Western Interstate Commission for Higher Education

Mental Health Program

ALASKA

ARIZONA

CALIFORNIA

COLORADO

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

HAWAII

IDAHO

MONTANA

NEVADA

NEW MEXICO

NORTH DAKOTA

OREGON

SOUTH DAKOTA

UTAH

WASHINGTON

WYOMING

www.wiche.edu/mentalhealth

Alaska Psychiatric Institute

Nursing Administration

and

Chilkat Program

Consultation Report

November

2016

TABLE OF CONTENTS

Alaska Psychiatric Institute

WICHE Onsite Consultation October 4-7, 2016

Kevin Huckshorn Ph.D. and Deb Kupfer, M.H.S

Purpose of Consultation: The Western Interstate Commission for Higher Education (WICHE) was asked to provide consultation services to the Alaska Psychiatric Institute (API) Department of Health and Social Services (DHSS) to review current, focused practices and processes at API and develop a report with recommendations on:

- ✓ API's Nursing Department Structure, Function, Staffing Models, Scheduling, Key Policies, Fiscal Issues, Best Practices
- ✓ Chilkat Unit (child/adolescent services) Structure, Processes, Policies, Best Practices

Overview of API and Outcomes Requested of Consultation

Brief Overview of API

Alaska Psychiatric Institute (API) is the sole, publicly-funded, state mental health hospital in the state of Alaska. API has a total of 80 beds spread out between five discrete treatment units. Two of these units serve persons with acute mental health presentations; one unit is 24 beds and one is 26 beds. These two adult-only units are most accurately described as acute care behavioral health services with very short lengths of stay (5-8 days). The other three API units have 10 beds each, and serve a varying population of people with a) forensic involvement, b) complex medical and mental health issues, and c) adolescents through age 17. These smaller units have longer stays, as compared to the two acute care units, from an average of 30 days to some months. API is accredited by the Joint Commission.

Alaska Psychiatric Institute (API) is a relatively newly built hospital facility that is characterized by a lot of natural light; one to two resident beds per room; private baths per each room; a semi-open nursing station; and two to three hallways to monitor from the nursing station hub. These units are made up of a lot of walled in specific "rooms" that are visible from one room to the other through windows.

Each of these units also houses an "Oak Room" that is the seclusion or restraint room and a "Level Room" that does not seem to be defined or used much. All units toured were bright with natural or soft lighting and comfortable furniture. There was not much individual artwork on the walls and most of the facility was painted the same neutral color.

The hospital has a partial EMR that does not include treatment plans. Most legal documents are still in hard copy. Staff appear to use the EMR and did not complain about the functionality. From the standpoint of a "surveyor or consultant" getting the "story" of an individual's admission was somewhat difficult, but could have been due to the consultants' lack of familiarity with the EMR.

There was a comment made in the API staff survey that a high-level executive would intervene if decisions made by the acting CEO and Medical Director did not meet some staff's approval (at least that is what consultants interpreted from this comment). This statement needs to be explored. When a hospital seeks to make significant culture changes in their clinical units there is no room for an executive staff person to be communicating a different message to staff. All the executive staff at API must be fully on board with plans to move forward.

Issues Currently Facing API

- In SY2018, Alaska Psychiatric Institute (API) faces a mandate to reduce their budget by $3.3 million, a 10% budget reduction. API nursing staff overtime exceeded $1.0 million in SY2015.
- The Alaska legislature has passed SB 74 mandating a study to determine the feasibility of API operated by a private contractor. It seems that this decision is being driven by financial issues, and overall state budget concerns, less than about the quality of care.
- One report reflects API Nursing Department has increased their administrative staff by 30%. Nursing Leadership disputes this and would like to see the data that went into this calculation.
- The API Nursing Department is also being asked about their overtime expenses. There is a reported overuse of overtime, and mandatory use of overtime (forced unscheduled work by staff on duty to fill next shift gaps). Also, API uses of on-call (temporary) staff to fill staffing shortages daily (reported to be from 7-14 staff per day). In addition, recent federal legislation (the ACA) requires temporary staff working over 130 hours per calendar months receive benefits. This legislation reduced the hours on-call temporary staff may work requiring full time staff to cover the units these on-call staff used to work.

- The adolescent service, Chilkat, is seeing a lot of adverse events that are leading to the use of restraint and seclusion. In addition, this unit is struggling with an unclear mission, vision and values template; a lack use of child and youth evidence-based practices and staff who are confused about the unit's philosophy and model of care.

Nursing Issues Addressed through this Consultation with Recommendations:

Clinical Practice Nursing Leadership and Evaluation Processes and Program Management:

- Nursing Structure
- Nursing Scheduling Process
- Nursing Evaluation Process
- Nursing Hiring Practices
- Nurse Executive Back-up Plans

API Chilkat Unit's Issues to Address through this Consultation with Recommendations:

- Chilkat Unit's Purpose
- Unit's Model that Guides Staff Treatment and Support Services including use of Point and Level Systems
- Evidence-based Practices and what this means and how to provide
- Chilkat's staff's roles and responsibilities while on duty
- Suggested Training for Chilkat staff
- Chilkat Documents that require Revision (Staff handbook for New Employees; Patient Handbook; Parent/Caregiver Handbook; Individualized Discharge Suggestions
- Traumatized Staff and how to assist them

Additional Findings/Recommendations:

- Performance Measures to Monitor for Improved Unit Quality
- API Mission, Vision, Values
- API Treatment Planning Processes
- API Seclusion and Restraint Policy
- API Grievance Procedures
- API Use of Close Observation (COSS) Processes
- API Use of Staff Personal Cell Phones
- API Job Descriptions

API Nursing Findings and Recommendations

Nursing Structure Findings

API currently has a rich nursing administrative structure for an 80-bed facility. API currently employs a DON, ADON, a Nursing Operations Coordinator, a Nursing Clinical Operations Coordinator, a senior Nursing Shift Supervisor on all shifts/365 days, and five Nursing Clinical Leads that work on the five individual units. In addition, some of these leadership staff's offices are not located on these clinical care units but are located on the second administrative floor.

One issue that became clear was API's current use of their "around the clock" staffing of Nursing Supervisors whom are all RN III's and senior staff. Most reports noted that these high-level RN supervisor staff spend 60-70% of their time in the nursing office trying to "call in staff to cover vacancies for the next shift."

The API clinical units are staffed using a basic core nursing staffing model that does not take into consideration the very different activities and workload in these units. The two acute adult units are much larger than the other three 10-bed units and have three to four times the admission and discharge work than does the smaller units. The child and adolescent unit (Chilkat) has the next shorter length of stay (30 days LOS) and the next largest amount of admissions and discharges along with an immense amount of discharge communication work with families, caregivers, the courts and foster care services. The Chilkat unit needs another Psychiatric Nurse Assistant (PNA) on at least day shift. That said, the core nursing staffing on these three units needs to take these very different activity levels into consideration.

It appears that the five unit Clinical Leads are serving in positions that straddle both a typical nurse manager position and a typical charge nurse position. This appears to be because at some point in the past these positions were intended to be filled by RN IVs who would be full members of the senior nursing management cohort and function as nurse managers with 24/7 responsibilities for the management of their units. Nurse manager responsibilities included authority for hiring functions and supervision of unit staff nursing; authority for providing disciplinary actions when necessary; staffing and scheduling and performance evaluations. This did not occur; it seems since the required number of RN IV positions never materialized or were used for other positions.

Currently, the Unit Clinical Leads are RN IIIs; are not considered managers in the API nursing union structure and so do not have authority to do much more than act as charge nurses during their shifts. However, the expectations for the Clinical Leads seem to be greater than just to act as charge nurses and these roles and responsibilities needs to be clarified. Also, apparently and

significantly missing, is a clear supervision framework by API nursing leader's regarding their roles in supervising and overseeing the API psychiatric nursing assistants (PNAs). This lack of formal supervision is a hospital practice issue. This consultant has never encountered this situation before.

