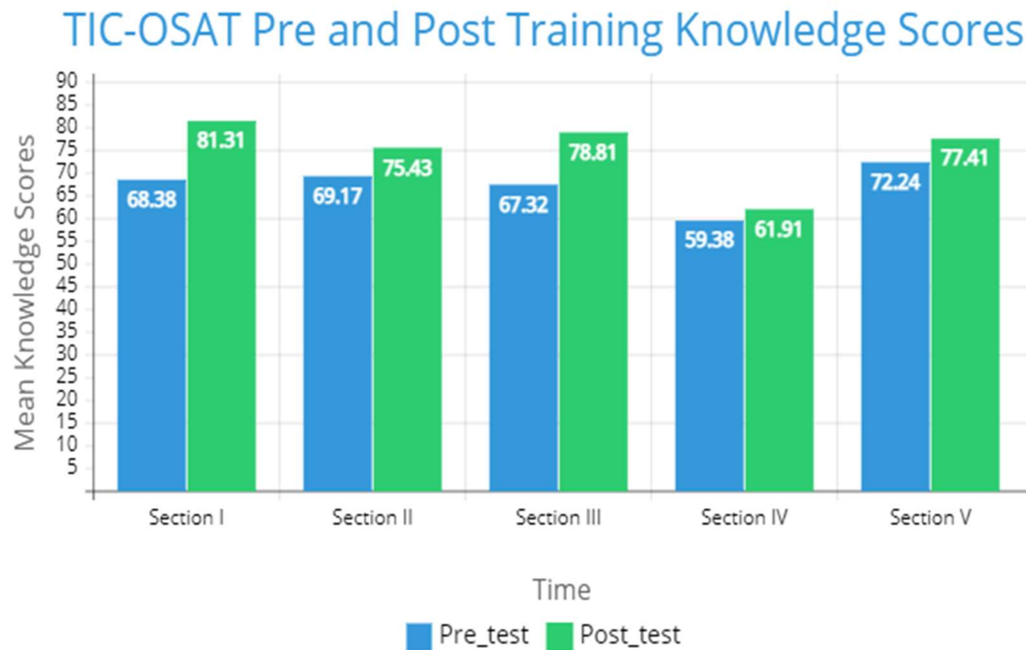

Figure 1. *TIC-OSAT Pre and Post Training Knowledge Scores*

Based on the data from Table 1, Section I "Supporting Staff Development", Section III "Assessing and Planning Service" and Section V "Adopting Policies" all have a two-tailed p-

value of .000, which shows that there is strong evidence of a relationship between training and staff understanding of TITC based on the statistically significant difference between the pre and post-implementation tests in these 3 sections. These data validate the hypothesis that education and training using the "talk me down" toolkit led to an increase in staff knowledge on these sections. Section II, "Creating a Safe and supportive Environment" and Section IV "Involving Consumers" had a two-tailed p-value of .086 and .119 respectively. This means that statistically, there was no significant difference between the pre and post-implementation tests for these sections. The results of these sections show a lacking in organizational support as perceived by staff and its implications will be discussed further in the discussion of the result section.

The Rate of restraints and seclusion pre/post "Talk me down" toolkit Implementation.

The Chi-square test was used to analyze the efficacy of the educational interventions and the use of the "talk me down" toolkit in reducing the rate of R/S before and after implementation. The assumption is that the rate of R/S will be reduced by at least 50%. To develop a category variable to analyze, data were collected for every "Code Orange" called pre and post-implementation of the "talk me down" toolkit. A "Code Orange" is activated when patients exhibit aggressive behaviors and warning signs of potential violence. When it is activated, all available staff is expected to respond immediately to the ward. The PM assessed the staff's ability to utilize TITC to avert a restraint or seclusion. Variables were recorded as "failures" if a code was called but de-escalation failed in averting an R/S and "success" if a code was called but R/S was averted. The total percentage of failure (number of R/S) pre-implementation was 82.61% and 38.89% post-implementation, which represents a 43.72% reduction in the rate of restraints and seclusions. The chi-square test result showed strong evidence of a relationship between the implementation of the "talk me down" toolkit and the reduction in the rate of R/S (chi-square =

8.32, df = 1 and p-value = .004 which shows that the result is significant at p<.05).

An illustration of the rate of R/S pre and post implementation of the "Talk me down" toolkit is provided in Figure 2.

Figure 2. *Rate of Restraint and Seclusion pre and Post Implementation of "Talk me down" toolkit.*

Discussion

This project implementation was found to be successful in achieving its objectives of increasing the staff knowledge and understanding of TITC and reducing the rate of R/S at the project site. Overall, there was an increase in the mean knowledge scores in all 5 sections of the TIC_OSAT assessed. The difference in the mean scores between the pre and post-implementation for Sections I, III, and V are 12.9% (t=6.80,p=.001) 11.5% (t=7.75, p=.001) and 5.16% (t=4.74, p=.001) respectively which shows a significant increase in staff understanding of TITC. Scores

for Sections II and IV were 6.27% ($t=1.83$, $p=.086$ and 2.53% ($t=1.64$, $p=.119$). This score shows an increase in knowledge after the project implementation, however, that increase was not statistically significant in these sections. It is important to note that the TIC-OSAT is an organizational assessment tool that allows organizations to assess their progress in implementing practice change initiatives, therefore, the insignificant difference in the scores post-implementation in these two sections should not be observed as a failure in the implementation process by the organization and staff but should be used as indicators for areas in need of organizational improvement. The components of the "talk me down" toolkit only addressed issues about TITC and reducing R/S and did not address overall organizational safety protocols. These results exposed some important areas where further assessment and policy evaluation is needed. These areas include establishing a safe physical and supportive environment, safety and crisis prevention planning, and organizational consistency and predictability. Scores in these areas exposed staff fears about their safety and that of their patients in the hospital. These fears could increase the risk of increased R/S as the staff who are on edge about their safety can easily misunderstand patient behaviors and instead of attempting to deescalate, can initiate unnecessary restraint or seclusion. It also highlights poor staff involvement especially the MHTAs in the crisis and safety prevention process as well as poor staffing consistency (shortage of staff). It will be important for the facility to investigate further into these issues as burnout not only leads to an increase in staff turnover but depersonalization and emotional exhaustion (Nantsupawat et al., 2017). The result also highlighted the lack of patient and staff involvement in program development. It is important to involve both current and former patients in program development as they can bring personal input on trauma triggers and failures they have observed while inpatient at the hospital. Staff input in program development is also essential as they can provide

excellent insight on helpful de-escalation practices as they are the ones that deal with the patients daily.

The rate of R/S reduced post implementation by 43.72% (chi-square = 8.32, df = 1 and p = .004) which showed a very strong evidence of relationship between the use of the "Talk me down" toolkit and reduction in the rate of R/S. Although, one of the project objectives was to reduce the rate of R/S by 50%, a reduction rate of 43.72%, is very encouraging. It is important to note that the rate of R/S identified as "failures" in de-escalation in the project was inversely proportional to the "success" in de-escalation. The number of de-escalations after a "code orange" activation without R/S increased from 17.39% to 61.11%. Also, the total number of "code oranges" post implementations of the "talk me down" toolkit also decreased from 63.41% to 36.59%.

This quality improvement project aimed to reduce the rate of R/S in the inpatient children's psychiatric hospital by using the "Talk me down" toolkit which consists of staff training, consistent communication, supervision, mentoring and follow up to ensure staff receives adequate knowledge of trauma-informed therapeutic communication (TITC) over one month. These project findings demonstrate a significant increase in the knowledge and use of TITC post-implementation. This increase appeared to have a positive impact on how staff responded to "code oranges" and their use of TITC in de-escalating patients in crisis and ultimately reducing the rate of R/S.

The use of the "talk me down" toolkit required diligent use of the knowledge of TITC culture in admission screening, treatment planning, and shift change procedure and promoted collaboration between staff, management, and patients. The shift change form provided an easily assessable trauma-informed cheat shift per shift for all staff, to be able to identify past traumas,

triggers, and coping strategies that were effective in the past for patients. The Training also provided staff with a better understanding of the effects of trauma on patients and how to provide a more therapeutic milieu that promotes better patient outcomes. This project utilized the TIC-OSAT which is designed to aid organizations in the evaluation of their current practice culture and to adjust their program based on the feedback received from staff to support recovery and healing among their patients (Center for Substance Abuse Treatment, 2014). The results of the TIC-OSAT also identified areas of improvement for further organizational evaluation such as inadequate staffing. Post-implementation, it was noted that staff was able to identify their paternalistic attitudes and bias as well as the power struggle between them and patients and utilize TITC to de-escalate aggressive behaviors, thus reducing R/S. The staff and leadership were very involved in the implementation of the "talk me down "toolkit and staff were compliant with its use.

Studies have shown that patients with post-traumatic stress disorder are more likely to be involved in R/S events due to behavioral issues such as threatening behavior, severe aggression, self-harm, or threat to harm self (Roy et al., 2019; SAMHSA, 2019). This project implementation utilized this knowledge in developing the "talk me down" toolkit with a focus on identifying the patient's past trauma history and incorporating triggers and successful de-escalation techniques in each patient's individualized treatment care plan. The results of this project support previous studies that have shown that TITC based on the Six Core strategies of trauma-informed care (6CSTIC) is effective in reducing the rate of R/S and has contributed to the continuous decline in its use in psychiatric hospitals all over the United States (Bryson et al., 2017). The project demonstrates the ethical need to continue to reduce or better yet eliminate the use of R/S as it has been found to have a negative physical and psychological impact on both the nursing staff and

patients (Raveesh et al., 2019; Smith et al., 2015).

Significance/Implications for Nursing

This is a quality improvement project aimed at the reduction of the rate of R/S in a children's inpatient hospital by implementing a TITC toolkit. The "talk me down" toolkit was utilized by the staff at the facility for identification and de-escalation of dangerous behaviors using TITC. Staff nurses and MHTAs adhered to the use of the toolkit for assessing and eliciting trauma history information from patients and family members during admission as well as in early identification of patient triggers and escalating behaviors. Through the implementation of this toolkit, admission trauma assessment information was passed on to oncoming shifts using the "change of shift form". This form made trauma history and personalized TITC information about each patient more easily assessable by all staff. There was also a significant increase in staff knowledge of TITC and TITC de-escalating techniques. This project is significant and important to nursing because R/S are intrusive interventions that carry the risk for injury for both the staff and the patient as well as leading to traumatized or re-traumatized by the experience, which can result in longer lengths of stay for the patient (Ferreira, 2010; Pogge et al., 2011). It also shows a failure by the facility to provide a therapeutic milieu for patient success in attaining their proposed treatment goals. It is essential for nursing staff (RNs and MHTA's) as well as all providers and leadership to continue to reduce and prevent the use of R/S because this can enhance patient quality of treatment, increase patient and staff satisfaction in service provided as well as yield significant savings.

The implementation of the "talk me down" toolkit in the inpatient children's psychiatric hospital created a change in the admission process as well as staff understanding of the importance of identifying patient past trauma history and providing TITC. It demonstrated the

importance of an outline protocol for continuing education on TITC for all staff as well as the use of a trauma-based toolkit such as the “talk me down” toolkit in reducing the rate of R/S. In completing this project, the opinion, question, and support of all stakeholders were valued and incorporated. This increased staff buy-in into the project and therefore increased commitment which leads to its ultimate success. Studies have shown that reducing the rates of R/S leads not only to a decrease in the physical risk of injury or death to both the patient and staff but also reduces the length of admission as well as the likelihood of readmission (Knox & Holloman, 2012). Inpatient psychiatric hospitals with supportive leadership and increase in TITC knowledge by training for all nursing staff increases the likelihood of the use of TITC toolkits such as the “talk me down” toolkit in the early identification of trauma history, triggers, and development of individualized treatment plans that includes input from both staffs, patients and their families in de-escalating techniques to reduce the rate of R/S. Reducing the rate of R/S is essential for nurses as most nurses identify R/S as a failure in maintaining a therapeutic milieu for the patient because it weakens the patient-nurse relationship because the sense of distrust developed by patients during R/S. This hinders their desire to seek help from medical professionals as well as reduces medication compliance. For the nurses, reduction in R/S removes that ethical and moral conflict that they feel about whether to initiate R/S or not (Ye et al., 2019).

