Implementing a PBS continuum in a large public psychiatric hospital

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This presentation will:
• Review planning and implementation of Tier 3 and 1 PBS adaptations in a large public sector psychiatric hospital.
• Describe the unique challenges of designing and implementing a positive practice model in a public sector psychiatric setting, particularly related to staff engagement and promoting culture change.
• Assess empirical and qualitative outcome data to gauge utility and value of PBS programming (Tier 1 and 3) in inpatient psychiatric facilities.

Worcester State Hospital

Patient Population
• 2 Court evaluation Units and 8 Continuing Care units (26 patients per unit)
• Length of stay- average 200 days
• Demographics: ~25% Women, 75% Men
  ▫ Diverse population
  ▫ Diagnostically:
    ▫ Severe and persistent mental illnesses
    ▫ Complex co-morbidities
      (physical/medical/cognitive)

Worcester Recovery Center and Hospital (WRCH)

Primary Components of Clinical Care
• Multidisciplinary treatment teams include psychiatry, psychology, social work, occupational therapy, peer specialists, and nursing.
• Medication administration and education.
• Opportunities for individual and group therapeutic interventions including a variety of evidence-based treatments.
PBS Consultation Service

- Introduced September 2015 through a collaboration of Clinical/Hospital Administration and Psychology and Nursing departments.
- Aim to reduce rates of aggression/violence and occurrence of restraint and seclusions
- Focus on patients with the most challenging behaviors and intensive treatment needs in the state/DMH system.

Overview and Rationale

- Challenging behavior is a significant concern in inpatient settings.
- Associated with a range of negative outcomes:
  - Patients:
    - Restrictive practices
    - Prolonged hospitalization
    - Poor quality of life
  - Staff:
    - Injury
    - High stress
    - Burnout
    - Low job satisfaction

Program Development

- Year 1 (September 2015-August 2016):
  - Developed PBS consultation program and began individual case intervention.
  - Developed collaborations with four continuing care units
- Year 2 (September 2016-August 2017):
  - Established a postdoc program and served two more continuing care units
- Year 3 (September 2017-August 2018):
  - Expanded individual consultation/intervention services to two more units
  - Begun planning for Hospital-Wide Tier 1 (Primary Prevention).
- Year 4 (September 2018-August 2019):
  - Ongoing maintenance of individual PBS caseload, including increased consultation capacity.
  - Continued planning and began implementation of Hospital-Wide PBS implementation.
- Year 5 (September 2019-present):
  - Reduced caseload capacity due to loss of postdoctoral position and part-time funding for psychologist.
  - Ongoing planning and implementation of Hospital-Wide PBS, including intensive training and support with nursing department.

PBS Program Initiation

- Initial efforts were heavily focused on:
  - Getting buy-in from staff (i.e., nursing)
  - Collecting behavioral data to inform decision-making and PBS planning
  - Working directly with patients to engage and model specific intervention strategies.
- Significantly divergent from implicit models of care, beliefs about psychopathology, and challenging behavior.
- Shift from viewing problem as originating within the person and treated at the individual level recognizing and emphasizing the role of environment and context.

DMH - Dirty Words

- Behavior
  - Problem
  - Willful
- Behavioral
  - Coercion
  - Reward
- Behavior Plan
  - Punishment
- Reinforcement
- Consequence
- Positive
- Good
- Attention
  - Problematic
Patient Demographics

- 45 patients served throughout 4 1/2 years of service
- Age range: 16-66
- Diverse representation of gender, race/ethnicities, and primary/preferred languages
- Primary psychiatric diagnoses:
  - schizophrenia spectrum disorder
  - autism spectrum disorder
  - post-traumatic stress disorder
  - borderline personality disorder
  - developmental/intellectual disability
  - neuro-cognitive disorders
  - obsessive compulsive disorder

Patient Demographics

- Numerous lifetime psychiatric hospitalizations (15+), and some have been continuously institutionalized for 10 or more years.
- Have displayed behaviors that posed a high risk to staff and were described as having been unsuccessfully managed at other settings/facilities.
- Many are the highest users of specialized staffing statuses (e.g., 3:1, 2:1, 1:1, Constant Observation (CO)).
  - 20% require some special status daily or at all times,
  - 40% have been on status at some point in time or for partial hours of the day
  - 40% have not typically required special staffing (other than 15” checks).

Challenging Behaviors

- Primarily include aggressive behaviors (i.e., verbal and/or physical attempts or actual assaults).
- 75% of the cases in the program have physical aggression as the primary target behavior.
- Self-injurious behaviors and intrusive behaviors have also been targets for intervention.