The consultants were not totally clear on the staffing of the Nursing Education Department but it seems to be larger than usual for an 80-bed facility. API Nursing Education staff include three full time FTEs (2 RNs and 1 PNA). This staffing does not include another two RNs that work on the API EMR; and another RN FTE that provides services for Employee Health and Infection Control. Last, there is another nursing FTE that works in the PI department on data collection, patient education on metabolic syndrome, manages the durable medical equipment, oversees the Utilization Management Plan (audits for medical necessity), and other tasks. This role, considering all the tasks, still appears to be a half-time job.

It appears that each API Clinical Unit does their "face to face shift change report" differently. This face to face shift report is doable in the 30-minute overlap between 12 hours shifts and should be standardized once the staff RNs go to 12 hours shifts with the PNAs who already work these shifts.

Nursing Structure Recommendations

- ☐ API is an 80-bed facility. API also has several full-time RN IV nurse executives that include the ADON (supervises 5 FTEs), a Nursing Operations Coordinator who supervises the NSS's (7 FTEs), and a Nursing Practice Coordinator who supervises the Nursing Education Department (2-3 FTES). Most behavioral health hospitals do not employ this level of senior nursing staff in hospitals that are less than 150 beds. The employment of senior nursing staff FTEs depends on several variables (specific executive staff role responsibilities, number of staff supervised; and individual hospital expectations). That said API should review their current Nursing Senior Staff positions and determine what roles are necessary to move this department forward. All executive nursing staff should supervise no more than 8 staff, per AK state standards, depending on other responsibilities and their scope of work.
- ☐ The API nursing structure would benefit from full time Nurse Managers on the five units. The two acute adult units with 24-26 beds require a full-time Nurse Manager for each of these units. Given the unique competencies required for the management of a child and adolescent, that unit should have a full-time Nurse Manager even though it is a small unit. The other two 10 bed units could be managed by one Nurse Manager. The promotion of these RN IIIs to RNIV positions would greatly reduce the administrative

load on the DON/ADON and Nursing Operations Coordinator; to the point that one of the latter two positions could be eliminated.

- ☐ API should be well able to manage their Nursing Administration Positions with a DON who is responsible for overall nursing practice quality; oversight of nursing policies and procedures development and revisions; daily rounds of all units; review of daily scheduling issues; and review of daily adverse events in depth. These duties need to be reviewed as it was reported they are not current being done by the DON.
- ☐ In addition, the DON should be able to supervise the five Nursing Clinical Leads on the five units; three of which are 10 bed units. Supervision in this case requires a 30-minute face to face each week as well as open door meetings when necessary and performance evaluations annually.
- ☐ API may well need RNs to manage the EMR implementation but in most hospitals, this primary IT work is not necessarily provided by RNs although the nursing department has significant involvement in this work. API may want to review the use of two RNs in this role where a non-RN IT expert may serve just as well and in a more cost-effective manner.
- ☐ For an 80-bed hospital that mostly serves mid-age adults, adolescents and just one unit with older people the role of Infection Control Nurse could be a half-time or contracted position. It was not at all clear why this position is full-time in a facility that does not have physically vulnerable patients as in a geriatric unit or a substance abuse unit dealing with HIV, AIDs and Hepatitis C.
- ☐ The use of high level nursing supervisors (NSS positions) (one RN IV, the rest RNIIIs) should be restricted to aiding the five clinical units during the NSS staff person's shift. Hospital nursing supervisors are generally responsible to be the hospital's highest level administrative designee during evenings, nights, weekends and holidays; to provide clinical and administrative oversight functions when the usual hospital executive staff are not present. In these roles, nursing supervisors generally spend most of their time making clinical unit rounds; assisting the unit charge nurses; helping to cover gaps in staffing and assisting staff to take meals and breaks; providing emergency pharmacy coverage; attending any code calls or any other emergency situations; assisting with admissions and discharges off hours; and assuring that the hospital is well functioning throughout.
- ☐ API's use of NSS staff during the Monday through Friday day shifts needs to be reviewed. With so many other Nursing Leaders available it is very unclear why these NSS day staff members are also needed.
- ☐ The NSS positions at API are reported to be mostly involved with providing emergency staffing coverage; a task that keeps them confined to the nursing office or otherwise engaged in making phone calls during their shifts, up to between 50-70% of their shifts.

Most hospitals use non-RN positions to do this kind of work, albeit with RN oversight. API should review the use of their current NSS positions which were reported by staff to be engaged in staffing activities most their shifts. This is not a good use of high level, expensive, experienced RNs and does not assist the clinical units in doing their clinical work.

- ☐ The API core staffing requirements for the two adult acute units needs to be revisited. These two 24-26 bed units are also dealing with highly acute, often un-medicated new admissions at a rate of three to four times the other units. These two units require an additional RN on days and evenings to manage new admissions and the attention that new patients in acute distress require.
- ☐ The consultants were not clear on the use of an RN to provide what seemed like restricted duties in the PI Department. Hospital PI departments are not necessarily run by RNs but certainly can be. Usually the DON or ADON hold PI duties for the nursing department as do a senior staff member from each of the other disciplines and departments (physicians, social workers, etc.). At API this work appears to be tasked to the ADON so it is questionable why another RN is assigned to PI. Suggestion is to review the scope of work and tasks by all RNs in the PI department to be sure these are mandatory tasks that add up to full time FTEs. The consultants also want to note that each hospital's PI Department is often different and what needs to be reviewed in this case is the nature of the Nursing Departments PI projects to see if these support a full-time RN in the PI Department. Otherwise this RN position could be re-allocated to patient care.
- ☐ The API face to face shift change report is quite doable in the 30-minute overlap between 12 hours shifts and should be standardized once the staff RNs go to 12 hours shifts with the PNAs who already work these shifts. However, API policy also needs to clarify and direct the manner with which this shift change happens, twice a day, in a 12-hour shift rotation. This includes a clear direction from administrators that the oncoming shift staff to include both the RNs and PNAs to be present at this face to face shift exchange with the off-going shift RN. What this means, in practice, is that the current off-going shift PNAs and, at least one off-going RN on the adult units, needs to stay with the units' patients while this report is going on. Attendance at shift reports needs to be mandatory for all incoming nursing staff (RNs and PNAs) and that needs to be clear to all staff going forward. Missing shift report should be a mandatory counseling unless an emergency occurred. In addition, Shift Report Sheets need to cover all people in care and be standardized.
- ☐ The roles of the Nursing Supervisors to provide staffing management, 24/7 and 365 days is addressed below.

Nursing Scheduling Process Findings

API leaders sent current staffing configurations for each API unit and for the API Nursing Executives. This document and verbal reports by a number of staff informed the rest of this section.

At the time of this consultation the Executive Nursing staff were working four days a week and that is an unusual schedule in these consultants' experiences. In most hospitals, public and private, senior nursing executive staff work the same hours as the rest of the executive team; generally, Monday through Friday.

The Nursing Shift Supervisors (NSS) are working on both 10 and 12 hours shifts that include day shifts (that occur while the DON, ADON and the Nursing Ops Coordinator are also on site). The PNAs are working 12 hour shifts while the unit RNs are working ten hour shifts. Reports reviewed note multiple layers of overlap between the API senior nurses (NSS, Clinical Leads, DON, ADON, Ops Coordinator) that work 10 and 12 hours shifts through each weeks schedule.