Limitations

Some limitations were identified during the implementation of this quality improvement project. The main limitation noted is the effect of COVID 19 and mandatory quarantine of staff that participated in the training during the period of implementation. The sample size was of clinical staff that participated in the training was (N=18), however, during the 3rd week of implementation, the facility had a breakout of positive COVID cases, which led to 2 “Champion

nurses" 4 MHTAs being quarantined for several days while waiting for the results of their COVID teste to return from the labs. During these periods, float staff that was not part of the training from the adult hospital were utilized to replace the full-time staff. Some of these float staff were not aware nor familiar with the project and forms were given a crash course by the PL on the project basics. During shift change, the PL also had to constantly remind the float staff to complete the "shift change form" as it was not used at their facility. The COVID 19 pandemic lockdown also led to restrictions on some inpatient activities during the active lockdown which occurred in week 3 of the implementation process. The patients were confined to their ward only with providers and social workers instructed to limit unnecessary exposures by going to the wards. During this period, the increase in aggression observed and frustration by the patients could have been due to parents and visitors not being allowed during the lockdown. Studies have found that fear of the unknown and frustration from patients and their families can lead to verbal and physical aggression towards staff members and other patients (ECRI Institute, 2017).

Another limitation noted was from the generalization of the data variables and sample collection. For this project, the rates of R/S collected was generalised to all patients admitted during the implementation period without accounting for the other factors that could affect or increase the risk of R/S. These factors included patient diagnosis, Intelligent quotient functioning (IQ) level, and general level of violence. Studies have found no association between PTSD and lower IQ (below 70), however, they did find that lower IQ was a precursor to the onset of behavior disorder (Keyes et al., 2017). Therefore, patients with lower IQ and functioning level in combination with a behavioral disorder will have increased risks for aggressive and assaultive behavior compared to patients with a higher IQ. It is important to note that if the number of patients with lower IQ increased in the inpatient hospital compared to patients with average IQ,

the chances of aggressive behavior are higher and thus rate of R/S will increase as well. Patients with psychotic symptoms, conduct disorders, and bipolar disorder were also found by studies to be more apt to be aggressive during inpatient hospitalization which in turn can increase the rates of R/S (Volavka, 2014). Therefore, the rate of R/S can be affected by the diagnosis of the patients admitted at the inpatient facility at any time as patients with a diagnosis of conduct disorders, bipolar disorder, schizophrenic disorders, and intellectual disability(ID) can increase the risk of aggressive behavior leading to more R/S when compared to patients with the diagnosis of depression or anxiety.

Another limitation noted was the duration of the study which was only 5 weeks. This short-term project and its short duration is capable of skewing the project results because of lack of randomization and diversity in the diagnosis of patients admitted during the project period. Short term implementation can also affect results because some patients go through a "honeymoon" period after inpatient admission when they assess and familiarize themselves with the hospital. During this period, there are little to no aggressive behaviors noted as the patients are still trying to adjust to the rules and consequences for actions and this leads to reduced R/S episodes. After the "honeymoon" period, patients with aggressive behaviors tend to exhibit more of these behaviors which can lead to an increase in R/S.

For inpatient hospital organizations, in order to maintain a therapeutic milieu that is void of re-traumatization via the use of R/S, it is important to identify aggressive high-risk patients so as to provide individualized interventions to prevent aggression in inpatient settings (Dean et al., 2008). There is evidence-based consensus that there is a link between inpatient aggression and developmental disorders, disruptive behavior disorders, bipolar disorders, schizophrenic disorder, conduct disorder, learning disorders, and trauma history (Dean et al., 2008; Volavka, 2014).

However, research studies into how these psychiatric diagnoses can increase the risk for R/S are lacking and highly warranted.

Dissemination

The publication of the results of quality improvement projects is extremely important in the current nursing era of evidence-based practice. DNP projects potentially provide new findings or can help in the validation of best practices and nursing interventions (Carter-Templeton, 2015). This QI project finding and outcome dissemination play essential roles in informing psychiatric providers, nurses, and other stakeholders in the project site of the importance of the evidence-based practice of TITC. After this projects implementation was completed, the PL disseminated the project results and findings to the treatment team leaders, medical providers and the nursing staff at the inpatient hospital during the weekly huddle meeting using printed PowerPoint handouts. These handouts can become professional resources that can continue to aid in staff commitment to the use of TITC in the reduction of the use of R/S. Next, the results of the project will also be presented to the Facility Management Team (FMT) which includes leadership from all departments in the hospital system. The PL will also present the findings of this QI project during the New York State OMH quarterly Restraint and Seclusion meeting which will be coming up on the 29th of January 2021.

The New York State Office of Mental Health (OMH) has a policy that requires all research conducted in their facilities to be reviewed by the Nathan S. Kline Institute for Psychiatric Research (NKI) before submission for possible publication can be approved. Once the project is accepted by the NKI, the Quality Improvement department in conjunction with the OMH Bureau of Policy will review the recommendations from the project to decide if the “talk

me down" toolkit can be adapted into the OMH policy.

With NKI approval, the PL intends to submit an abstract of this project to the American Psychiatric Nurses Association's "Journal of the American Psychiatric Nurses Association" which is a bi-monthly peer-reviewed journal that focuses on the promotion of psychiatry nursing, improvement of mental health care for culturally diverse individuals, communities, families, and groups. It also helps to shape health care policy for the delivery of mental health services such as addressing nursing staffing issues and other issues relevant to inpatient psychiatric units (American Psychiatric Nurses Association, 2015). Finally, the PL intends to share the completed project and findings with the instructors and students in the Touro University, Nevada Doctor of Nursing Practice program

Project Sustainability

Short term projects can have a limited impact on an organization and the effected change might not be sustainable long term. It is important to continue to add to the foundation built by the project by continued investment in staff through the continued building of staff awareness on the importance of the use of TITC. It is also essential to continue to assess their commitment to the implemented change and to address obstacles that they face which could lead to resistance to the change. The organization also needs to continue to promote and support the culture of improvement and providing training for staff (Silver et al., 2016). Through this project, the organization has identified areas of strength and weaknesses and will continue to work with the project lead in the continuous promotion of TITC with the possibility of adopting and incorporating the "talk me down" toolkit and using its components to modify their current protocol to update their current policy.

Conclusion

In conclusion, impulsive or overt aggressive behaviors which include physical and verbal aggression remain the most common reason for the referral of young people to psychiatric inpatient and mental health service facilities. The importance of the staff TITC education and the identification of a patient's past trauma history as well as making that information easily accessible to all staff on all shifts cannot be understated. There was an overall improvement in the pre and post-implementation TIC-OSAT as well as a significant decrease in the rate of R/S. However, there is a need for continued research into the effects of certain psychiatric diagnoses such as inpatient aggression and developmental disorders, disruptive behavior disorders, bipolar disorders, schizophrenic disorder, conduct disorder, learning disorders, and trauma history on increasing the risk for R/S in inpatient hospitals. This will help in the development and adoption of better admission procedures. These procedures can include special patient ward assignments for patients with high risk for aggressive behaviors and the assignment of seasoned staff in TITC to these high-risk wards. This will not only reduce the rate of R/S but will provide a better quality of care for all patients as it can help reduce aggressive behaviors in the high-risk patients as well as provide a therapeutic environment void of constant aggression and ward disturbances for the low risk for aggression patients.

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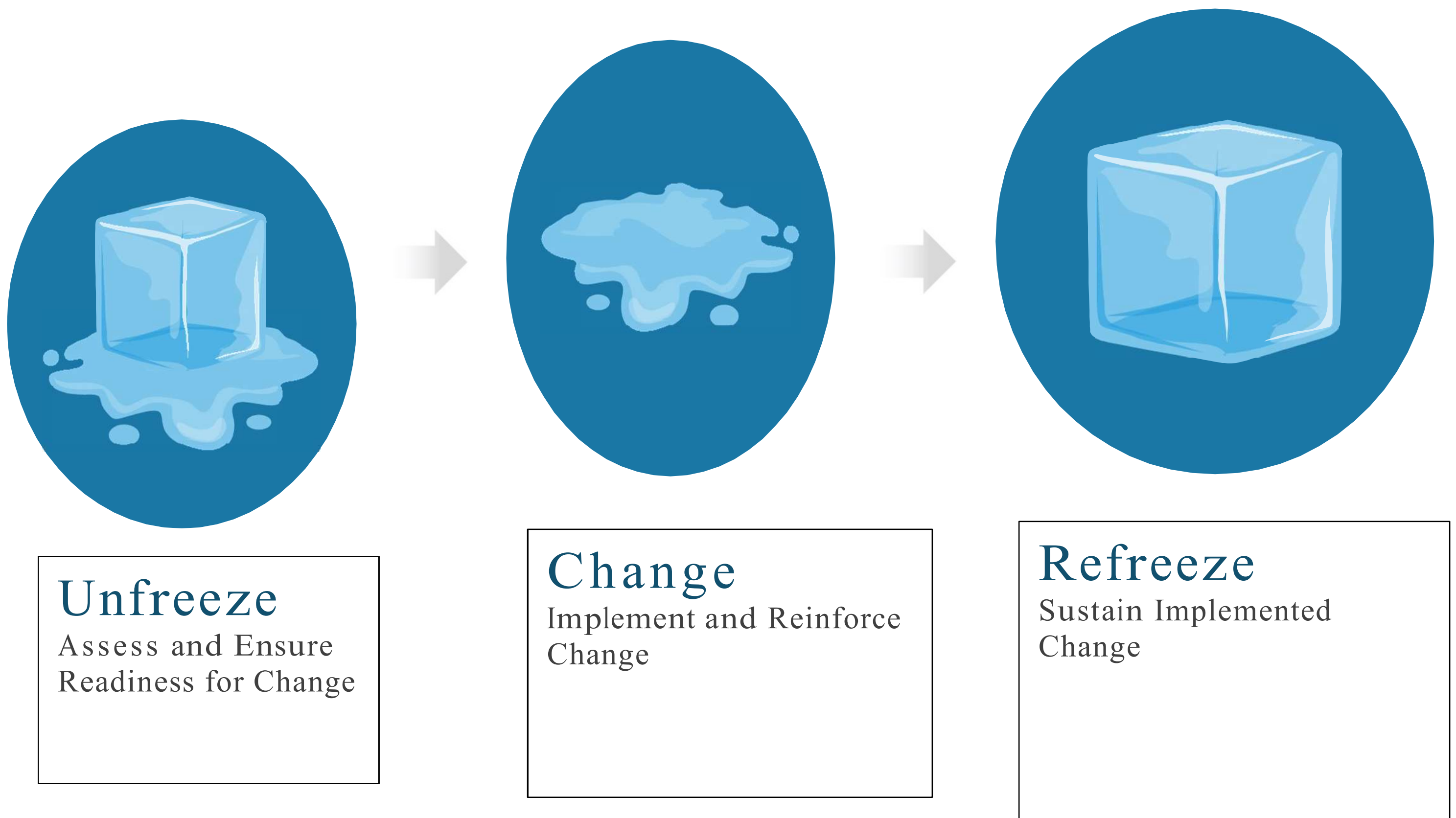
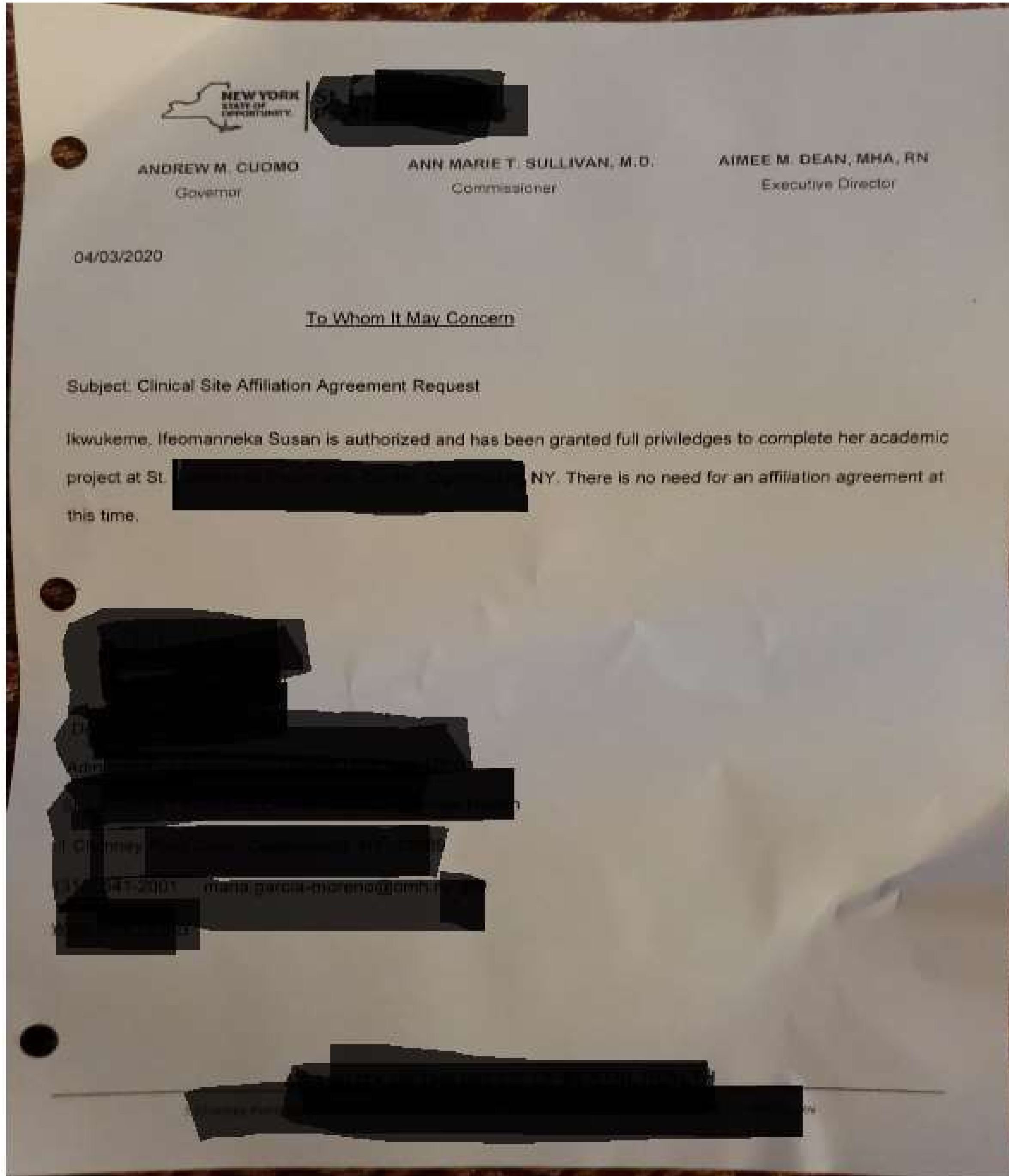
Appendix A