Proactive Strategies

- Goals:
  - Improve the person’s overall quality of life
  - Give the person more control over his or her life
  - Teach the person skills (e.g., communication, coping/tolerating distressing experiences)
  - Reduce the need for restrictive/reactive strategies
- Includes:
  - Ecological/Environmental Strategies
  - Positive Programming
  - Focused Support Strategies

Ecological/Environmental Strategies

- Interventions designed to reduce triggers or antecedents to problematic behaviors by making changes environment to better fit the person’s characteristics and needs.
- Challenging behavior often occurs because there is a mismatch between needs and environment:
- Physical Factors:
  - Setting, light, noise, crowding
- Interpersonal Factors:
  - Communication, culture
  - Social interactions
  - Clear and consistent expectations
- Programmatic Factors:
  - Choice, predictability and control
  - Activity scheduling
  - Instructional methods

(LaVigna and Willis, 2009)
Positive Programming

• Interventions designed to teach skills and competencies to facilitate behavioral changes for the purpose of social integration.
  ▫ Functional skills
    ▪ Useful: if the person does not learn, someone will have to do it for them
    ▪ Fun: does it allow access to something the person wants
  ▫ Functionally equivalent skills (e.g., communication skills)
    ▪ Challenging behavior has a function
    ▪ The problem is not the function, it's the behavior (work to separate the two)
  ▫ Functionally related skills
    ▪ Discrimination
    ▪ Choice
    ▪ Predictability and control
  ▫ Coping skills
    ▪ Desensitization
    ▪ Relaxation training

(LaVigna and Willis, 2009)

Focused Support Strategies

• A strategy to reduce and, if possible, eliminate the need for a reactive strategy. May include:
  ▫ Time-based schedules: Activity being delivered by a schedule/clock not based on behavior (noncontingent)
  ▫ Increase the density of time-based preferred events
    ▪ Can also be looked at as an ecological change (more permanent) vs. support strategy (temporary).
  ▫ Contingency-based reinforcement: Positive reinforcement plans designed with the person to increase the frequency of an adaptive behavior.
  ▫ Differential schedules of reinforcement.
    ▪ **VERY DIFFICULT TO IMPLEMENT IN SETTING**

(LaVigna and Willis, 2009)

Reactive Strategies

GOAL: Interrupt the behavioral chain/de-escalate

• Facilitative Strategies
• Redirection
• Proximity control (e.g., closeness may increase or decrease behavior)
• Introduce humor
• Stimulus change (e.g., choice of alternate locations)
• Counterintuitive Strategies:
  ▫ Diversion to a Preferred Activity or Event

• Emergency Physical Containment:
  ▫ Is emergency physical intervention absolutely necessary

(LaVigna and Willis, 2009)

Key Components

Behavioral Assessment

• Understanding the meaning of behavior; why is it occurring?

Data-based decision making

• Are we making valid interpretations/judgments?

Proactive Strategies

• Whole-person approach
• Improving quality of life

Staff/team interventions

• Supporting staff to support patients
• Enhancing psychosocial perspective/approach of team

Definitions/Terms

• Restraint or Seclusion Episode (R/S)
  ▪ Medication
  ▪ Physical Hold
  ▪ Open Door Seclusion
  ▪ Mechanical Restraint (4 or 5 point)

Case Illustrations- Patient 1

Monthly Attempted Assaults by Year of Hospitalization
Case Illustrations - Patient 2

Monthly Attempted and Actual Assaults by Year of Hospitalization

<table>
<thead>
<tr>
<th>Year</th>
<th>Assailed Assault</th>
<th>Assault with Contact</th>
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Attempted Assault

Year 1                  Year 1               Year 2               Year 2              Year 3            Year 3

Attempted and Actual Assaults by Year of Hospitalization

<table>
<thead>
<tr>
<th>Year</th>
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Restraint/Seclusion Episodes by Type and Year

<table>
<thead>
<tr>
<th>Type</th>
<th>Year 1</th>
<th>Year 2</th>
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<tr>
<td>Hold</td>
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Restraint/Seclusion Episodes by Type and Year

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<tr>
<td>Year 3</td>
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<td>Year 4</td>
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<tr>
<td>Year 5</td>
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Episode

Year 1                  Year 2               Year 3

Hold

<table>
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<tr>
<th>Year</th>
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Episode

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<th>Mechanical</th>
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</tr>
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<td>Year 2</td>
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Case Illustrations - Patient 3

R/S Episodes by Type and Month

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<th>Month</th>
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Episode