These different nursing staffing schedules are causing unnecessary overlap and wasted staffing resources without any accompanying data to show improved quality of care. Also, the current use of ten hour shifts for senior executive nursing leaders means that at least one day per work week is left uncovered while executive nursing leader roles require daily coverage in all hospitals.

As noted in the Overview Section, API is now having to cut the hours of their temporary on-call nursing staff (RNs and PNAs) that have been heavily relied upon for years to avoid staffing gaps and forced mandation of overtime. API is going to have to move fast to avoid a large uptick in mandation, as well as, to try and avoid the loss of these temporary on-call staff who have, to now, relied on full time employment at API. This is a difficult path to manage but could be managed with a careful analysis of how many additional "on-call" staff who will need to be added to make up these hours while not infringing on current on-call staff schedules and workloads.

Nursing Scheduling Process Recommendations

- ☐ The API CEO, Medical Director and CNO/DON should review the API senior nurses' FTE's roles and responsibilities. Nursing staff usually make up the largest mental health state hospital department and, as such, over 60-70% of a hospital's budget. Hospital Nursing staff are also the only hospital staff that provide 24/7 hours of care to persons served in hospitals. However, all hospitals must stay within budget so the current table of organization for the entire nursing department should be clear and each position justified based on clear, data-based rationales for each of the senior, administrative

nursing positions. In addition, all senior administrative nursing administration positions should be expected to be cross-trained to work on any unit in emergency situations, provide coverage during training, as well as to make routine, consistent rounds during their working hours in all clinical areas of the hospital.

- ☐ The consultants understood that there were recent increases to the API Nursing Administration FTE's that caused the reported 30% increase in Nursing Department Administrative staffing at API. This data was not understood by the senior nursing leadership, during the consultant's visit, and should be shared with the API nursing executive leadership timely so all API executives are working from the same knowledge base.
- ☐ The consultants recommend a full discussion with the API nursing executive team to discuss a return to five days, regular, Monday through Friday schedules as noted above. Hospitals run 24/7 and 365 days and high Level Nurse Executives at API (the DON and the RNIVs) need to work the same schedule as the rest of the API executive staff.
- ☐ The consultants also have understood that unit staff RNs will be joining the unit staff PNA's in going to 12 hours shifts in the next month or so. This is a very good move to reduce staffing overlap times and settle staff into regular routines.
- ☐ Attention needs to be paid to why there are Nursing Shift Supervisors working regular day shifts, Monday thru Friday, when the DON, ADON, the Nursing Practice and the Nursing Operations Coordinator are also working. This a not a usual practice in most state hospitals, even in much larger state hospitals, and could reflect a cost saving measure for API, if could be changed. The Nursing Shift Supervisor role should move to evening/nights only (7pm to 7am)12-hour shifts to be consistent with the above trends. This action will be very difficult for API's day supervisors and needs to be approached carefully and compassionately. In all cases these day shift supervisors need to be offered positions on the clinical units that are as close to their current positions as is possible. We understand the issues related to union bargaining agreements.
- ☐ In addition, if the day nursing shift supervisors are eliminated, the duties of these nursing supervisors, working day shift at API, need to be studied and these tasks need to be clearly re-allocated to the other senior nursing staff members that are not NSS staff. Otherwise there will be unintended consequences and uncovered tasks.
- ☐ In general, most state mental health hospitals in the US use a nurse manager (or similar role) on day shifts and, nursing shift supervisors on evenings, nights, weekends and holidays to provide nursing administrative oversight for all administrative and clinical operational processes and practices on a 24-hour basis, every day. This model should be explored for API's use due to both the improvement in clarity on what senior staff are responsible for what tasks, as well as, cost efficiencies.

- ☐ At API, this change in roles, titles, and responsibilities (for the current Unit Clinical Leads) have confused everyone involved including API's current administration who were not there when this change in job status was done.
- ☐ As previously noted, API senior executives need to decide whether they want to support a "Unit Manager" model for their units where this RN Manager has 24-7 responsibility for their unit. This would require moving these 4-5 RN IIIs's to RN IVs and will be a relatively small budget issue though potentially difficult to do politically. Or, if API has to work with unit charge RNs, on day shift, that have no power or authority to manage, hire, discipline, or provide 24-hour guidance to their individual unit staff persons, then API needs to expect this work from their CNO/DON and any other senior Nursing leads. And if this is the plan going forward, these daily responsibilities for the API senior nursing management staff needs to be put in writing as this oversight is not functional now.
- ☐ Last, API executives need to get out ahead of the reduction of the "On-call" staff that were working full time at API to fill in nursing schedule gaps. These staff include both RNs and PNAs that have been used to working full time. For one action, API executive staff need to find out quickly if temporary On-call staff can sign a legal waiver that they already have health insurance and do not want or need benefits from AK State Government to provide a "work around" regarding this federal law that has affected all the states in this country.
- ☐ API executives and budget people need to immediately figure out how many hours are now lost that your usual on-call staff used to provide and calculate how many more on-call staff are needed to fulfill these lost hours. In no way should API seek to cut down their loyal on call RNs and PNAs work but API does need to fill these gaps to avoid regular staff mandation and resulting worse morale.

Nursing Evaluation Process Findings

Nursing evaluations at API are still only done by RN IVs in the nursing Department. The consultants did not see these evaluations.

What the consultants did notice was a very varied spread of nursing staff evaluation responsibilities across the organization that included individual nursing staff evaluations by persons who did not have daily contact with persons they were expected to supervise. These include the direct care staff performance assignments to the DON, ADON, RN Operations Coordinator and the RN Clinical Practice Coordinator. None of these latter four executive staff work the units or supervise unit staff daily. In general, executive staff for all disciplines should supervise and evaluate the performance of the middle manager staff that they work with.

These middle managers should supervise the direct care or unit staff they work with. And, frankly, regarding nursing staff, a nurse manager model would allow the Nurse Managers to evaluate the staff they work with, 24/7.

In addition, when queried, the spread of staff nursing evaluations over the API nursing department appeared to be quite varied from seven nursing staff to over 30 nursing staff.

Nursing Evaluation Process Recommendations

- ☐ The API policy on nursing staff expected to perform performance evaluations needs to be revised to include both clinical and attitudinal competencies, not just clinical competences. In addition, all nursing staff need to receive performance evaluations from the lead RN that has the most experience with them, during their work day. Last, no RN should be expected to do more than 24 performance evaluations during one year or some equal amount as the other RNs, including senior executive RN staff including the DON.
- ☐ WICHE consultants suggest consideration that API use "360 Performance Evaluations" for the API Nursing Department Executive and Middle Manager staff and all other Clinical Department leaders and middle managers for the next year. After 12 months of doing this kind of evaluation API should review this feedback and determine the API leadership performance evaluation policy, going forward. In general, 360 degree evaluations need to be managed by a very savvy HR staff that understand this kind of evaluation process and are trusted to do this well by API Leaders (with no politics involved and complete anonymity). The consultants can provide specifics on this kind of evaluation process. The consultants also realize that this may not be doable, politically.
- ☐ All nursing staff members should be evaluated for performance only by senior staff that work directly with them. If current union rules mandate that only nursing administrators can do performance reviews than 1.) this rule should be changed at next CBA negotiation as it is far from best practice, and 2.) a senior staff nurse can still fill out the evaluation with a sign-off signature by a nursing executive. This, of course, will put the non-supervisor executive leader in an uncomfortable position on whether to sign off on a staff member she or he does not know and has never seen work. This, herein, is the basic flaw in the API current practice regarding performance evaluations. It should not be surprising that API executive staff do not act timely to sign off on discipline on nursing staff that they do not know and have not observed.