Lewin's Change Management Theory Diagram



Appendix B:

Permission to Use Site



NEW YORK STATE OF OPPORTUNITY

ANDREW M. CUOMO
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

AIMEE M. DEAN, MHA, RN
Executive Director

04/03/2020

To Whom It May Concern

Subject: Clinical Site Affiliation Agreement Request

Ikwukeme, Ifeomanneka Susan is authorized and has been granted full priviledges to complete her academic project at St. [redacted] NY. There is no need for an affiliation agreement at this time.

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Appendix C

I. Supporting Staff Development

A. Training and Education	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
Staff at all levels of the program receive training and education on the following topics:						
1. What traumatic stress is.						
2. How traumatic stress affects the brain and body.						
3. The relationship between mental health and trauma.						
4. The relationship between substance use and trauma.						
5. The relationship between homelessness and trauma.						
6. How trauma affects a child's development.						
7. How trauma affects a child's attachment to his/her caregivers.						
8. The relationship between childhood trauma and adult re-victimization (e.g., domestic violence, sexual assault).						
9. Different cultures (e.g., different cultural practices, beliefs, rituals).						
10. Cultural differences in how people understand and respond to trauma.						
11. How working with trauma survivors impacts staff.						
12. How to help consumers identify triggers (i.e., reminders of dangerous or frightening things that have happened in the past).						
13. How to help consumers manage their feelings (e.g., helplessness, rage, sadness, terror, etc.).						
14. De-escalation strategies (i.e., ways to help people to calm down before reaching the point of crisis).						
15. How to develop safety and crisis prevention plans.						
16. What is asked in the intake assessment.						
17. How to establish and maintain healthy professional boundaries.						

B. Staff Supervision, Support and Self-Care	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
18. Staff members have regular team meetings.						
19. Topics related to trauma are addressed in team meetings.						
20. Topics related to self-care are addressed in team meetings (e.g., vicarious trauma, burn-out, stress-reducing strategies).						
21. Staff members have a regularly scheduled time for individual supervision.						
22. Staff members receive individual supervision from a supervisor who is trained in understanding trauma.						
23. Part of supervision time is used to help staff members understand their own stress reactions.						
24. Part of supervision time is used to help staff members understand how their stress reactions impact their work with consumers.						
25. The program helps staff members debrief after a crisis.						
26. The program has a formal system for reviewing staff performance.						
27. The program provides opportunities for on-going staff evaluation of the program.						
28. The program provides opportunities for staff input into program practices.						
29. Outside consultants with expertise in trauma provide on-going education and consultation.						

II. Creating a Safe and Supportive Environment

A. Establishing a Safe Physical Environment	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
1. The program facility has a security system (i.e., alarm system).						
2. Program staff monitors who is coming in and out of the program.						
3. Staff members ask consumers for their definitions of physical safety.						
4. The environment outside the program is well lit.						
5. The common areas within the program are well lit.						
6. Bathrooms are well lit.						
7. Consumers can lock bathroom doors.						
8. Consumers have access to private, locked spaces for their belongings.						
9. The program incorporates child-friendly decorations and materials.						
10. The program provides a space for children to play.						
11. The program provides consumers with opportunities to make suggestions about ways to improve/change the physical space.						
B. Establishing a Supportive Environment						
Information Sharing						
12. The program reviews rules, rights and grievance procedures with consumers regularly.						
13. Consumers are informed about how the program responds to personal crises (e.g., suicidal statements, violent behavior).						
14. Consumers are informed about who will be checking on them and their spaces (e.g., how often and why it is important).						

Information Sharing, cont...	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
15. Expectations about room/apartment checks are clearly written and verbalized to consumers.						
16. Consumer rights are posted in places that are visible.						
17. Material is posted about traumatic stress (e.g., what it is, how it impacts people, and available trauma-specific resources).						
Cultural Competence						
18. Program information is available in different languages.						
19. Consumers are allowed to speak their native language within the program.						
20. Consumers are allowed to prepare or have ethnic-specific foods.						
21. Staff shows acceptance for personal religious or spiritual practices.						
22. The program provides on-going opportunities for consumers to share their cultures with each other (e.g., potlucks, culture nights, incorporating different types of art and music, etc.).						
23. Outside agencies with expertise in cultural competence provide on-going training and consultation.						
Privacy and Confidentiality						
24. The program informs consumers about the extent and limits of privacy and confidentiality (e.g., the kinds of records that are kept, where they are kept, who has access to this information, and when the program is obligated to report information to child welfare or police).						

Privacy and Confidentiality, cont...	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
25. Consumers are asked about the least intrusive ways for staff to check on them and their spaces.						
26. The program gives notice prior to doing room/apartment checks.						
27. The program gets permission from consumers prior to giving a tour of their room/apartment.						
28. If permission is given, the consumer is notified of the date, time and who will see their room/apartment.						
29. Staff does not talk about consumers in common spaces.						
30. Staff does not talk about consumers outside of the program.						
31. Staff does not discuss the personal issues of one consumer with another consumer.						
32. Consumers who have violated rules are approached in private.						
33. There are private spaces for staff and consumers to discuss personal issues.						
Safety and Crisis Prevention Planning						
For the following items, the term "safety plan" is defined as a plan for what a consumer and staff members will do if the consumer feels threatened by another person outside of the program.						
34. Consumers work with staff to create written, individualized safety plans for their family.						
35. Written safety plans are incorporated into consumers' individual goals and plans.						

Safety and Crisis Prevention Planning, cont...	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
For the following items, the term "crisis-prevention plan" is defined as an individualized plan for how to help each consumer manage stress and feel supported.						
36. Every **adult** in the program has a written crisis-prevention plan.						
37. Every **child** in the program has a written crisis-prevention plan.						
Written crisis prevention plans include the following:						
38. A list of triggers (i.e., situations that are stressful or overwhelming and remind the consumer of past traumatic experiences).						
39. A list of ways that the consumer shows that they are stressed or overwhelmed (e.g., types of behaviors, ways of responding, etc.).						
40. Specific strategies and responses that are **helpful** when the consumer is feeling upset or overwhelmed.						
41. Specific strategies and responses that are **not helpful** when the consumer is feeling upset or overwhelmed.						
42. A list of people that the consumer feels safe around and can go to for support.						

Open and Respectful Communication	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
43. Staff members ask consumers for their definitions of emotional safety.						
44. Staff members practice motivational interviewing techniques with consumers (e.g., open-ended questions, affirmations, and reflective listening).						
45. The program uses "people-first" language rather than labels (e.g., "people who are experiencing homelessness" rather than "homeless people").						
46. Staff uses descriptive language rather than characterizing terms to describe consumers (e.g., describing a person as "having a hard time getting her needs met" rather than "attention-seeking").						
Consistency and Predictability						
47. The program has regularly scheduled community meetings for consumers.						
48. The program provides advanced notice of any changes in the daily or weekly schedule.						
49. Program staff responds consistently to consumers (e.g., consistency across shifts and roles).						
50. There are structures in place to support staff consistency with consumers (e.g., trainings, staff meetings, shift change meetings, and peer supervision).						
51. The program is flexible with rules if needed, based on individual circumstances.						

III. Assessing and Planning Services

A. Conducting Intake Assessments	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
The intake assessment includes questions about:						
1. Personal strengths.						
2. Cultural background.						
3. Cultural strengths (e.g., world view, role of spirituality, cultural connections).						
4. Social supports in the family and the community.						
5. Current level of danger from other people (e.g., restraining orders, history of domestic violence, threats from others).						
6. History of trauma (e.g., physical, emotional or sexual abuse, neglect, loss, domestic/community violence, combat, past homelessness).						
7. Previous head injury.						
8. Quality of relationship with child or children (i.e., caregiver/child attachment).						
9. Children's trauma exposure (e.g., neglect, abuse, exposure to violence).						
10. Children's achievement of developmental tasks.						
11. Children's history of mental health issues.						
12. Children's history of physical health issues.						
13. Children's history of prior experiences of homelessness.						

Intake Assessment Process	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
14. There are private, confidential spaces available to conduct intake assessments.						
15. The program informs consumers about why questions are being asked.						
16. The program informs consumers about what will be shared with others and why.						
17. Throughout the assessment process, the program checks in with consumers about how they are doing (e.g., asking if they would like a break, water, etc.).						
18. The program provides an adult translator (not another consumer in the program) for the assessment process if needed.						
Intake Assessment Follow-up						
19. Based on the intake assessment, **adults** are referred for specific services as necessary.						
20. Based on the intake assessment, **children** are referred for further assessment and services as needed.						
21. The intake assessment is updated on an on-going basis.						
22. The program updates releases and consent forms whenever it is necessary to speak with a new provider.						
B. Developing Goals and Plans						
23. Staff supports consumers in setting their own goals.						
24. Consumer goals are reviewed and updated regularly.						
25. Consumers work with staff to identify a plan to address their children's needs.						

Developing Goals and Plans, cont...	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
26. Before leaving the program, consumers and staff develop a plan to address potential safety issues.						
27. Before leaving the program, consumers and staff develop a plan to address future service needs related to trauma.						
28. Before leaving the program, consumers and staff develop a plan that addresses their children's service needs related to trauma.						
C. Offering Services and Trauma-Specific Interventions						
29. The program provides opportunities for consumers to receive a variety of services (e.g., housing, employment, legal and educational advocacy, and health, mental health and substance abuse services).						
30. When mental health services are needed (e.g., individual therapy, group therapy and/or family therapy), the program refers **adults** to agencies with expertise in trauma.						
31. When mental health services are needed (e.g., individual therapy, group therapy and/or family therapy), the program refers **children** to agencies with expertise in trauma.						
32. The program coordinates on-going communication between mental health and substance abuse providers.						
33. The program coordinates on-going communication between early intervention and mental health service providers.						
34. The program educates consumers about traumatic stress and triggers.						
35. The program provides opportunities for consumers to express themselves in creative and nonverbal ways (e.g., art, theater, dance, movement, music).						
36. The program has access to a clinician with expertise in trauma and trauma-related interventions (on-staff or available for regular consultation).						