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<th>Month</th>
<th>Mechanical Restraint</th>
<th>Seclusion</th>
<th>Physical Hold</th>
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<tbody>
<tr>
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<td>Month 3</td>
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Case Illustrations - Patient 4

R/S Episodes by Year and Type

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<th>Physical</th>
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<td>Year 2</td>
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<td>49</td>
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<tr>
<td>Year 3</td>
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<tr>
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Episode

<table>
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<th>Year</th>
<th>Hold</th>
<th>Mechanical</th>
<th>Physical</th>
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<tbody>
<tr>
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<td>88</td>
<td>88</td>
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<tr>
<td>Year 2</td>
<td>43</td>
<td>44</td>
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Case Illustrations - Patient 5

R/S By Type and Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Physical</th>
<th>Seclusion</th>
<th>Mechanical</th>
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</thead>
<tbody>
<tr>
<td>Year 1</td>
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<td>Year 4</td>
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<td>Year 5</td>
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Episode

<table>
<thead>
<tr>
<th>Year</th>
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<th>Mechanical</th>
</tr>
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<td>Year 2</td>
<td>43</td>
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</tr>
<tr>
<td>Year 3</td>
<td>43</td>
<td>44</td>
<td>44</td>
</tr>
</tbody>
</table>
Case Illustrations - Patient 6

Average Duration (Minutes) Per R/S Episode

Limited Resources

Tiers of Intervention and Support

Tier 2: STRATEGIC/TARGETED
Secondary Interventions
~15%

Tier 1: SYSTEM-WIDE/UNIVERSAL
Primary Interventions
~80% of the population (ALL)

Highly specialized and individualized multi-modal assessment and interventions for individuals with high risk behaviors who require the most support.
Examples include:
- Individualized and function-based positive behavior support plans
- Supports developed through wraparound process

Current PBS work consists of almost entirely intensive (Tier 3) interventions.
- Individual PBS Plan with strategies used for patients with longstanding challenging behavior/s (e.g., assaultive).
- Includes:
  - Comprehensive behavioral assessment
  - Collecting and monitoring of data
  - Development and implementation of individualized intervention strategies
  - Training staff

Targeted strategies put in place for individuals who are at increased risk or for whom Tier 1 interventions are not effective.
Examples include:
- Check in/Check out
- Skill-based groups
- Mentoring

Some strategic strategies exist at WRCH, though they aren't currently thought of as being a part of PBS.
Tier 2 at WRCH might include:
- Anger management, DBT, sensory or other groups
- Standard practice response to substance use
- Individual check-ins or diary cards

Proactive and preventative interventions implemented to support all patients and staff.
- Establish, teach, post, and reinforce a small number of positively stated setting-wide expectations (e.g., Be Safe, Be Responsible, Be Respectful).
- Increase structure and engagement in activities.
- Continuum of responses to problem behavior.
Targeted Positive Outcomes

- **Improved quality of life**
  - e.g., more adaptive behaviors, engagement in meaningful activities, shorter inpatient LOS
- **Improved quality of care**
  - e.g., provision of more choice, activities, interaction, and staff assistance
- **Improved staff outcomes**
  - e.g., decreases in staff injuries, trauma and stress, increases in job satisfaction
- **Decreases in inappropriate/unsafe behaviors**
  - e.g., aggressive and disruptive
- **Reduction in restrictive practices**
  - e.g., restraint/seclusions, prolonged hospitalizations
- **Reduced need for more intensive and expensive interventions**
  - e.g., 2:1, 1:1, Continuous Observation

Universal/Primary Prevention

<table>
<thead>
<tr>
<th>Systems</th>
<th>Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership team with active administrator participation</td>
<td>Set of hospital-wide positive expectations and behaviors are defined and taught</td>
</tr>
<tr>
<td>Efficient routine, schedule, and structure for conducting efficient team meetings</td>
<td>Procedures for establishing expectations and routines that are consistent with hospital-wide expectations</td>
</tr>
<tr>
<td>Commitment statement for establishing a positive hospital-wide social culture</td>
<td>Continuum of procedures for encouraging expected behavior</td>
</tr>
<tr>
<td>Procedures for on-going data-based monitoring, evaluation, and dissemination</td>
<td>Continuum of procedures for teaching and coaching skills for expected behavior</td>
</tr>
<tr>
<td>Procedures for selection, training, and coaching personnel</td>
<td>Procedures for encouraging hospital-family partnerships</td>
</tr>
</tbody>
</table>

Hospital-Wide PBS (HW-PBS)

- An organization-wide initiative focused on positive culture change, with the goal of supporting positive behavior to, in turn, cultivate a more respectful and nurturing environment for staff and patients.
- Working towards creating a shared understanding of how we want to interact (what we say, how we act) with one another (staff-staff, staff-patient; patient-patient) by developing a set of positively stated hospital wide values/expectations.
- Proactively teach and model the expectations/skills. When we don’t see respectful behavior, the reason is a lack of skills and/or an inability to use skills in that situation/environment.
- Notice and richly reinforce when prosocial and valued behaviors occur for staff and patients.
- Establish a consistent continuum of responses (and consequences) when behaviors divert from expectations/values.
- Increase structure, predictability and support in the environment.