Nursing Hiring Practices Findings

The most important finding regarding API nursing staff hiring practices centers on the fact that the individual unit's nursing clinical leads do not have lead roles in hiring staff for their units. Given that four of these five nursing units have very individualized populations, the fact that these unit nursing leaders do not have a full lead on hiring their own staff is a finding that has some potential consequences, including the quality of care, level of staff morale, and ability to create a true "unit team". In other words, is seems that currently other API nursing department staff make hiring decisions for these units though the Clinical Leads do have some inconsistent input. This is problematic as it minimizes the actual leadership of the Unit Clinical Leads and does not necessarily allow for the hiring of the best fit applicants.

Another issue regarding nursing hiring practices relates to API's current new employee Orientation Processes and Schedule. This previous nursing employee orientation process was scheduled for four weeks of classroom work, followed by 4 weeks of on-unit orientation time. These time frames were recently changed to two weeks of classroom work and two weeks of on-unit orientation time. There were a lot of comments, complaints and suggestions related to the old process and the new process. Other issues that arose included the fact that new employees do not get a full tour of the hospital during orientation and often do not even tour the clinical unit they were hired for until their 5th week of employment. Reports included that some new, inexperienced staff were very uncomfortable about their new roles on the clinical unit and resigned shortly after being introduced to their actual job on one of the clinical units which is a waste of API resources.

Nursing Hiring Practice Recommendations

- ☐ API senior leaders need to determine if individual Unit Nursing Leaders (RN III's and PNA IV's) can assume the lead in hiring staff for their individual units with oversight by union approved nursing RN IV's staff. In general, unit nursing leaders are recommended to have the lead in interviewing and making hiring decisions (with oversight by RN IV's with the latter only as pro forma union management requirements) unless that RNIV has a clear and substantial concern over that hire.
- ☐ Adult Peer API employed staff should be involved in hiring processes for new staff the adult units, if possible. Another option is to include and pay external peer specialists to participate, for stipends. This practice sends the message to all hospital staff that Peer Specialists are important in determining inpatient staff hiring based on the applicant's knowledge, attitudes, empathy, and understanding of what characteristics are important for inpatient mental health hospital staff to hold.

- ☐ Also suggested is that all hiring practices and applicant interviews include "value-based" interviews that have questions that help determine the applicants' personal values and fit to work at API. In addition, many healthcare organizations have moved to "behavioral" questions where the applicant is asked about how they would respond to certain events. These questions do not have right or wrong answers but are a way to evaluate the applicant's judgement in critical situations such as; "What would you do if a client cursed at you? What would you do if a patient kicked over a chair? What would you do if a client kicked you and ran off?" What would you do if a patient spit out their medication and told you to FO?"
- ☐ API's new employee orientation and training process has been reviewed at length to try and make this process more condensed and useful for the new employee as well as to improve hospital operations and first steps have already been implemented. However, given the comments and concerns shared by many knowledgeable nursing staff employees the consultants recommend that executive leaders take another look at this process. For one, it became clear to the consultants that the reduction in classroom time, from four weeks to two weeks was welcomed by many. However, given the needed practice at API to often hire nursing staff, both RNs and PNAs, that have little to no experience in a psychiatric facility, some other suggestions were made that have great merit.
- ☐ Include a full hospital tour for all new employees during the first week of general hospital orientation. This tour should not be too intrusive as staff noted that most orientation classes are small.
- ☐ After the first week of general orientation (for all new employees) divide the following two weeks (for clinical staff) into half-days in classroom and half-days on the clinical units. This exposure to the actual work environment will assist new employees to quickly determine if they want to do this work. As well, this on-site work orientation will help make the classroom learning more relevant. Finally, having new employees on the clinical units for just half-days will reduce the stress on working employees who are also expected to orient new staff.
- ☐ Allow experienced staff to complete their competency checklists as quickly as possible to be able to include them in the count. These experienced employees do not necessarily require the same amount of orientation under supervision that inexperienced employees require.
- ☐ Individually tailor the on-unit orientation schedule for each new employee's needs, being careful to assign these employees to senior unit staff that are competent and enjoy mentoring new staff. Avoid, if possible, any "judgement" by unit staff if a new employee requires more orientation than another might.

- ☐ Consider the use of some of the PNA 3s to assist in mentoring new PNAs to avoid putting too much responsibility on the unit PNA 4.
- ☐ Have each cohort of new nursing employees (RNs and PNAs) meet separately with a member of senior nursing management on Week 2 and 4 to assure that this new employee is getting what they need from orientation and an opportunity to discuss concerns in a safe place.

Nurse Executive Back-up Plans

Given the nursing structure at API it appears that the logical back up for the executive nursing administrators (DON, ADON) would be the Nursing Shift Supervisors (NSS). In an emergency, these responsibilities would fall on the NSS currently working. This process seems to be in place.

Clinical Practice Nursing Leadership and Evaluation Process Findings

The clinical practice evaluation processes that are described in the job descriptions for DON, ADON, the Nursing Operations Coordinator (NSS supervisor), and the Nursing Practice Coordinator (Nursing Education Director) all appear to be solid practices. However, it is notable that while all these positions are RNIVs and therefore the only nursing staff able to hire, supervise, evaluate, train and discipline API nursing staff none of these positions work on the clinical units, have offices on the clinical units, or work directly with staff nurses. This creates a problematic situation for staff on the units, especially the Clinical Leads (RNIIIs) who are most closely working with direct care staff. What this model means is that if the Clinical Lead or off-shift unit charge nurse has a concern or problem with any of the nursing staff working under his or her direct supervision they cannot, themselves, do much. Instead they must document the problematic clinical or attitudinal behavior and then get an audience with one of the above senior managers to follow through; a senior manager how has not personally seen this problematic behavior putting the latter also in a difficult position. As reported by a number of staff nurses, this is not an easy, timely or well-functioning process. In result, unit nursing staff with problematic behaviors often can continue to perform below satisfaction with little consequences.

Best practices for employee supervision include the following goals; direct, consistent observation of employee performance; timely coaching and mentoring during the workday; addressing staff trauma responses; building a team; supervisor accessibility to answer questions and concerns by the employee; routine recognition of good to great employee performance; routine role modeling by the supervisor; an understanding by the employee that this supervisor

will be providing their annual performance reviews; and an understanding by the employee that this supervisor can direct disciplinary action when training and supervision has failed to change employee behavior. (Lorman, 2016; Hughes, 2008). None of these best practices are in place in the current nursing supervisory structures at API.

Clinical Practice Performance Recommendations

- ☐ Daily supervision of the direct care nursing staff working on clinical units at API needs to be re-organized if API hopes to improve the performance and morale of its nursing staff, overall. Current nursing management and supervision of direct care nursing staff have been assigned to four RNIV staff members that have full time mostly administrative positions, are not located on the units, and do not have the time to provide ongoing, timely, quality supervision of nursing staff working on the units with patients.
- ☐ While the four RNIV's reference above hold positions that currently require inclusion in the API nursing union's cohort of senior management staff the lack of RNIV supervisors at the individual unit level is a real barrier to efficient, quality nursing practice performance. The best option now may be to revise the current job descriptions of the four RNIVs to reduce those responsibilities to 3 RNIV positions and use the extra RNIV salary to pay to upgrade 4 RNIII Clinical Leads to become Unit Nurse Managers, with the necessary authority to manage these units and staff. If this could be done the consultants could see a much lessor need for an RNIV in either the Nursing Practice or Nursing Operations role. The consultants understand the obstacles to this work but suggest these changes in any case.
- ☐ For instance, with the elimination of day shift NSSs, the Nursing Operations Coordinator position would not be necessary going forward. For instance, the need for the Nursing Practice Coordinator to hold management authority is unclear. Most nursing education department directors do not hold the authority to hire, fire, coach, counsel, or schedule staff nurses working on clinical units as these are not the tasks that they are mainly responsible to do. This statement is not meant to indicate that the education director is not an extremely important position; just to make the point that using an RNIV position for this role is probably unnecessary.