IV. Involving Consumers

A. Involving Current and Former Consumers	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
Current Consumers						
1. The needs and concerns of current program consumers are addressed in community meetings.						
2. The program provides opportunities for consumers to lead community meetings.						
3. Current consumers are involved in the development of program activities.						
4. Current consumers are given opportunities to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways (e.g., suggestion boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc.).						
Former Consumers (refers to anyone who has experienced homelessness)						
5. Former consumers are hired at all levels of the program.						
6. The program recruits former consumers for their board of directors.						
7. Former consumers are involved in program development.						
8. Former consumers are involved in providing services (e.g., peer-run support groups, educational, and therapeutic groups.).						
9. Former consumers are invited to share their thoughts, ideas, and experiences with the program.						

V. Adapting Policies

A. Creating Written Policies	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
1. The program has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.						
2. Written policies are established based on an understanding of the impact of trauma on consumers.						
3. The program has a written commitment to demonstrating respect for cultural differences and practices.						
4. The program has a written commitment to hire staff who have experienced homelessness.						
5. The program has a written policy to address potential threats to consumers from persons outside of the program.						
6. The program has a written policy outlining program responses to consumer crises (e.g., self-harm, suicidal thinking, aggression towards others).						
7. The program has written policies outlining professional conduct for staff (e.g., boundaries, responses to consumers, etc.).						
B. Reviewing Policies						
8. The program reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.						
9. The program involves staff in its review of policies.						
10. The program involves consumers in its review of policies.						

Appendix D

Date of Issue: 7/19 By T.L.: 2019-04 Section: II Page 1
Subject: Restraint/Seclusion Policy

NOTE: This policy directive shall not preclude the application of security measures during transportation of patients who are committed to a facility pursuant to an order of a criminal court or who have been admitted to a facility in accordance with Article 10 of the Mental Hygiene Law.

A. Policy Statement

The purpose of this policy directive is to supplement the provision of 14 NYCRR Section 526.4 which set forth conditions and procedures for the use of seclusion and restraint in facilities under the jurisdiction of the Office of Mental Health, including State operated psychiatric inpatient facilities. In this regard, the policy maintains the recent focus of requirements governing the use of restraints.

Historically, requirements focused on the type of device or restraint being used, and the setting in which it was being employed. Under current federal and NYS regulations and The Joint Commission (TJC) standards, a restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to freely move his or her arms, legs, body, or head. Further, a drug or medication is also considered a restraint when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

In medical or post-surgical care, a restraint may be necessary to ensure good medical outcomes when mechanical supports are not effective. For example, restraint may be used to prevent an intravenous (IV) line or feeding tube from being removed, or to prevent a patient who is temporarily or permanently incapacitated with broken hip from attempting to walk before it is medically appropriate. In these circumstances, a medical restraint may be used to limit mobility or temporarily immobilize a patient in relation to a medical, post-surgical, or dental procedure.

For behavioral management purposes, seclusion and restraint are interventions to be used only as a measure of last resort to avoid imminent injury to the patient or others. The use of seclusion or restraint should serve as a prompt for treatment teams to review patients. It is the goal of the Office of Mental Health to make the use of seclusion and restraint a rare occurrence, and to continue efforts to reduce the rate of such rare occurrences.

The Office of Mental Health always seeks to provide a safe and therapeutic environment to reduce risk to self and others and to prevent violent behavior. While violent behavior may lead to seclusion and restraint, in other instances violent behavior may begin or increase following the initiation of seclusion and restraint. Statistically, seclusion and restraint are associated with increased risk of injury to both patients and staff.

Seclusion and restraint also may have deleterious effects on patients, including those who are survivors of sexual trauma and/or physical abuse, and patients with hearing impairments who are unable to communicate without the use of their hands. In assessing the need to use these interventions, therefore, OMH staff should consider the potential for any negative impact of the procedure on the particular patient.

For any given patient at a particular point in time, the use of a comprehensive individual patient assessment will determine whether the use of less restrictive measures poses a greater risk than the risk of using a restraint or seclusion. Assessment should include a physical assessment to identify medical problems that may be causing behavior changes in a patient. For example, temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions, and drug side effects may cause confusion, agitation, and combative behaviors. Addressing these medical issues may eliminate or minimize the need for the use of seclusion and restraint.

The use of seclusion and restraint for behavioral management can be reduced through the creation and maintenance of an environment which promotes the empowerment of patients, identifies and implements strategies to advance positive behavior management and restraint reduction efforts, incorporates strategies in hiring or workforce development practices to advance these efforts, and emphasizes the education and sensitization of staff regarding the appropriate use of restraint and seclusion. This policy seeks to encourage this result.

Procedures for use of seclusion or restraint for behavioral management purposes are established in section E of this policy directive, while procedures for the use of restraint for medical or post-surgical care are set forth in section F.

Additional interpretive guidance regarding 14 NYCRR Section 526.4 and the principles outlined in this policy directive can be found in OMH Implementation Guidance available at https://www.omh.ny.gov/omhweb/guidance/implementation-guidelines.pdf (affixed hereto as Appendix B).

B. Relevant Statutes and Standards Mental Hygiene Law 33.04
14 NYCRR§526.4 (Appendix A)
OMH Implementation Guidelines (Appendix 8):
https:l/www.omh.ny.gov/omhweb/guidance/implementation-guidelines.pdf
42 C.F.R.§482.13
P.L. 106-310 (Children's Health Act of 2000)

The Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH) Provision of Care, Treatment, and Services Chapter

C. Definitions

In addition to the terms defined in 14 NYCRR§526.4 for purposes of this policy directive, the following terms are defined:

1. Comfort Wrap means a lightweight blanket or sheet that a person may voluntarily use when they experience the need to feel safer and/or to provide an artificial boundary. When used in this manner, a comfort wrap is not a form of restraint.
2. Clinic Director or designee means the individual in charge of clinical services at the State-operated psychiatric facility, or a physician designated by that individual to carry out the responsibilities of the head of the clinical staff described in this directive.
3. Five-point restraint means a four-point restraint with the addition of a strap, which is placed over the person's upper torso and secured to the bed frame.
4. Formal Debriefing is a collaborative process that includes the patient, the treatment team, and other involved parties. It should occur no later than the next business day following the use of seclusion or restraint and shall be constructed by a senior manager.
5. Four-point restraint means restraints that encase the wrists and ankles of a person lying on a bed, which are secured to the bed frame.
6. Individual crisis prevention plan means a document that identifies a patient's individual preferences and behaviors related to behavioral management interventions.
7. Manual Restraint means the involuntary holding or pinning of an individual to restrict movement of the head, arms, and body. Manual restraints include, but are not limited to, physical restraints required to facilitate the safe administration of court ordered or emergency medications administered over a patient's objectives, physical take downs, or other physical interventions that are designed to involuntarily hold or pin the individual to restrict movement.
8. Mechanical restraint means an apparatus which restricts an individual's movement of the head, limbs or body, and which the individual is unable to remove.
9. Mechanical support means a device intended to keep a person in a safe or comfortable position or to provide the stability necessary for therapeutic measures such as immobilization of fractures, administration of intravenous solutions or other medically necessary procedures, which the patient can remove at will.
10. One to one constant observation means a situation in which a staff member is responsible for maintaining continuous watch of a single patient, keeping the

11. patient in view at all times, and, if clinically appropriate, attempting to initiate dialogue with the patient. In this situation, the staff member must remain in close enough proximity to the patient to be able to respond immediately if needed and shall have no supervisory responsibilities for other patients.
12. Seclusion means the placement of an individual alone in a room or area from which he or she cannot leave at will (or where the patient reasonably believes that he or she will be prevented from leaving). This includes restrict ing the patient's egress through the presence of staff, by coercion, or by imposing implicit or explicit consequences for non-compliance. However, it shall not mean confined on a locked unit or ward where the patient is with others.
13. Wrist to belt restraint means a belt, secured around a person's waist, with attached restraint that encase the person's wrists. The tethers that secure the restraints to the belt may be of adjustable lengths, which allow degree of restriction of the person's a variation in the rms. This is not an approved form of restraint for clinical staff use at SLPC. It is an approved safety/security devise when applied by Safety Officers in according with the provisions of OM-660 "Use of Safety and Security Devices for Transport Purposes."

D. General Principles

1. The health and safety of the patient are the primary concerns of the Office of Mental Health at all times. Therefore, whenever a patient demonstrates a need for serious medical attention in the course of an episode of seclusion or restraint, medical priorities shall supersede psychiatric priorities, including the placement of the patient in seclusion or restraint.

2. Seclusion or restraint for behavioral management purposes are considered emergency safety interventions and shall be employed only when necessary to prevent a patient from seriously injuring self or others and less restrictive techniques have been tried and failed, or in the rare instance in which the patient's danger is of such immediacy that less restrictive techniques cannot be safely applied.

3. Seclusion or restraint for behavior management is not a substitute for treatment. When it occurs, it indicates the need for a post event analysis by appropriate supervisory staff, and a treatment plan review. (See subdivision E-5).

4. Seclusion or restraint shall not be used as punishment, for the convenience of staff, or as a substitute for treatment programs.

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5. The criterion for release of a patient from seclusion or restraint for behavior management is that the patient no longer presents an imminent risk of danger to

self or others. To assist staff in making this determination, the physician must note in the order for seclusion or restraint a description of the specific behavior of the patient that resulted in the determination that seclusion or restraint was necessary. Examples that would satisfy this criterion include, but are not limited to: the patient is no longer hitting staff; the patient is no longer attempting to hit staff; the patient is no longer assaulting or attempting to assault other patients; or the patient is no longer attempting to hurt self.

6. Simultaneous use:

    a) Seclusion and mechanical restraint shall never be used simultaneously.
    b) Two forms of restraint should not be used simultaneously, with the following exceptions:
        i. the use of mitts and helmets together;
        ii. the use of manual restraint while placing a patient in mechanical restraint or seclusion; and
        iii. the use of a drug as a restraint with other forms of restraint.

7. The decision to use seclusion or restraint shall not be based on the individual's seclusion or restraint history or solely on a history of dangerous behavior.

8. Drug used as a restraint.

a) When medication is used as a restriction to manage behavior or to restrict patient's freedom of movement, the use of the medication shall be deemed a restraint (i.e. drug used as a restraint).

b) Consistent with other forms of restraint, all uses of drugs as a restraint can only be implemented following a written order of a physician. An order for the use of medication as a restraint must specify that the medication is to be used as a restraint. In addition, the physician must further identify the duration of time for which the patient must be monitored once the medication has been given, as there is no defined time limit for medication effects. This duration of time shall be determined by the physician, based upon the anticipated effect of the medication on the patient.

c) One defining factor in determining when the use of medication meets the criteria for restraint is the intended purpose of the physician's order for the medication, if the purpose is to use the medication as an emergency safety intervention to prevent imminent harm or injury, then the use meets the criteria for restraint. Whether or not an order for a drug or medication is STAT (immediate one-time order), PRN (as needed) or a standing order does not determine whether or not the use of that drug or medication is considered a restraint. The determining factors in whether or not medication is used as a restraint is the purpose for which the medication is being ordered. If the patient's behavior has risen to a level where there is an imminent risk of serious injury to the patient or others, the purpose of the medication is to "disable" the patient, the medication is a restraint if the primary purpose of a drug is to calm a patient to "enable" him or her to remain in the therapeutic milieu, the medication is not being used as a restraint. The use of PRN or standing order drugs or medications is prohibited if a drug or medication meets the definition of a drug or medication used as a restraint.

d) Monitoring and observation must include post-medication administration assessment by a registered nurse and shall include the same monitoring requirements as mechanical or manual restraint, as set forth in this policy directive, provided, however, that monitoring of vital signs shall be

done more frequently than with mechanical or manual restraint, in accordance with good clinical practice and facility policy.