Goal 1: Establish Hospital Wide Expectations/Values

- **Starting with the value of RESPECT, we met with ALL staff (beginning at the top) in order to:**
  - Get buy-in at all levels of the organization (goal of 80%)
  - Promote a common vision/values (what are the outcomes we want?)
  - Develop a common language
  - Begin to set the stage for a common experience
  - Create space to process experience and share perspective

HW-PBS Leadership Team

- A primary focus of hospital-wide implementation has been establishing cross-sectional representation with an intricate multidisciplinary system.
- Current team includes the following discipline representatives:
  - Psychology (PBS, Psych IV, Director of Psychology)
  - Social Work
  - Psychiatry
  - Rehabilitation (Rehab Counselor, in past also had Occupational Therapist)
  - Nursing (1st shift Nurse, 2nd shift Mental Health Worker)
  - Peer Specialist
  - Administration (Assistant COO)
  - Staff Development

Respect Exercise

- Met with approximately 30 different groups and departments in the hospital to complete an exercise on respect.
- This included:
  - Executive Leadership
  - Clinical (psychology, social work, psychiatry, rehab)
  - Operations (facilities, kitchen, housekeeping)
  - Nursing (nursing and mental health workers)
Respect Exercise

<table>
<thead>
<tr>
<th># Total Staff</th>
<th># Attended</th>
<th>% Attended</th>
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<tbody>
<tr>
<td>Hospital-Wide Exercise</td>
<td>797</td>
<td>675</td>
</tr>
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</table>

4 Core Values/Expectations

Goal 2: Behavioral Expectation Matrix
- Define behavioral expectations/examples of the values by specific location/situation.
- Collect responses and distill down most popular responses into simplified language.
- Develop visual representations of expectations for each key situations/locations and get printed and laminated by Business Center.
- Post visually in a matrix format in each of the specific locations to ensure shared understanding and frequent reference.
- The expectations become the basis for skills education and coaching both for staff and for patients.

MEDICATION LINE/WINDOW EXPECTATIONS

| RESPECT | Give space to each other |
| RESPONSIBILITY | Be patient |
| SAFETY | Get the correct medications |
| COMMUNICATION | Be polite - Hello, Goodbye, Please, Thank you |

MEALTIME EXPECTATIONS

| RESPECT | Speak Softly and Help Mealtime Be Peaceful |
| RESPONSIBILITY | Arrive On Time, Wait Your Turn, & Help Clean Up |
| SAFETY | Only Eat Your Own Food in Dining Room/C-Pod |
| COMMUNICATION | Work with Each Other and Be Polite (Please, Thank you) |

Concierge Area
- For the Concierge Area, the approach was a bit more intensive, as it was acknowledged that the expectations were different depending on an individual’s role. Specifically:
  - Three separate versions were created:
    - 1) Expectations Around the Concierge Area (for ALL)
    - 2) All Staff Expectations to Concierge Staff
    - 3) Assigned Concierge Staff Responsibilities.
  - Process and specific expectations were presented at a full department heads leadership meeting, multiple program meetings, and in relevant department meetings.
  - Pre and post data collection procedures
EXPECTATIONS AROUND THE CONCIERGE CIRCLE

RESPECT
- Be Kind to Each Other and Gentle with Property

RESPONSIBILITY
- Keep Calm and Respect Others
- Wait Patiently
- Understand Staff May Be Busy

SAFETY
- Keep Noise Low and Area Clear

COMMUNICATION
- Be Specific and Polite with Requests and Responses

ALL STAFF EXPECTATIONS TO CONCIERGE STAFF

RESPECT
- Respect the Role and Responsibilities of the Concierge Staff (*EYES and EARS of the Unit and Central Communication Point)

RESPONSIBILITY
- Check-in with Concierge Before/After Meeting with a Patient
- Help Support Staff and Patients