API Adolescent Service (Chilkat) Findings and Recommendations

Chilkat Unit's Purpose Findings

Based on comments made by some staff in the API survey that was done some few months ago (data sent to consultants) it does appear that API leadership needs to assist the Chilkat leaders to clarify the core purpose of this unit's services. This unit is serving relatively acute adolescents ages 13-18 years for an average length of stay of 30 days with frequent outliers. Based on the adolescents being admitted, their issues, and the relatively short length of stay on this unit it appears that the Chilkat Unit's staff need to be fully trained on how trauma in childhood sculpts the developing brain and responses to stress, as well as, learning how to integrate trauma-informed care principles and practices throughout the unit's services. Effective training for staff could assist them to decrease the use of coercive interventions and extend their tolerance for non-dangerous, while also problematic/obnoxious behaviors. At the least Chilkat staff need to learn that "what worked with their own children is unlikely to work with kids with significant trauma histories." It was a bit disconcerting to hear, staff and after staff, talk about their experiences with their own kids as an experience that was driving their interactions with the very traumatized kids on this unit.

Chilkat Unit's Purpose Recommendations

- ☐ What the Chilkat unit should not get engaged in is trying to "fix" these youth, long term; that is a goal for longer term treatment program. Instead this unit may want to concentrate on doing no harm; stabilizing youth admitted; successfully engaging these youth in early treatment; and helping youth build solid relationships with staff during this admission as a template for their future.
- ☐ Suggested goals for the Chilkat could focus on:
  - Keeping kids safe,
  - Developing relationship-building skills through staff and client interactions and programmatic changes,
  - Helping these kids feel successful every day,
  - Making families/caregivers feel important and welcome in the care of their youth,
  - Assisting these young people to understand what has happened to them and why they are struggling,
  - Assisting these young people to participate in school or other meaningful and productive experiences during each day, including part time employment (for minimum wage) for the older youth who stay longer (this work is being done in a

number of public state facilities for older youth and adults). Education first, work second, at the two most normalizing activities that older youth normally experience; as such are valid clinical interventions, and,

- Always involving these clients in their treatment planning sessions.

☐ PNA and staff RNs will require coaching to provide this kind of support for each of the children and youth they are assigned to. Staff do not necessarily know how they should act in these situations so staff will need training and mentoring by supervisors or external people to learn how to do this work.

The ARC model as authored by Kinniburgh, Blaustein, & Spinazzola (2005) is a useful model but will need to be "chunked down" into understandable outcomes and interventions for unit staff. This is doable but beyond the scope of this consultation.

Chilkat Unit's Model that Guides Staff Treatment and Support Services including use of Point and Level Systems Findings

The current Chilkat model uses a point and level system that is not evidence-based and does not result in consistently good outcomes, on this unit and on similar units in most of country. However, some of the Chilkat staff believe strongly in this model and rue the day that this model was weakened, according to their observations, both in the survey and onsite with the consultants. As such, the Chilkat staff need training on how to replace this Point and Level System Model that is based on "making patients be compliant" while downplaying their individual histories and behaviors. Point and Level systems seek to make every person (child, youth, adult) on any unit a "homogenous" group of people whether adults or younger people. At best these programs create "compliant patients." At worst, they further estrangement from staff; and further feelings of humiliation, shame, being different, and being a failure. What point and level systems do is create class systems (in behavioral health settings) where "good kids" get all the rewards while the kids that are most deeply troubled do not have any reason to move forward.

Point and level systems are based on the very common human "belief" that "consequences" for objectionable behavior work as a deterrent for that behavior. Any seasoned behavioral health staff person knows this does not work and that trying to treat traumatized children and adolescents the same way as most parents "parented their non-traumatized children" is an ineffective set of interventions. When a child that has been so traumatized has lost hope that the future will be any different, for them, these interventions are counterproductive and more damaging. That is NOT what the Chilkat Unit wants to do.

Chilkat Unit's Model Recommendations

- ☐ The Chilkat Unit needs to re-focus and re-vamp their inpatient milieu to include individualized daily activities and rules, such as:
    - Every staff member does informal check-in rounds to check in with each child**/**adolescent in care after shift report. This provides an opportunity for staff to introduce themselves by name and role, learn the child's name, assure the child that they are there "for them" for this shift' and to do an emotional "affect check" so each staff member has a baseline at start of shift. Asking the child what they are doing or planning for the day is also suggested.
    - Each child on Chilkat needs to have an initial safety/calming plan done on admission and these strategies shared during shift report and in easy reach by staff. Some facilities have created client copies of these plans for the child to keep. When a planned intervention fails, the plan is re-done within 24 hours. It was noted that API Chilkat uses a model like this but that it could be simplified for better outcomes.
    - On admission, the expectation and need for safety for everyone on the unit is discussed, as well as the staff's wish to not have to take control or use coercive interventions. The client is asked about their thoughts on this goal and that is documented.
    - Next day after admission, initial assessments continue. Each youth is met in treatment team within 48-72 hours (this is a usual time frame based on 30-day average length of stay); the reasons they were admitted are discussed in a kind manner; and a daily initial unit schedule is devised. If the youth will not yet commit or engage in treatment or school than this "engagement goal" becomes the goal on the plan and individual staff are identified to meet with that child multiple times a day to try and engage them in a variety of individual activities (cards, games, computer work, art, reading, music (listening with staff), current events, general one to one sessions. This latter work continues with these adolescents until they agree to go to school. For adolescents who may be older, and who end up admitted for months, a hospital-based part-time employment opportunity may work best (with minimum wages paid to the individual).
    - Current best practices for child and youth inpatient treatment are clear that these stays should be only for stabilization, engagement, relationship building practices, and more intense assessment work Caldwell et al., 2014). Children and youth should get most long-term care services in their natural communities, including schools and home. (please see the Building Bridges Initiative work)

- If any client refuses school, on whatever day, staff should make efforts to talk them into going to school. But if they continue to refuse than a “non-school” plan should be immediately put into place that includes any activities where the child can feel successful, effective and productive and be praised for. All activities are open to be used by unit staff, individually or in small groups to engage these kids that, for some reason, are refusing school that day. The goal is to make that day feel good for the child and that they have been successful, while prompting the importance of school and trying to find out why the child refused to attend. In addition, API should adopt a practice where no staff may cancel an activity without an executive clinical leader approving that cancellation. It is often way too easy for unit staff to cancel activities.
- Every morning the Chilkat unit should continue to hold a community meeting with all kids and staff to discuss how everyone is doing and find out if there are any milieu issues that the staff need to solve. This kind of meeting should also occur before bed to again “check in” with each kid to see how their day went.
- Every day these kids need to get at least two hours of strenuous exercise if possible. Strenuous exercise releases endorphins and makes us all feel better, overall. These activities should be prioritized and all efforts put into exercise activities that each youth is excited or, at least, willing to do.
- The kids need to tell staff what kinds of leisure group activities they would like to have available and these can change from kids to kids. All efforts should be made to meet these requests.
- The Point and Level System should be phased out and replaced with only a “Safety Level System” where kids are only restricted to the unit based on significantly unsafe behaviors in the last 8-12 hours. A restriction of a kid to the unit should only be based on credible imminent danger. Otherwise all these kids should have the same privileges.
- Once staff find out each of the “kids in care” preferences for daily activities these should be provided, if possible. API needs to consider providing computer and social media access for these kids as that is what is normal for their age group in their communities. There are ways to manage this and block sites etc. but restricting kids over age 12 from social media contact with family and friends is not normal anymore. Of course, access to social media should be somewhat restricted to three or four hours per day and in between treatment activities.
- Finally, the Chilkat unit staff (not sure whom) should be responsible for praising each child in care, every day. No matter how their day went, each child is bound to have done something worth praise.