9. It is against Office of Mental Health policy to place objects on or over a patient's face during restraint procedures, provided, however, certain spit guard products may be used if specifically approved by the Commission as safe, provided the technique used does not violate the provisions of 13 NYCRR§526.4. In situations in which infection control precautions need to be taken to protect staff against biting and spitting during restraint episodes, staff may wear bite gloves, masks or clear face shields.

10, Mitts and helmets. The use of mitts and helmets as an emergency intervention to avoid imminent injury to the patient or others constitutes a restraint for behavioral management purposes and must follow the procedures set forth in section E of this policy directive.

11. When manual restraint is required to facilitate the safe administration of court ordered or emergency medications administered over a patient's objection; an ordered physician's order for such manual restraint is required, and all provision of this policy directive governing the use of manual restraint shall apply.

12. The use of manual restraint is the only form of restraint permitted with children less than 9 years of age in facilities operated by the Office of Mental Health. Other forms of restraint, as well as seclusion, shall be prohibited for this age group, except upon prior approval on a case-by-case basis by the Chief Medical Officer of the Office of Mental Health or his/her designee.

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13. When manual restraint is used for the purpose of facilitating the placement of a patient in seclusion and/or the administration of emergency medications over

objection, ALL interventions must be included in a physician's order. A separate order is not needed for the manual restraint if the seclusion order includes the directive to use manual restraint. The entire event must be documented in the patient's clinical record. For example, an order for seclusion could read, " Restraint to administer medication over objection and seclude for up to 30 minutes." The duration of each intervention (manual restraint and seclusion) should be noted when reporting via NIMRS or any successor format.

14. All clinical staff shall demonstrate competence in alternatives to and the appropriate application of seclusion and restraint prior to participating in the restraint or seclusion of a patient. Techniques sanctioned and taught by the Office of Mental Health must be employed. Excessive force shall not be used by initiating the use of seclus ion or restraint. To enable staff to check the patient's airway and to prevent the possibility of positional asphyxia, care shall be taken to assure that patients are not placed in a face-and/or-chest down position.

15. In the case of patients who are known or reasonably believed to have a history of physical or sexual abuse, or in the case of patients with hearing impairments who would be unable to communicate without the use of their hands, an explanation of why restraint is the most appropriate intervention under the circumstances shall be included in the patient's case record when an order for the use of restraint is written pursuant to section E)3).

16. The standard forms of mechanical restraint are the four-point restraint, and five-point restraint. No facility shall use these devices unless the related manufacturer and model have been approved by the Chief Medical Officer of the Office of Mental Health or his or her designee. Such approval shall be interpreted to allow facility-wide use.

17. Except as provided in paragraph 18 of this section, mechanical restraints which employ a locking mechanism released by a key shall never be used or considered approved for use.

18. Facilities may use other types of mechanical restraints for specified patients for a specified period when so authorized by the

Chief Medical Officer of the Office of Mental Health or his/her designee.

19. In choosing among the possible forms of intervention for a particular patient, staff shall utilize the least restrictive type that is appropriate and effective under the circumstances and shall use restraint or seclusion only as a last resort. Similarly, in cases where restraint or seclusion is used as a last resort, the least restrictive type which is appropriate and effective under the circumstances must be used. In determining whether or not a physical intervention reached a level where it constitutes manual restraint, reasonable consideration must be given to the nature of the behavior of the patient that precipitated the intervention, the behavior of the patient subsequent to the intervention, federal guidance, clinical judgment, and common sense. For example, if a staff member were to place his arm around a slightly agitated patient as he escorted him to a quiet room to regain control of his behavior, and the patient did regain control of his behavior and returned to the common area, such physical intervention would not constitute manual restraint. If an upset child was briefly held by staff to calm or soothe him, and the child soon quieted down, such physical intervention would not constitute manual restraint. If a patient erupted in violence and attempted to physically assault another patient or staff, and the patient had to be physically held prior to placing him in restraint or seclusion, such physical intervention would constitute manual restraint.

20. The facility shall convey the intentions of OMH to make the use of restraint a rare occurrence, and to continue efforts to reduce the rate of such rare occurrences, to patients and to those families who, upon patient agreement, are involved in the patient's treatment planning process. Every state operated facility shall have a plan to reduce and ultimately try to eliminate the use of restraint and seclusion.

21. Time out is not considered a type of seclusion or restraint. In order for an intervention to be considered time out, (regardless of the name of the intervention,
e.g., "calming time"), the patient must be permitted to enter the area/room completely voluntarily, and the patient's ability to exit the time out area or room must not be restricted by any means. Whenever feasible, rooms

used for time outs should not be the same room as that used for seclusion or restraint.

E. Procedures for Seclusion or Restraint for Behavioral Management Purposes

1. Individual Crisis Prevention Plans

a) Within its assessment procedure for all patients, facilities must incorporate a patient interview, as clinically indicated, in which a number of specific inquiries are made regarding the patient's individual preferences and behaviors related to behavioral management interventions. These preferences or recommendations must be documented in the clinical record and used to develop an individual crisis prevention plan. Additional guidance regarding the development of individual crisis prevention plans may be found in Implementation Guidelines for 14 NYCRR§526.4.

b) Individual crisis prevention plans are designed to:

i. help patients during the earliest stages of distress or escalation before a crisis erupts;

ii. help patients identify practicable coping strategies;

iii. help staff plan ahead and know what to do with each person if a problem arises; and

iv. help staff use interventions that reduce risk and trauma to individuals

c) Individual crisis prevention plans should have at least three distinct sections: triggers, early warning signs and coping strategies. The plans should encourage creativity and should be individualized to each patient's needs, linked to any personal history of trauma, and tailored to environmental resources.

d) Each facility shall develop a mechanism to be sure that all staff on all shifts, as well as floating staff, are aware of the patients' individual crisis prevention plans. At a minimum, the crisis plans should be attached to the patient's treatment plans and appear in condensed form which is readily accessible by staff. The information may also be included in other places where patient alerts are noted.

e) A copy of the individual crisis prevention plan should be given to the patient and routinely reviewed and updated throughout his/her inpatient admission when changes are warranted. Once the specific coping strategies are identified, they should be incorporated into the

patient's individual crisis prevention plan. To provide an opportunity for the patient to build proficiency and increase the probability that they will be effective during times of crisis, the patient should be given an opportunity to practice the identified coping strategies at times when he/she is not in crisis.

f) Any preferences expressed by the patient regarding the gender of and/or languages spoken by the observing staff person shall be honored when practicable and clinically appropriate.

2. Strategies to Reduce the Use of Seclusion and Restraint

a) Appropriate staff shall be made aware of patients' individual crisis prevention plans and shall be instructed to implement these plans in the early stages of patient crisis to help him or her regain control.

b) In addition, consistent with OMH's emphasis on recovery, facilities shall demonstrate commitment to reduction of the use of seclusion and restraint through hiring practices, training and hands-on involvement of executive, administrative and supervisory staff. Such commitment can be demonstrated by assuring that all staff are encouraged and trained to utilize clinical intervention strategies that contribute to therapeutic communication, negotiation, problem solving, prevention of power struggles between patients and staff, and proactive prevention and management of crisis behavior through use of verbal de-escalation strategies, trauma informed interventions, and least restrictive measures.

c) Each state-operated facility is required to develop and have in operation a place to become violence and coercion-free, the program of which must be monitored regularly by the Facility Director or his or her designee.

3. Initiating Seclusion or Restraint

a) Except as provided in section E)3)j), the implementation of seclusion or restraint shall only be pursuant to a physician's written order, based on the results of a documented personal examination of the patient by the physician.

b) The examination of the patient conducted by the physician shall include an assessment of the patient's psychiatric status and physical condition, as well as a review of the clinical record for any preexisting medical diagnosis and/or physical condition that could contraindicate the use of seclusion and/or restraint.

i. The psychiatric status assessment shall include an evaluation

of the person's immediate situation, the patient's reaction to the intervention, assessment of the patient's behavior, thought content, actual dangerousness to self or others, level of consciousness, and any other assessments which are clinically necessary, including whether or not other factors, such as medication interactions, electrolyte imbalances, etc., may be contributing to the patient's violent or self-destructive behavior, and the need to continue or terminate the restraint or seclusion.

NOTE: The only reason that can justify the use of seclusion or restraint is imminent danger.

ii. The physical assessment shall include an assessment of the patient's general condition and vital signs, and any other examinations which are clinically necessary.

iii. The results of the examination shall be documented in the patient's clinical record, along with the inadequacy of less restrictive interventions and the specific behaviors that necessitate seclusion or restraint.

iv. When any element of the examination cannot be performed due to the condition of the patient, an explanation for the omission and the physician's clinical observations of the patient shall be recorded.

v. Any prior medical diagnosis, conditions, or behaviors that could serve as relative contraindications to the use of seclusion or restraint, including but not limited to a history of physical or sexual abuse or hearing impairment, should be documented, c) as well as the physician's rationale for offering such an intervention at this time.

The physician shall review the patient's existing medication orders and shall assess the need for modifying orders during the period of seclusion or restraint. Documentation of this medication review shall be included in the patient's clinical record.

d) The physician must document the time at which he or she examined the patient in the patient's clinical record.

e) The physician's written order shall:

i. be written on the Order Sheet or electronic equivalent and included in the patient's clinical record;

ii. specify the facts and behaviors justifying the intervention and set forth the time of initiation and expiration of the authorization; when writing an order for seclusion or restraint, and time frame should be written using language indicating the patient should only remain in restraint or seclusion until he or she has met the behavioral release criteria. Phrases such as
"for a maximum of" or "up to" should be used to indicate staff
have the discretion to release the patient before the time of the order has elapsed, if the behavioral release criteria have been met;
iii. specify the type of intervention to be used. If a physician orders the use of restraint, the written order shall specify the type of restraint to be used;
iv. identify the behavioral criteria for release; and
v. include any special care or monitoring instructions.

f) Notwithstanding the provision of 14 NYCR§526.4, the maximum time period of orders of seclusion or restraint shall be in accordance
g) with the following; provided, however, that when a drug is used as a restraint, the provisions of 0)8) of this policy directives shall apply:
i. one hour for adults; ii. 30 minutes for patients ages 13 to18, or for patients over age
18 in a children's facility or unit;
iii. up to 15 minutes for manual restraint of patients of any age;
iv. the use of mechanical restraint is not permitted within SLPC Children & Youth services, manual restraint and seclusion are the only forms of restraint permitted for children ages 13 to
18;
v. the use of manual restraint is the only form of restraint permitted with children 12 years old or younger at SLPC; other forms of restraint, as well as seclusion, are prohibited for this age group, except upon prior approval on a case-bycase basis by the Clinical Director;
vi. children under 10 years old require additional approval on a case-by-case basis by the Clinical Director in consultation with the OMH Chief Medical Officer.

h) Seclusion shall not be used with persons with a sole diagnosis of a developmental disability. However, seclusion shall be permitted for persons with a dual diagnosis of mental illness and intellectual

developmental disorder, only if performed in accordance with the requirements of this policy directive which govern seclusion interventions, in order to ensure compliance with 14 NYCRR Section 526.4.

i) PRN orders shall not be used to authorize the use of seclusion or restraint.

j) Continuous use of seclusion or restraint
   i. The use of seclusion or restraint beyond a continuous 4-hour period requires prior approval by the clinical director or his/her designee. Continuous use shall not exceed 24 hours without notification of the Chief Medical Officer of the Office of Mental Health, or his or her designee.
   ii. The Clinical Director or his/her designee shall immediately be notified of the issuance of 2 or more separate orders for the use of seclusion or restraint on any patient within any 12-hour period.

k) The Office of Mental Health expects that staff will immediately interact/intervene to prevent a patient from seriously injuring him/herself or others. When patients display antecedents to

l) aggressive behavior and a potential crisis appear to be evolving, the registered nurse or nurse practitioner and physician should be immediately notified. Seclusion or restraint may be initiated in the absence of a physician's written order if a patient presents an

imminent danger to self or others and a physician is not immediately available to examine the patient. Every effort should be made to implement any applicable provisions of the patient's individual crisis intervention plan, except in those rare instances in which the patient's

dangerousness is of such immediacy that less restrictive interventions cannot be safely applied. The use of a restrictive intervention shall only be employed in accordance with the following directives:
   i. A physician must be called immediately to conduct a personal examination of the patient. If the physician cannot arrive on the ward or unit within 5 minutes, he/she must issue a telephone order to initiate the restraint or seclusion. Telephone orders to initiate restraint or seclusion will be issued sparingly. ii.