- ☐ Cultural Diversity and Linguistic Competencies - The Chilkat Unit serves many Native Alaskan children and adolescents but when you tour that unit the visitor sees almost nothing that is culturally relevant for these kids. In contrast, when you visit New Zealand behavioral health units, every unit is covered with art from the Maori tribes, signage is in both languages, and every effort is made to make a native Maori to feel at home and accepted. The Chilkat Unit needs to hire a native Alaskan to come into Chilkat on a daily basis and perhaps all of the other adult units (consultants did not get info on cultural breakdown on all units) to do this much-needed work. In addition, the kitchen and the dietician needs to assure that usual native foods are available to these kids and adults. Last, signage and all youth received documents need to be in both languages.

Evidence-based Practice Implementation, what this means. and how to provide these services Findings

API does not seem to be using literature promulgated evidence-based or promising practices on this unit based on a review of the activity schedule and discussions with a number of staff.

Evidence-based Practice Implementation Recommendations:

- ☐ API needs to choose several EBPs to implement in this unit. The top choices considering the venue and goals of this unit point to Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), Trauma-informed Care (TIC); and Family-psycho Education or First Episode Psychosis (FEP) [Families Only]. Children and Youth or Families should get sessions on these EBPs at least 2-4 times a week. For all involved families, this latter training could be done via webinars.
- ☐ API will likely need to bring in external trainers for these EBPs. API should ask for "train the trainer models" for any EBP training. Following the trainings, staff will need support, mentoring and supervision to successfully implement the EBPs.

Chilkat Staff Roles and Responsibilities Findings

Chilkat staff seem to have been trained in basic unit control, the use of points and levels, and generally trained for custodial management that is not their fault, or anyone's fault. This is common across the country.

Chilkat Staff Roles and Responsibilities Recommendations

- ☐ Chilkat staff duties need to be made clear and carefully defined. A revised core mission and unit core values need to direct staff actions in all changes going forward. This consultant would borrow from Lee (2004, pg. 3) as one author who wrote about strategies to meet the basic needs of human beings:
    - Maintain a safe environment but do not go overboard, this does not mean controlling everything kids do, just dangerous behaviors,
    - Always be courteous and kind, acknowledge every child, every time you walk by them and give good eye contact,
    - Sense people's (kids) needs before they ask,
    - Help each other (teamwork/staff),
    - Acknowledge people's (kids) feelings,
    - Respect the dignity and privacy of everyone, and
    - Explain what is happening to the kids and each other, constantly.

- ☐ Lee (2006) goes on to talk about the usual "mishmash" that makes up hospital mission and values statements and how these are mostly always a list of expected staff performance expectations that are not listed in any way where staff understand what they are to do in any situation, due to the lack of prioritization of these core goals and values. Lee makes the point that an organizations goals and values need to guide staff at work. He posits the following goals for all hospital staff and notes that these goals and expectations direct staff on what road to take in all situations. Please note that these goals to not include adherence to policy or procedures. And that staff use these values as a ruler as to what comes first and then next.
    - Safety: (always the primary goal for all staff)
    - Courtesy: basic customer service that most behavioral health staff, nationwide, do not understand or perform)
    - Show: everything that makes a sensory impression on a new customer including welcoming/rejection; judgement/full inclusion; safety/not safe; we want you here/you are another burden...
    - Efficiency: Note that organizational efficiency is not the first goal but the last. Some leaders have realized that if people do not get better in our services our efficiency ratings are moot as they will just come back; usually in worse shape.

Chilkat Staff Training on Evidence-based and Promising Practices Findings

It appears from a review of new employee orientation and ongoing annual staff competency reviews that direct care staff (unit based RNs and PNA's) are not getting a comprehensive training on trauma informed care, or how to prevent conflict or violence on their unit. Nor have they received training on how to manage to avoid coercive measures.

Training Chilkat Staff Training on Evidence-based and Promising Practices Recommendations

Training for Chilkat staff is very important both due to the turnover of direct care staff and the lack of core knowledge and competencies of most nurses and PNAs who are hired to work on this unit. As such the following training is strongly suggested for this unit's staff and also all the other adult units:

- ☐ When approved, training on a new staff mission and list of goals for this program: (TBD by API leadership, less than 3 months).
- ☐ Six Core Strategy© training is recommended for API leadership, middle managers, and lead direct care staff. [See attachment.] WICHE consultant (Huckshorn) discloses her involvement in this work and can recuse herself from this training work as she would want to avoid any perception that this recommendation is a conflict of interest. That said, API current staff would benefit from this two-day training. The Six Core Strategies© faculty have many testimonials and references if required. The formal reference for this evidence-based practice is as follows: *Six Core Six Core Strategies© to Prevent Conflict and Violence Huckshorn, K.A.; LeBel, J.; Caldwell, B. (Eds.) (2016). Six Core Strategies©: Preventing Violence, Conflict and the Use of Seclusion and Restraint in Inpatient Behavioral Health Settings. An Evidence-based Practice Curriculum Training Manual. Originally developed with the National Association of State Mental Health Program Directors (2002-2009): Alexandria, VA. All rights apply to use of these author edited materials.*
- ☐ Attention to patient/family complaints or grievances (and an attitude that whatever happened DID HAPPEN) and timely follow through (TBD based on API staff education department); and
- ☐ Supervisor role modeling of appropriate practices while training line staff (TBD based on API Clinical Leadership decisions)

Chilkat Documents that Require Revision (Staff handbook for New Employees, Patient Handbook, Parent/Caregiver Handbook, Individualized Discharge) Findings

A review of some Chilkat customer oriented educational documents reflect documents that are much too long and written in clinical language that families and kids will not understand.

Chilkat Documents that Require Revision with Recommendations

- ☐ Current documents need to be revised for patients and families. The New York Times writes in 6th grade language to assure that all readers understand content. In addition, for families and patients, all language needs to be framed in clear, concise language that is easy to understand. All documents for customers, patients and families, needs to be in large print and less than 2 pages. The current documents are meant for clinical staff and need to be revised. Suggestion is for API to ask their local NAMI or MHA affiliate to help with this work. These patient and family documents can be shortened for the former while the full expectations on API policies can be more extensive for staff and can be sectioned into adult and youth specific documents.
- ☐ All API client and family documents should be informed by real mental health customers and families as to what resonates with them. This could be done with small funding. This is important for all units and these documents should be different for Adult Acute, Chilkat and the other two longer term units.

Traumatized Staff and How to Assist Them

It appears that API has not developed a response team to respond when staff are involved in adverse incidents, or worse, injured.

Traumatized or Injured Staff, Response Recommendations

- ☐ The best way to help traumatized staff is to make available a trusted and anonymous call in service for staff to get help when that is needed. It is not at all advised that staff supervisors get involved in counseling staff who are struggling, other than to encourage them to seek external assistance. Otherwise staff supervisors will find themselves in sticky, dual roles that are not helpful. API leaders need to involve the staff unions to help in this endeavor. The staff Unions need to vouch for the anonymity of this EAP assistance. All API leaders can do is to encourage staff to call.
- ☐ Another in-house response service has been developed to try and respond to these situations. This “in-house” response is the identification of 3-5 staff that are well-liked and respected and or are department leaders who, following an adverse event, will meet with or call the staff victim of violence to see how they are doing and if there is anything the hospital can do to help this employee. These calls start on day of event and continue till the staff member comes back; perhaps every day to every 2-3 days depending on circumstances.