   A nurse, nurse practitioner, or physician's assistant shall note in the patient's clinical record the time of the call, the

name/title of the person making the call, the name of the physician contacted who gave the order, and the name of the person or persons who initiated the seclusion or restraint and shall complete a telephone order in accordance with facility policy. All actions taken must be recorded on the Restraint or Seclusion Monitoring Form.

iii. The physician who ordered initiation of the restraint or seclusion via telephone order must authenticate the order in writing and perform an examination of the patient within 30 minutes of the time that he or she was notified. If the physician's arrival exceeds 20 minutes from the time called:

1. the registered nurse, nurse practitioner, or physician's assistant shall record the delay in the patient's clinical record, in addition to a description of the patient's behavior which requires seclusion or restraint, the type of procedure used, any condition for maintaining the seclusion or restraint pending the arrival of the physician, the reasons why alternative interventions were not used, and a description of the steps taken to assure the patient's comfort and safety; and
2. the physician shall record in the patient's clinical record the explanation for his or her delay in arrival.

iv. In no event, shall seclusion or restraint be applied for longer than 30 minutes without the written authenticated order of a physician.

v. If, based on the results of the physician's personal examination, the physician determines that the use of seclusion or restraint was and/or continues to be indicated, he or she shall authenticate the telephone order and write an order for the procedure consistent with the requirements of section E)3). The order shall commence from the time at which the patient was initially placed in seclusion or restraints. The combined duration of the period specified in the physician's written order and the period of seclusion or restraint initiated by the registered nurse, nurse practitioner, or physician's assistant shall not exceed the time period allowed pursuant to section E)3)f).

vi. If, based on the physician's personal examination, it is determined that seclusion or restraint is not needed, the physician shall document his or her rationale in a progress note. This should not be interpreted as a reflection of the judgment of the registered nurse, nurse practitioner, or

physician's assistant; the crisis may have passed. In addition, the physician must write an order to cover the period of time in which the patient was in seclusion or restraint prior to the physician's examination.

m) Prior to placing a patient in seclusion or restraints pursuant to section E)3)a) or E)3)j), he or she shall be searched for potentially dangerous objects, and such objects shall be removed. If such search cannot safely be conducted, the reason for the delay shall be documented in the patient's clinical record. However, such search shall be conducted at a later time, as soon as it can be completed safely. In no event shall a patient be placed in seclusion or restraint in a nude or semi-nude state.

n) Implementation of the seclusion or restraint order shall be consistent with the techniques sanctioned and taught by the Office of Mental Health.

o) To enable staff to check the patient's airway and prevent positional asphyxia, care shall be taken to assure that patients are not placed in a face- and- chest- down position. In cases where the patient moves, or

is inadvertently moved, to a chest- down position, he or she shall be immediately repositioned.

p) Immediately after the application of the seclusion or restraint, a physician or registered nurse shall conduct an assessment of the patient to ensure that the intervention was safely and correctly applied without undue harm or pain to the patient.

q) If the patient has granted permission for notification of his/her family and/or a patient advocate of the initiation of seclusion or restraint, a professional staff member shall promptly make such notification. If the seclusion or restraint is applied during the night, such notification may occur the following morning. If a family has submitted a written request not to be notified of instances of seclusion and restraint, the facility shall honor this request.

r) If, at any time after application of seclusion or restraint, clinical assessment indicates that the patient has met the behavioral criteria for release, release shall be immediate.

4) Monitoring Persons in Seclusion or Restraint

a) A patient in seclusion or restraint shall be monitored and assessed to ensure that his or her physical needs, comfort and safety are properly care for.

i. A patient in seclusion or restraint shall receive one-to-one constant observation and assessment by a staff member who is trained and competent in Office of Mental Health policies and procedures regarding seclusion and restraint with demonstrated skills in minimizing the use of seclusion and restraint, assisting patients in meeting behavior criteria for the discontinuation of seclusion or restraint, assisting patients in meeting their physical needs (e.g., nutrition and hydration, hygiene and elimination, circulation and range of motion in the extremities, and vital signs), assessing physical and psychological signs of distress or injury of patients who are in seclusion or restraint, and recognizing readiness for the discontinuation of these interventions.

ii. A written assessment of the need for seclusion or restraint and of the general comfort and condition of the patient shall be done at the time of the initial application of the seclusion or restraint and every 15 minutes thereafter, or at more frequent intervals as

directed by the physician. The assessment shall be recorded on the Restraint and Seclusion Monitoring Form.

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b) Although audiovisual monitoring may be useful for time-out, one-toone constant observation shall be used to monitor persons in seclusion or restraint. Staff members assigned to provide one-to-one constant observation may not have other assigned responsibilities during the time period that they are assigned this supervision responsibility.

c) For patients held in manual restraint, a separate staff member not involved in the manual restraint shall carefully observe the patient's physical status. If the patient is complaining of physical discomfort or difficult breathing, or the staff person "witnessing" the event notices a physical change of color or similar concern, the RN or physician must assess the situation and alleviate the physical problem.

d) In order to reduce the possibility of choking, unless clinically indicated, patients shall not be fed while in restraints. If a patient has been restrained and not fed during mealtime, immediately after release from restraints, he or she shall be offered food and fluids.

e) In order to assess the patient's physical status during the use of seclusion or restraint, vital signs, consisting of blood pressure, temperature, pulse and respiratory rate, shall be taken and recorded on the Restraint and Seclusion Monitoring Form according to the following guidelines:

   i. For patients in restraint, vital signs should be taken immediately after application of restraint, every fifteen minutes thereafter, and upon release, or more frequent as ordered by the physician.

   ii. For patients in seclusion, vital signs should be taken immediately after placement in seclusion and upon release if the patient's behavior is such that vital signs can be taken safely.

   iii. If a patient is in seclusion beyond a period of 1 hour, vital signs should be taken every fifteen minutes or more frequently as specified by the physician, if the patient's behavior is such that vital signs can be taken safely.

   iv. If vital signs of a patient in seclusion or restraint cannot be taken safely at the frequency required, the reason for each omission shall be documented in the patient's clinic record.

f) A patient shall be released from seclusion or restraint as soon as he or she no longer presents an imminent risk of danger to self or others,

consistent with the behavioral description provided by the physician in determining that seclusion or restraint was warranted. Unless the nurse, doctor, or physician's assistant determines that the patient is obviously dangerous, an attempt should be made to release the patient at least once every 15 minutes.

i. If a patient, upon this attempt to release him/her from seclusion or restraint, is determined to be a continued danger to self or others, the intervention may be continued, unless the order pursuant to section E)3) has expired.

ii. If the order has expired, a subsequent episode of seclusion or restraint can only be initiated in accordance with the procedures set forth in section E)3).

iii. If a patient, upon being released from seclusion or restraint, makes no overt gestures or verbalizations that would indicate a threat of serious harm or injury to self or others, the procedure shall not be re-imposed.

g) It is the responsibility of the physician who has ordered seclusion or restraint to be accessible to staff in the event of an emergency. Accordingly, the physician shall advise appropriate staff how to contact him or well, or a relief physician, during the period of the order.

h) Each State-operated psychiatric facility shall develop and implement written procedures to ensure that physicians are accessible to staff on all shifts when the physician who has ordered seclusion or restraint is off duty after writing the order. These procedures shall include mechanisms for communication among shifts regarding the names of patients in seclusion or restraint, the condition of the patients, changes in medication and any complications or problems encountered during the period of seclusion or restraint.

5) Reviewing the Use of Seclusion or Restraint

a) <u>Patient Evaluation:</u> Upon the patient's release, the registered nurse, nurse practitioner, or physician's assistant shall conduct an in-person re-evaluation of the patient document on form a description of the patient's response to the use of seclusion or restraint.

b) <u>Post-Acute Event Analysis:</u> Immediately following the episode of seclusion or restraint, the key individuals involved in the procedure, including the staff who authorized and ordered the seclusion or restraint shall conduct and document a post-acute event analysis.

i. When possible, the debriefing should be led by the on-site supervisor, and an individual who is not part of the treatment team should be invited to participate.

ii. The post-acute event analysis should include the patient, if clinically appropriate, and significant others at the patient's request.

iii. This analysis must include an assessment of the patient's immediate needs (e.g., physical well-being, psychological comfort, and right to privacy), which shall be documented in well as the patient's clinical record, as determination of the steps that need to be taken to return to the pre-crisis milieu.

iv. An assessment of the involved staff member's physical and psychological well-being shall also be made.

c) <u>Formal Debriefing:</u> The formal debriefing is a collaborative process that includes the patient, the treatment team, and other involved parties. It should occur no later than the next business day following the use of seclusion or restraint and shall be conducted by a senior manager.

i. The purpose of this debriefing is to review what happened, and how the participants feel about what occurred during the event. ii. The scope and depth of the formal debriefing shall be commensurate with the nature and duration of the intervention utilized, provided minimum Joint Commission and CMS requirements are met. iii. The formal debriefing shall include a review of the patient's plan of care (treatment plan and individual crisis plan) and a modification of such documents where indicated or documentation why revisions were not made.

iv. As part of this debriefing, the patient should be assisted in identifying what led to the incident and what could have been done differently_ A determination should also be made whether or not alternatives to seclusion and restraint were considered, with a goal of avoiding the need to have to use such interventions in the future.

d) <u>Quality Assurance Review of restrictive intervention</u>

i. Application of information gained. The information gathered from the post-acute event analysis and formal debriefing should be used to identify, evaluate and modify facility policies and procedures, unit environments, rules, practices, staff interactions, individual crisis prevention plans, individual treatment plans, training needs and other areas, as appropriate.

ii. Such information shall be documented in a record that is not part of the patient's clinical record, (such as NIMRS).

However, any recommended solutions or intervention preferences offered by the patient during the Post-Acute Event Analysis or Formal Debriefing must be noted in the patient's clinical record, to ensure such information is considered in future situations, and implemented whenever clinically appropriate.

e) It shall be part of the treating psychiatrist's responsibilities upon coming on duty to review the clinical record of any patients for whom he or she is responsible who have been in seclusion or restraint since he/she was last on duty, and to ascertain their current status.

f) A report indicating the utilization of seclusion and restraint is available to clinical director or designee on a daily basis."

i. the patient's name and ward;
ii. the type of seclusion or restraint used;
iii. the length of time that the patient was in seclusion or restraint for each written order;
iv. the behavior(s) necessitating the intervention; and
v. any less restrictive techniques attempted and a statement of why there were found inadequate.

g) The clinical director or designee shall review the use of seclusion and/or restraint daily and shall immediately investigate unusual or unwarranted patterns of utilization. Each episode of seclusion or restraint involving patients under the age of 18 shall be reviewed by the clinical director or designee no later than the next working day.

h) Multiple episodes of seclusion or restraint with an individual patient shall be reviewed by the patient's treatment team and the clinical director or his or her designee. At a minimum, such reviews, which shall include a review of the patient's treatment plan, including an assessment of current medications, shall be conducted whenever three or more orders are written for a given patient within a 30-day period. The review team shall include a senior psychiatrist and, if available, at least one peer specialist.

i) As part of the facility's quality management program, the incidence of violent behavior and the associate use of seclusion and/or restraint shall be monitored. Data regarding each order of seclusion and/or restraint shall be collected, analyzed, and reported to Central Office. These data shall be integrated into facility and Office of Mental Health performance improvement activities.

j) Injuries and deaths related to the use of seclusion and/or restraint shall be reported as incidents pursuant to the mandates of 14 NYCRR Part 524 and the Office of Mental Health clinical risk management and incident management plans policy (QA-510). Staff injuries shall also be reported, pursuant to employee accident reporting policies.

k) The Office of Mental Health shall report to the Centers for Medicare and Medicaid Services any death that occurs while a patient is secluded and/or restrained, or in which it is reasonable to assume that the death is a result of seclusion and/or restraint. This notification will be made by the Office of Mental Health Director for Quality Management after consultation with Associate Commissioner for State

Psychiatric Center Management and the Chief Medical Officer or his/her designee and will occur by the next business day following the patient's death.

6) Training

a) The facility shall assure that clinical staff, including professional staff, as well as any staff that may be involved in the seclusion and restraint, receive orientation and instruction in alternatives to both seclusion and restraint, the appropriate techniques of applying both seclusion and restraint, the potentially traumatic impact of seclusion and restraint, and the laws, regulations, policies and procedures governing the use of seclusion and restraint. The training shall also address the sensitization of staff regarding the use of seclusion and restraint and shall allow each staff member the opportunity to experience at least one of these interventions. When appropriate, persons who have experienced seclusion and restraint as patients shall be included as providers of training. If such persons are not available as trainers, the viewpoints of persons who have experienced seclusion or restraint shall be presented using written or audiovisual material, as available. A written record of training shall be maintained.
b) Such training must be provided to all staff working an inpatient setting who interact with patients as follows: a 3-day minimum training program should be provided initially, with a 2-day review program provided on an annual basis.
c) Staff must initially demonstrate competency in all of the training areas identified in paragraph a) of this subdivision prior to their participation in the seclusion or restraint of a patient and shall further be required to demonstrate such competence on an annual basis.

7) Use of Mechanical Supports

a) The requirements of this directive do not preclude the use of mechanical supports. For devices intended to keep a person in a safe or comfortable position, however, the patient must be able to release the device at will, otherwise, the procedure needs to be defined and handled as a restraint.
b) The use of mechanical supports shall be ordered by a physician as part of the patient's treatment program in accordance with facility policy. Such order shall be documented in the patient's clinical record.
c) As a matter of policy, mechanical supports shall not be used as a substituted for restraint. In those rare events in which they are used as a form of restraint, such use shall only be implemented following the prior approval of the Chief Medical Officer of the Office of Mental

Health or his/her designee and in accordance with the provisions of Section F below

F. Procedures for use of Restraints for Medical or Post-Surgical Care

As with all restraint, risks associated with restraints for medical or post-surgical care must be considered in the ongoing loop of assessment, intervention, evaluation, and reintervention. The greater the risks associated with an intervention, the more thorough the assessment must be. The following guidelines apply to restraint of a patient in a facility operated by the Office of Mental Health for purposes of medical or post-surgical care:

1. A restraint for medical or post-surgical care shall not serve as a substitute for adequate staffing to monitor patients.
2. The use of restraints for medical or post-surgical care shall be implemented in accordance with a written modification of the patient's treatment plan.
3. Implementation of medical or post-surgical restraint shall be pursuant to a physician's written order, based on the results of a documented personal examination of the patient by the physician.
4. The examination of the patient conducted by the physician shall include an assessment of the patient's mental status and physical condition, as well as a review of the clinical record for any pre-existing medical diagnosis and/or physical condition which may contraindicate the use of restraint.
   a) The assessment shall include an evaluation of the patient's general condition and vital signs, and any other examinations which are clinically necessary.
   b) The results of the examination shall be documented in the patient's clinical record, along with the inadequacy of less invasive interventions, the specific circumstances that necessitated the restraint, and the purpose that the intervention is to serve.
5. The physician's written order shall:
   a) be written on the Order Sheet or electronic equivalent and included in the patient's clinical record;
   b) specify the facts and circumstances justifying the intervention and set forth the time of initiation and expiration of the authorization;
   c) specify the specific type of restraint to be used; and
   d) include any special care or monitoring instructions.
6. The maximum time period for each order of restraint for medical or post-surgical care shall be 24 hours.
7. Implementation of the restraint order for medical or post-surgical care shall be consistent with standard techniques to ensure safety and efficacy. The facility shall assure that clinical staff, including professional staff, receive orientation and annual instruction in all techniques commonly used in the facility for restraining patients in medical and post-surgical care.
8. A patient in restraint shall be monitored to ensure that his or her physical needs, comfort and safety are properly addressed, including

administration to the patient's limbs of range of motion exercise at least every 2 hours, when the patient is awake.

9. When utilizing four point or five-point methods of mechanical restraints for medical or post-surgical care, written assessment of the need for the restraint of the general comfort and condition of the patient shall be done at the time of the initial application of the restraint and every 15 minutes thereafter, or at more frequent intervals as directed by the physician. The assessment shall be recorded on the Restraint and Seclusion Monitoring Form. Such patients shall be continually monitored on a one-to-one basis. For all other forms of mechanical restraint used for this purpose, written assessment of the need for the restraint of the general comfort and condition of the patient shall be done at the time of the initial application of the restraint and every hour thereafter, or at more frequent intervals as directed by the physician. The assessment shall be recorded on the Restraint and Seclusion Monitoring Form.
10. When utilizing four point or five point methods of mechanical restraint for medical or post surgical care, in order to assess the patient's physical status during the use of restraint, vital signs, consisting of blood pressure, temperature, pulse and respiratory rate, shall be taken and recorded immediately after application of restraint, hourly thereafter, and upon release, or more frequently as ordered by the physician. For all other forms of mechanical restraint used for this
11. purpose, such vital signs shall be taken and recorded immediately upon application of the restraint and thereafter on a daily basis, or at more intervals as directed by the physician.
12. It is the responsibility of the physician who has ordered the medical post-surgical restraint to be accessible to staff in the event of an emergency. Accordingly, the physician shall advise appropriate staff how to contact him or her, or a covering physician, during the period of the order.
13. The clinical director or designee shall review the use of medical or post-surgical restraint daily and shall immediately investigate unusual or unwarranted patterns of utilization.
14. Injuries and deaths related to the use of medical or post-surgical restraint shall be reported as incidents pursuant to the mandate of 14 NYCRR Part 524 and the Office of mental Health incident management policy (QA-510).
15. The Office of Mental Health shall report to the Centers for Medicare and Medicaid Services any death that occurs while a patient is

restrained, or in which it is reasonable to assume that the death is a result of restraint. This notification will be made by the Office of Mental Health Director for Quality Management after consultation with the Associate Commissioner for State Psychiatric Center Management and the Chief Medical Officer or his/her designee and will occur by the next business day following the patient's death.

G. Clean/Aftercare of Restraint and Seclusion Equipment

1. Leather Restraints
   a) Wear gloves
   b) Clean between individual use with facility approved disinfectant
   c) Allow disinfectant to fully air dry
   d) If restraints are heavily soiled, they should be discarded.
2. Restraint Bed
   a) Wear gloves
   b) Clean between individual use with facility approved disinfectant
   c) Allow disinfectant to fully air dry

H. Code Orange Policy

Purpose: To provide rapid response to psychiatric emergencies.

<u>Staff Responsibility and Action</u>

<u>Safety Department</u>

1. Staff at scene alerts the Safety Department (verbally, 3333, personal alarm, drop phone)
2. Makes immediate overhead announcement: "CODE ORANGE/CODE ORANGE: A PMCS alarm has been activated (location). All trained staff please respond to scene."

<u>Ward Charge</u>

1) Responsible for the overall direction of the code maintaining the safety of the patient and directing available staff in various roles.

2) Determines what happened and obtains verbal report from the staff member who witnessed the behavior which resulted in the code.

3) Ensures patient safety and proper PMCS techniques are being used

4) Ensures that only one staff member is speaking with the patient (point person) and monitors the interaction for effectiveness (Directs other staff to refrain from talking to patient).

5) Makes decisions about movement of patient, need for PRN, informs the responsible physician, evaluates need for seclusion or restraint. Directs other staff to contact medication nurse, summon physician, or ready the mechanical restraint bed as needed.

6) Gives report to NA1 upon arrival.

7) Monitors the CODE environment and takes actions as necessary.

   a) Others present are to speak only when necessary, and then very quietly.
   b) Other patients and visitors are to be removed from immediate area.
   c) Directs staff to turn off radios and TVs to decrease noise level and stimuli.
   d) Excuses excess staff who may have responded.
   e) Excuses staff who are not using appropriate PMCS techniques or who may be disruptive to the process. (i.e., angry response to patient).

8) Assures the psychiatric emergency is appropriately documented in the medical record and reported in the Grounds Report and to the oncoming shift.

Nurse Administrator 1 (NA1)

---

1) Immediately responds to scene of psychiatric emergency.

2) Provides assistance to Ward Charge as directed.

Attending Physician

1) Reports to scene if restraint or seclusion is initiated, physician must respond in accordance with directives outlined in Section E3j) of this policy.

I. Restraint Rooms and Seclusion Rooms Location

Bridgeview

Trinity

Ward 093 Restraint Room

Ward 094 Restraint/Seclusion Room

Children & Youth Services

Ward 066 Manual Restraints
Ward 067 Seclusion Room
Ward 068 Seclusion Room

Date of Issue: 7/19 By T.L.: 2019-04 Section: II Page 26
Subject: Restraint/Seclusion Policy

GUIDELINES

	Children/Youth	Adult	SOTP
Manual	Yes *up to 15 minutes per order*	Yes *up to 15 minutes per order*	Yes *up to 15 minutes per order*
Mechanical	NO	Yes *up to 1 hour per order*	Yes *up to 1 hour per order*
Seclusion	UNDER 10: Requires case by case prior approval of Clinical Director and OMH Chief Medical Officer *up to 30 minutes per order*	Yes *up to 1 hour per order*	Yes *up to 1 hour per order*
	AGES 10-12: Requires case by case prior approval of Clinical Director *up to 30 minutes per order*		
	AGES 13-18: Yes--up to 30 minutes per order*		

Appendix E

Affix pt sticker here

C & Y SHIFT CHANGE FORM

Ward: ___________________________ Date: ______________

Shift:____

Shift Charge Nurse: ____
MHTA:____

Trauma/Behavioral Informed Data

Reason for Admission
Assigned Target Skill
Trauma History: Yes_____ No______ Triggers
Current Presentation
Calming Techniques and Coping Skills

Appendix F

"Talk me down" Toolkit

Ifeomanneka Susan Ikwukeme

Trauma includes:

- Direct experience of the traumatic event
- Witnessing the traumatic event in person;
- Learning that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental)
- Experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).

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  unless work-related).

Emotional response to trauma

Immediate emotional response to trauma include numbness and detachment, anxiety or severe fear, guilt (including survivor guilt), exhilaration as a result of surviving, anger, sadness, helplessness, feeling unreal, depersonalization, disorientation, feeling out of control, denial, constriction of feelings and feeling overwhelmed

Delayed emotional trauma response to trauma include irritability and/or hostility, depression, mood swings, instability
Anxiety (e.g., phobia, generalized anxiety), fear of trauma recurrence, grief reactions, shame, feelings of fragility and/or vulnerability, emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)

- (Center For Substance Abuse Treatment (U.S, 2014)

Delayed cognitive trauma response

- Delayed cognitive trauma response includes intrusive memories or flashbacks, reactivation of previous traumatic events, self-blame, preoccupation with event, difficulty making decisions, magical thinking such as belief that certain behaviors, including avoidant behavior, will protect against future trauma, belief that feelings or memories are dangerous, generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) and suicidal thinking
- (Center For Substance Abuse Treatment (U.S, 2014)

Cognitive trauma response

- Immediate cognitive trauma response include difficulty concentrating, rumination or racing thoughts (e.g., replaying the traumatic event over and over again), distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes), memory problems (e.g., not being able to recall important aspects of the trauma) and strong identification with victims
- Delayed cognitive trauma response includes intrusive memories or flashbacks, reactivation of previous traumatic events, self-blame, preoccupation with event, difficulty making decisions, magical thinking such as belief that certain behaviors, including avoidant behavior, will protect against future trauma, belief that feelings or memories are dangerous, generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) and suicidal thinking
- (Center For Substance Abuse Treatment (U.S, 2014)

Physical trauma response

- Immediate physical trauma response include nausea and/or gastrointestinal distress, sweating or shivering, faintness, muscle tremors or uncontrollable shaking, elevated heartbeat, respiration, and blood pressure, extreme fatigue or exhaustion, greater startle responses and depersonalization
- Delayed physical trauma response include sleep disturbances, nightmares, somatization (e.g., increased focus on and worry about body aches and pains), appetite and digestive changes, lowered resistance to colds and infection, persistent fatigue, elevated cortisol levels, hyperarousal, long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
- (Center For Substance Abuse Treatment (U.S, 2014)

Behavioral trauma response

- Immediate behavioral trauma response include startled reaction, restlessness, sleep and appetite disturbances, difficulty expressing oneself, argumentative behavior, increased use of alcohol, drugs, and tobacco, withdrawal and apathy and avoidant behaviors
- Delayed behavioral trauma response include avoidance of event reminders, social relationship disturbances, decreased activity level, engagement in high-risk behaviors, increased use of alcohol and drugs and withdrawal

- (Center For Substance Abuse Treatment (U.S, 2014)

Typical Trauma-related Symptoms

- **Triggers** are sights, sounds, smells, and touches, that remind the person of the trauma.
- **Flashbacks** are recurring memories, feelings, and thoughts.
- **Traumatic stress** brings the past to the present.