Additional Findings and Recommendations

Performance Measures to Monitor for Quality of Care Recommendations

- ☐ Reduced Adverse Events as evidenced using seclusion, restraint, involuntary medication, client and staff injuries, elopements, suicide attempts, basic aggression toward other clients or staff.
- ☐ Increased Engagement with unit staff and/or peers (Interpersonal relationships) as evidenced by attendance at team meetings and ongoing meaningful interactions, documented, by key Chilkat staff assigned to individual kids/youths.
- ☐ Increased Engagement in Treatment as evidenced by attendance at treatment team meetings, school, work in hospital, or other productive work (art, journaling, prep for work, computer work, personal work).
- ☐ Reduced Recidivism
- ☐ Improved Patient Satisfaction
- ☐ Improved Staff Satisfaction

API Mission, Vision, Values

API has a Mission, Vision statement and Values Template that is used to base clinical and administrative practices.

Mission To provide emergency and court-ordered inpatient psychiatric services in a safe environment using culturally-sensitive, effective, person-centered treatment followed by a referral to an appropriate level of care and support for recovery from mental illness.

Recommendation: The API Vision should include "provision of inpatient evidence-based practices to assure a state of the art, person-centered treatment experience for all persons admitted to that they return to their community as soon as possible with new skills to manage their personal symptoms and illness.

Vision Excellent experiences for patients, families, community supports, students and staff with quality treatment and best practices in mental health care.

Recommendation: Would consider including the following: Every customer will

feel safe in our hospital, agree that they received individualized care, and will feel like they are a full partner in their care. Persons in care, families and students will experience a behavioral health treatment facility that listens to their concerns and make changes when necessary.

Values	**S**afety **E**ducation—Life-long Learning **R**esponsibility **V**aluing Hope and Recovery **I**ntegrity **C**ompassion—Fairness and Honesty **E**xcellence

<u>Recommendation</u>: Would consider re-thinking these values to adopt the SAMHSA values for BH settings that have been developed over last 10 years. Or consider using the key values of Disney where their values template serves as a decision tree that guides staff on what to do in their daily work, on a minute by minute basis.

-Safety (always first)

-Courtesy (next)

-Show (making the environment conducive to the customer's satisfaction always)

-Efficiency. Please note that "efficiency" is last as an organization cannot meet the courtesy and show goals if all they are interested is in efficiency. Disney's approach is rather brilliant in clearly directing staff practices. Disney's approach makes clear to staff what they should focus on at any given time. In comparison, healthcare settings often run up a list of values, in no specific order or priority, creating confusion for staff on what to do and when.

API Treatment Planning Processes Findings & Recommendations

The hard copy treatment plans reviewed did not lend any information on the involvement of the person served, adult or child or youth. From conversations with staff and attendance at team meetings it appears that only the Chilkat unit routinely invites and includes the person in care to participate in treatment team. A team meeting observed on this unit was an outstanding example.

It is very important, in 2016, that clinical staff understand the importance of inviting persons served to participate in their own treatment planning activities and that they are well included

in this process. This expectation needs to be in API treatment planning policy and procedures. If the patient refuses to attend their own treatment planning meeting the only behavioral health goal should be to engage that person in participating. No other behavioral health goal should be sought but engagement with staff and in unit activities including treatment planning. This would solidify the use of individualized treatment planning that both The Joint Commission and Centers for Medicare and Medicaid Services expect. However, API leaders need to be on board with the importance of this approach and be ready to stand by, and defend, it.

API Seclusion and Restraint Policy

The API policy on S/R is very well done but very long which suggests the potential inability of direct care staff to really understand all the specifics in this policy. A few areas of concern were noted and these are listed below in no specific order.

- ☐ The use of spit hoods is always a concern as it is dangerous to place anything that might restrict breathing on a person in care that is also escalated. Many facilities no longer use spit hoods but do expect staff to use protective clothing themselves.
- ☐ The use of bed rails for persons at risk for falls are fine but the policy should state that if the patient cannot lower these rails themselves that the use of bed rails is a restraint.
- ☐ The use of seclusion and the definition of seclusion needs to include the use of staff standing in front of the room that the patient is in that the patient interprets as a "message" that they cannot leave that room. That use of staff is coercive and reflect seclusion without a locked door.
- ☐ Any episode of S/R lasting over an hour needs to be reported to the NSS and reviewed timely. CMS is not on top of best practices regarding the use of S/R and many states have reduced the ability to order S/R to less than 2 hours or even less. The entire state of PA has reduced orders to 15 minutes and MA has reduced orders to one hour.
- ☐ The requirement or expectation of a person to change into hospital gowns or clothes is not best practice and should be avoided. It is expected that staff will expect the removal of belts or shoelaces etc. for persons who are suicidal.

API Grievance Procedures

The API policy on grievance procedures is well done. Would, however, recommend that complaints vs. grievances be better explained including adding a definition of "complaint" vs. "grievance" to the definitions section. The latter is a well-documented expectation by JC and CMS. Many hospitals have clearly defined "complaints" as patient concerns that can be

immediately addressed by unit staff, in the care environment such as a need to make a phone call off hours; get another blanket; talk to the physician or LIP; get clothes washed. Just basic issues and complaints that unit staff can and should handle. Grievances are defined as "concerns by persons served" that cannot be solved by direct care, unit staff within 8-12 hours. The reason that this is important is that it lessens the list of actual grievances for API formal follow-up. Additionally, the data table provided to the consultants on the resolution of grievances and complaints is not thorough or comprehensive in describing the resolutions of these issues. It is recommended that this data table be much more descriptive in documenting the issue and the resolution. (The consultants requested this data but only received a summary table that does not include specifics; later we were informed that additional information was documented elsewhere.)

API Use of Close Observation (COSS) Processes

The use of Close Observations including "line of sight", "one to ones", and "two to ones" orders are very expensive strategies that should be restricted to very specific patient behaviors that are considered high risk and imminently dangerous. The literature indicates that the use of these procedures are often experienced as very intrusive by individuals in care and can escalate behaviors if staff are not trained in how to manage these strategies (Cleary, 2004; Cuttcliff, 2006; Page, 2006; Stewart et al., 1010). In addition, the use of one to one observations for persons believed at risk for falls has been studied and found to be ineffective to reduce falls (Inouye, 2009). In general, the use of close observations needs to be carefully monitored by hospital leaders, including a daily meeting with physicians regarding these orders and their rationales.

API Use of Staff Personal Cell Phones

Many API staff noted that API nursing staff use their personal cell phones during their work shifts. The use of personal cell phones was also observed by the consultants on all units during tours. This practice is very unsafe and needs to be stopped as soon as possible. One RN in another state was punched and ended up in a coma as she was ignoring the patient she was assigned to and texting her friends on her phone. The patient later said "I just tried to talk to her, over and over again, and she just ignored me. I had to go to the bathroom…" These reports are not uncommon. One API senior nursing staff person noted that they have tried to hold staff accountable to stop this use of personal cell phones but that they were not supported by API Executive Nursing Staff. This lack of support for an RN, worried about personal cell phone use, is telling and very problematic as it demonstrates that some API Executive Nursing staff are ok with ignoring key API policies. API executive staff need to immediately bring all their clinical leaders together and mandate that staff leave their cell phones home or in locker rooms. At no time should direct care staff have their personal cell phones on them to use during active work hours. This is a unit safety issue for all direct care staff. If an external emergency occurs all staff

should have provided hospital numbers to their loved ones to call to get in touch with them. In no circumstance, should direct care staff be using personal cell phones except during their breaks. The use of personal cell phones while on duty should be a simple mandatory disciplinary action.