Trauma-Informed Care: Competency Assessment

- **Assess if your organization…**
  - Causes patient more harm ?
  - Lacks Capacity to handle trauma patients?
  - Is Trauma-Neutral?
  - Is Trauma-Sensitive?
  - Is Trauma-Informed?
  - Is Trauma-Proficient?

Training Objectives

- Define Trauma and Trauma-Informed Care
- Review Prevalence and Implications
- Compare Trauma-Informed and Trauma-Insensitive Systems
- Identify Core Elements of Organizational Commitment

What Happens when Traumatized People are Restrained or Secluded?

Research studies have found that children who were secluded:

- Experienced vulnerability, neglect, shame
- Repeatedly express being reminded of their original abuse
- Express feelings of fear, rejection, anger and agitation (verbally and in drawings) (Chieze, Hurst, Kaiser, & Sentissi, 2019)

Trauma and PTSD

- Effects of a traumatic event may occur a few hours, several days, or a month after exposure to traumatic events, including after restraint or seclusion. Trauma symptoms would be present. PTSD may develop if symptoms continue and if left untreated.
- Our work in TIC will help alleviate the symptoms and potential of developing PTSD.

Trauma Trigger

- The memory of the traumatizing event can trigger a response of intense fear, horror and helplessness in which extreme stress overwhelms one's capacity to cope.
- We must be aware of the negative impact that exposure to those or people, places or things can have in triggering or re-traumatizing. For example, a dark room may trigger a memory of abuse in a dark room. Just hearing a voice similar to the abuser's may create a crisis situation for the child.

Important Note !!!!!

It is important to know that the symptoms of trauma are survival strategies that patients develop to helped them cope with terrible pain and challenges. The key is learn how the behavior developed and teach new coping strategies. We need to presume that the clients we serve have a history of traumatic stress, and exercise "universal precautions" by creating systems of care that are Trauma-Informed

Hodas, 2005

Important facts about Trauma

- One-time events can be as traumatic as repeated events. It is important to not minimize single occurrences like a rape, a serious automobile accident, or being involved in a natural disaster.
- 90% lifetime trauma exposure has been reported among psychiatric patients
- 61% of the patients in a psychiatric setting had experienced at least one traumatic event
- Childhood and sexual abuse in between 34% and 81% of patients with severe mental illness (Floen & Elklit, 2007)
- American study of 100 adolescent inpatients: 93% had trauma histories and 32% had PTSD (Sareen, 2014)

Trauma-Informed Care

- Recognition of prevalence of trauma
- Assessment and treatment for trauma
- Focus on *What happened to you?* vs. *What is wrong with you?*
- Informed by current research
- Recognition that coercive environments are re-traumatizing

Long Term effects of Trauma

- The more adverse/traumatic a childhood, the higher the health risk. Brain development, cognitive, and emotional abilities are influenced by trauma. This promotes high-risk behaviors such as substance abuse and sexual acting-out that in turn increase health issues and can lead to early death.

- In addition, just being in the mental health system can produce circumstances that affect long-term health and well-being.

De-escalation: trauma informed care Trauma Assessment: Key Principles

- **Assessment:** Trauma assessment must be completed during admission or shortly afterwards. It is used to identify past or current trauma, violence, and abuse, and assess related issues. It also provides context for current symptoms and guides clinical approaches and recovery progress and informs the treatment team to minimize potential for re-traumatization. Trauma assessment should include type of abuse, age of event, identify of perpetuator of the abuse and assessment of such symptoms such dissociation, flashbacks, hyper-vigilance, numbness, self-injury, anxiety, depression, poor school performance, conduct problems, eating problems, etc.
- **Therapeutic engagement and communication:** Importance of therapeutic engagement during interview cannot be over-emphasized
- **Focus:** Focus on what 'happened to you' in place of what is 'wrong
- with you' (Bloom, 2002)
- **Understanding:** Attempt to gain an understanding of the impact of the trauma focusing on cognitions, emotions and behaviors

Safety Planning

- **A safety plan is and Safety Plan is** an individualized plan developed proactively by a patient and staff before a crisis occurs. It is a therapeutic process and involves task that are trauma sensitive and are developed in partnership with patient, family and staff
- Safety plans can be used;
- A. During the earliest stage of escalation before a crisis occurs
- B. The patient identify coping strategies before they are needed
- C. Staff use interventions that reduce risk and trauma to individuals
- D. Staff plan ahead and know what to do with each person if a problem arises

Components of a Safety Plan

- **What are the safety plan components?**
- Essential components of a safety plan are: Triggers, Early waring signs and Calming strategies.
- Triggers such as not being listened to, lack of privacy, feeling lonely, darkness, being teased or picked on, feeling pressured, people yelling, being isolated, arguments, loud noises feeling of loss of control, room checks, being touched, staff reminding them of abuser, contact with family. Each patient has unique trauma histories and unique special triggers, so it is very important to identify triggers in each safety plan.
- Early warning signs such as clenching teeth, wringing hands, bouncing legs, shaking, giggling, crying, heart pounding, singing inappropriately, pacing, breathing hard, eating more, shortness of breath, loud voice, rocking, restlessness and swearing.
- Calming strategies include reading a book, pacing, coloring, weighted blankets or comfort blankets and animals, taking a hot/cold shower, deep breathing, taking space away, talking to peers, therapeutic touch as specified by patient (as permission first), exercising, eating, writing in a journal, listening to music, calling friend and family , crafts.

Shift Change Form

- As we all know the purpose of shift change report is to ensure that the staff on the next shift are fully aware of what is happening on the ward: what has gone well, problems which have arisen, and anything else outstanding which needs to be addressed.
- Using the shift change report, for each patient, you should be able to answer the following clearly, accurately and in a concise way.

a. Reason for Admission

b. Assigned Target Skill

c. Trauma History and Triggers

d. Current Presentation

e. Calming Techniques and Coping Skills

Trauma-Informed Care Culture

- Patient is center of his/her own treatment
- Patient and family are empowered
- Wellness and self management are the goal
- Transparent and open to outside parties
- Power/control are minimized
- Staff are trained and understand function of behavior

Trauma-Informed Care

- The focus is on collaboration and working together.
-
- Not engaging in interactions that are demeaning, disrespectful, dominating, coercive, or controlling
- Responding to disruptive behaviors with empathy, active listening skills, and questions that engage the person in finding solutions

Trauma-Informed Language

- Person-centered
- Respectful - get permission to use first name
- Conscious of tone of voice and noise level
- Body language
- Helpful and hopeful
- Objective, neutral language

Trauma-Informed *Environment*

- Always maintain a respectful interaction
- Create opportunities for individual "space" and activities
- Maintain a welcoming settings
- Facility is patient centered
- In Trauma informed Care, each person is appreciated and respected. Individuality and acknowledgement of individual needs is a priority.
- Open communication is signaled by an atmosphere where staff are approachable.
- Example: The use of "Do Not" signs and rules is transformed into helpful and encouraging verbiage. Always utilize Trauma Informed therapeutic communication

Non-Trauma-Informed Culture

- Lack of education on trauma
- Focus is on rule enforcement and compliance
- Behavior seen as intentionally provocative
- Labeling patients: Avoid verbiages such as *"manipulative, needy, attention-seeking"*

Problems Associated with a Controlling Culture

- Focus is on staff, not the recipient
- Addressing a problem is built around staff and program convenience
- Rules become more important as staff knowledge about their origin erodes
- The person's compliance and containment are mistaken as actual learning of new skills and/or real improvement

Problems Associated with a Controlling Culture

- Minor violations often lead to control struggles
- Fosters a belief that privileges (rights) must be earned
- Reinforces a need to control the patients
- Poorly trained staff who bully patients into compliance are not identified or disciplined
- These same staff may be rewarded for maintaining safety or creating a quiet shift

Organizational Commitment to Trauma-Informed Care

- Adoption of a trauma-informed policy to include:
  - Commitment to appropriately assess trauma
  - Avoidance of re-traumatizing practices
  - Key administrators on board
  - Resources available for system modifications and performance improvement processes
  - Education of staff prioritized (Fallot & Harris, 2009)

Organizational Commitment to Trauma-Informed Care

- Unit staff can access expert trauma consultation
- Unit staff can access trauma-specific treatment if indicated

Fallot & Harris, 2002; Cook et al., 2002

Organizational Commitment to Trauma-Informed Care

- Assessment data informs treatment planning in daily clinical work
- Advance directives, safety plans and de-escalation preferences are communicated and used
- Power & Control are minimized by attending constantly to unit culture

(Fallot & Harris, 2009)

In Summary

- Understand the effect of Restraint and Seclusion on trauma patients.
- Understand the characteristics of trauma-informed care and how this differs from care that is not informed by trauma
- Assess histories and symptoms of trauma and link to treatment plans/crisis plans
- Provide support and skill development

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Appendix G

“Talk me down” Project Chart Review Forms

TIC-OSAT Pre and Post Implementation Survey

Staff #	Role (RN/MHTA)	Part I Scores		Part II Scores		Part III Scores		Part IV Scores		Part V Scores	
		Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											

“Talk me down” Project Chart Review Forms

Number of Restraints and Seclusions(R/S) (Pre and Post Implementation)

5 weeks Pre-Implementation of “Talk me down” toolkit		
Total Population of patients sampled	**Total# of “Code Orange (CO)”**	**Total # of R/S**
27		

5 weeks of Implementation of “Talk me down” toolkit			
Population of patients sampled	**Week**	**Total # of “Code Orange”**	**# of R/S per week**
27	**Wk 1**		
27	**Wk 2**		
27	**Wk 3**		
27	**Wk 4**		
27	**Wk 5**		
Total Population Sampled		**Total # of “Code Orange” in 5 wks**	**Total # R/S in 5 wks**
27			

Appendix H

INSTITUTIONAL REVIEW BOARD

OF
THE NATHAN KLINE INSTITUTE FOR PSYCHIATRIC RESEARCH
&
ROCKLAND PSYCHIATRIC CENTER
140 OLD ORANGEBURG RD.
ORANGEBURG, NY 10962

Nigel Bark **CHAIRMAN** | **Fabien Tremeau** **Co-CHAIRMAN** | **Abel Lajtha** **Vice-CHAIRMAN**

To:	Ifeomanneka Ikwukeme
From:	Nathan Kline Institute/Rockland Psychiatric Center Institutional Review Board (IRB)
IRBNet ID:	1635172-1
TITLE:	Therapeutic Communication Techniques to Reduce Physical Restraint and Seclusion in a Psychiatric Inpatient Hospital for Children

Date: August 17, 2020

The IRB has reviewed your submission of the *Determination of Human Subjects Research Form*. The IRB Acknowledges receipt of the document and confirms that based on the information that has been provided, the activity described does not meet the definition of Human subjects research as delineated by DHHS regulations [45 CFR Part 46] and FDA regulations [21 CFR Part 50 and 56].

As such, no further correspondence is required to the IRB. As part of the review of this determination request, the facility director at the location where the activity will be conducted has been informed of the project.

A determination of "Not Human subjects Research" does not absolve individuals conducting the activity of any ethical and legal responsibilities and obligations that may apply. Be advised precautions should still be taken to maintain requirements that have been set forth by institutional security policies and HIPAA regulations.

If any aspect of this activity is altered, or changes in the future, create a new IRBNet submission and provide a new *Determination of Human Subjects Research Form* in IRBNet for a new evaluation. Any modifications must be submitted and acknowledged by the IRB before the modified activity may be initiated.

Please retain a copy of this letter for your records. This activity was acknowledged on August 17, 2020.

If any concerns arise during the project the IRB may be contacted at NKI-IRB@NKI.rfmh.org.

Sincerely,

IRB Administration

Generated on IRBNet