For non-direct care senior staff, the cell phone policy also needs to be clear that use during work hours is only for work issues. Best practice is that senior clinical staff that need to take phone calls for work, only use hospital issued cell phones so that use is separate from personal use. This will always be an issue for direct care staff who watch senior staff use their cell phones. If this is not possible than use of personal cell phones by senior clinical staff needs to be as minimal as is possible. The key difference here is that Direct Care Staff are 24/7 responsible for the safety and well-being for patients. Physicians, Nursing Supervisors and Administrative staff are not in roles or jobs that require that kind of responsibility and need to take calls as part of their jobs. This difference between direct care staff and supervisors/physicians should be made quite clear to all staff through a more direct and clear API policy.

API Job Descriptions

A review of API job descriptions for senior and unit level nursing staff are lacking any description of expected attitude competencies including kindness, compassion, empathy, therapeutic communication skills, de-escalation/mediation skills, or an understanding of the urgency required in meeting hospitalized persons' personal needs. Also lacking is an expectation of staff's knowledge, skills and competencies in providing care that is trauma-informed and recovery-oriented. These are all critical skills for inpatient staff. Job descriptions are a work contract and if these critical skills are not described or included in the API job descriptions you cannot hold staff accountable for these key behavioral health care skills or practices.

References

Cleary, M. (2004). The realities of mental health nursing in acute inpatient environments. *International Journal of Mental Health Nursing*, 13(1): 53-60.

Cuttcliff, J.R. (2006). *Key Debates in Psychiatric Mental Health Nursing*. Elsevier Health Sciences; pp. 251-279. [Book]

Inouye, S.K., Brown, C.J., & Tinetti, M.E. (2009). Medicare nonpayment, hospital falls and unintended consequences. *New England Journal of Medicine*; 360 (23): 2390-2393.

Kinniburgh, K.J., Blaustein, M., & Spinazzola, J. (2005.) Attachment, self-regulation, and competency. *Psychiatric Annuals*, 35(5):424-430.

Lee, F, (2006). *If Disney Ran Your Hospital*. Second River Healthcare Press. Bozeman, MT.

Page, M.J (2006). Methods of observation in mental health inpatient units. *Nursing Times*; 102 (22): 34-37.

Stewart, D., Bilgin, H., & Bowers, L. (2010). Special observations in psychiatric hospitals: A literature review. *Report from the Conflict and Containment Reduction Research Program*. Section on Mental Health Nursing, Institute of Psychiatry. London SE5 8AF.

Attachment - Six Core Strategies©

The Six Core Strategies© is an evidence-based best practice training curriculum with associated training materials that is effective in preventing the trauma, violence, and conflicts that lead to the use of coercive interventions such as restraint and seclusion. These strategies cover, among other issues, the importance of trauma Informed principles; therapeutic communication skills; engagement on admission to identify adults and youth with aggressive tendencies and modulate with immediate engagement and crisis planning; use of sensory modulation interventions; and a rigorous analysis of each adverse event and how this work informs policy and practice. These strategies have been developed through extensive and ongoing literature reviews (available upon request from kevin@kahassociates.com) and through the study of and dialogues with experts who successfully reduced the use of S/R in a variety of mental health settings for children and adults across the United States and internationally. These strategies are continually updated as new information and research emerges.

1. Leadership toward Organizational Change

This first strategy is considered core to reducing the use of seclusion and restraint (S/R) through the consistent and continuous involvement of senior facility leadership (most specifically the CEO, CNO, and COO). Leadership strategies to be implemented include defining and articulating a vision, values and philosophy that expects S/R reduction; developing and implementing a targeted facility or unit based performance improvement action plan (like a facility "treatment plan"); and holding people accountable to that plan. This intervention includes the elevation of oversight of every S/R event by senior management that includes the daily involvement of the CEO or COO in all S/R events (24/7) to investigate causality (antecedents), review and revise facility policy and procedures that may instigate conflicts, monitor and improve workforce development issues and involve administration with direct care staff in this important work. The action plan developed needs to be based on a public health prevention approach and follow the principles of continuous quality improvement. The use of a multi-disciplinary performance improvement team or taskforce is recommended.

This is a mandatory core intervention.

2. Use of Data to Inform Practice

This core strategy suggests that successfully reducing the use of S/R requires the collection and use of data by facilities at the individual unit level. This strategy includes the collection of data to identify the facility/units' S/R use baseline; the continuous gathering of data on facility usage by unit, shift, day; individual staff members involved in events; involved consumer demographic characteristics; the concurrent use of stat involuntary medications; the tracking of injuries related to S/R events in both consumers and staff and other variables. The facility/unit is encouraged to set improvement goals and comparatively monitor use and changes over time.

3. Workforce Development

This strategy suggests the creation of a treatment environment whose policy, procedures, and practices are based on the knowledge and principles of recovery and the characteristics of trauma informed

systems of care. The purpose of this strategy is to create a treatment environment that is less likely to be coercive or trigger conflicts and in this sense, is a core primary prevention intervention. This strategy is implemented through intensive and ongoing staff training and education and HRD activities. It includes S/R application training and vendor choice, the adequate provision of treatment activities that offer choices to the people we serve and that are designed to teach illness and emotional self-management of symptoms and individual triggers that lead to loss of control. This strategy requires individualized person centered treatment planning activities that include persons served in all planning. This strategy also includes consistent communication, mentoring, supervision and follow-up to assure that staff are provided the required knowledge, skills and abilities, with regards to S/R reduction through training about the prevalence of violence in the population of people that are served in mental health settings; the effects of traumatic life experiences on developmental learning and subsequent emotional development; and the concept of recovery, resiliency and health in general. This work is done through staff development training, new hire applicants interview questions, job descriptions, performance evaluations, new employee orientation, and other similar activities.

4. Use of S/R Prevention Tools

This strategy reduces the use of S/R using a variety of tools and assessments that are integrated into facility policy and procedures and each individual consumer's recovery plan. This strategy relies heavily on the concept of individualized treatment It includes the use of assessment tools to identify risk for violence and S/R history; the use of an universal trauma assessment; tools to identify persons with high risk factors for death and injury; the use of de-escalation surveys or safety plans; the use of person-first, non-discriminatory language in speech and written documents; environmental changes to include comfort and sensory rooms; sensory modulation interventions; and other meaningful treatment activities designed to teach people emotional self-management skills.

5. Consumer Roles in Inpatient Settings

This strategy involves the full and formal inclusion of consumers, children, families and external advocates in various roles and at all levels in the organization to assist in the reduction of seclusion and restraint. It includes consumers of services and advocates in event oversight, monitoring, debriefing interviews, and peer support services as well as mandates significant roles in key facility committees. It also involves the elevation of supervision of these staff members and volunteers to executive staff who recognize the difficulty inherent in these roles and who are poised to support, protect, mediate and advocate for the assimilation of these special staff members and volunteers. ADA issues are paramount here in terms of job descriptions, expectations, work hours, and an ability to communicate to staff the legitimacy of the purpose and function of these important roles.

6. Debriefing Techniques

This core strategy recognizes the usefulness of a thorough analysis of every S/R event. It values the fact that reducing the use of S/R occurs through knowledge gained from a rigorous analysis of S/R events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate, to the extent possible, the adverse and potentially traumatizing effects of a S/R event for involved staff and consumers and for all witnesses to the event. Recommended debriefing activities include two - an immediate post-event acute analysis

and the more formal problem analysis with the treatment team. Using the steps in root cause analysis (RCA) is recommended. (Please see the attached Debriefing Policy and Procedure template.) For facilities that treat kids and who use holds frequently, the use of full debriefing procedures for each event may not be manageable. These facilities need to discriminate their use of holds and target multiple holds on same children, identify same staff member involvement in these events to note training needs and explore holds that last longer than usual.