SAFETY
- Help Keep Noise Low and Area Clear

COMMUNICATION
- Say Hello, Know Each Other’s Names
- Increase Open Communication with Concierge Staff (e.g., where meeting, when done, if any issues/concerns)

ASSIGNED CONCIERGE STAFF RESPONSIBILITIES

RESPECT
- Maintain Confidentiality
- All Personal Matters Should Be Discussed in Private

RESPONSIBILITY
- Be Present and Focused
- Monitor Wings and Safety Check Person

SAFETY
- Know Where Patients/Staff Are
- Help Keep Noise Low and Area Clear

COMMUNICATION
- Be Friendly and Greet Others
- Validate Needs/Offer Support
- Be Specific with Responses and Follow Through

 PHONE USE EXPECTATIONS

RESPECT
- Give personal space
- Treat phone gently

RESPONSIBILITY
- Share phone
- Respect time limits

SAFETY
- Use phone safely
- Try to keep area clear

COMMUNICATION
- Use a soft voice
- Be courteous with language

Goal 3: Teaching Skills
- Develop curriculum to teach expectations to ALL patients.
  - Includes concepts and skill level instruction
  - Behavioral expectations are taught directly and redundantly and in ALL settings and apply to all staff and all patients
    - Introductory events (teaching hospital expectations and rules)
    - On-going direct instruction (specific content/skill demonstration and role play)
    - Teach in setting where behaviors are expected to occur (in the dining room, in meetings, in groups, in the medication line, etc.)
    - Embed in the curricula of existing evidence-based-practice recovery skills groups
    - Provide booster trainings to be easily used/applied as the need arises within any particular setting (patient milieu, meeting type, etc.)
    - Keep it out there (visual displays – posters, agenda covers, daily announcements)
    - Support and encourage repetition that is essential for learning new skills
Goal 3: Teaching Skills

- Develop plan/curriculum to train staff how to teach skills to patients (coaching sessions)
  - During the past year (January 2019-present) a focus on strengthening the coaching sessions (8 per week).
  - The primary goals of these sessions are to support staff skill development and improve the quality of staff interactions with patients to increase safe and therapeutic outcomes.
  - Given this will be a central avenue to roll out teaching/coaching, there were many aspects of it that needed to be addressed and improved.

Goal 4: Define Consistent Responses

- Define consistent responses to behaviors that deviate from expectations.
- Create a continuum of procedures for:
  - Encouraging expected behavior
  - Discouraging misbehavior
- Often traditional “consequences” have not been effective because they have not been aligned with:
  - Hospital-wide expectations
  - Clearly defined rules
  - A system for teaching expectations and rules
  - A system for rewarding appropriate behavior

Goal 5: Positive Reinforcement

- Develop structured reinforcement/recognition systems
- Procedures and practices for reinforcement/recognition (staff and patients)
- Determine ways to recognize positive behavior
- Keep ratios of reinforcement to correction high (4:1)
- Develop specific ways to reinforce behavior (and train/coach staff)
  - For example: name behavior and expectation observed, give positive verbal/social acknowledgment, other specific reward systems.
- Structured social reinforcement strategies are similar to informal strategies but involve an organization-wide approach to noticing and recognizing the skilled behaviors

Goal 6: Professional Development

- Develop and embed ongoing professional development
- PBS Values and behavioral expectations are integrated in staff orientation and annual training.
- Performance Evaluations (EPRS) include the PBS related performance (skills, behaviors) expectations and EPRS reviews are an opportunity for supervisors to reinforce behavioral performance and re-teach skills as needed.
Continual/ongoing processes/targets:
• Develop systematic way to report and review the data. Also develop specific procedures for:
  ▫ Ongoing monitoring and evaluation of data
  ▫ Using data to make decisions
  ▫ Sustaining implementation fidelity
• Coordinate and with other hospital committees and initiatives. These include: Diversity and Inclusion Committee, SHIFIT, Culture of Safety, Employee Recognition, Communications Performance Improvement, Mandt

Coordination

Fidelity Data
• The Facility-Wide Tiered Fidelity Instrument (FW-TFI) is an adaptation (to juvenile justice 24 hour facilities) of the gold standard Tiered Fidelity Instrument that is utilized in schools (Jolivette, Swoszowski, & Ennis, 2017).
  ▫ This is the closest instrument that applies to an inpatient hospital (additional adaptations needed).
• Provides an assessment and fidelity total score and rating across various modules, the TFI also serves to prioritize action planning efforts.
  ▫ Baseline: facilitated by Susannah Everett, Ph.D. and WRCH PBS Leadership team on 2/7/2019
  ▫ Annual re-evaluation occurred with Susannah Everett, Ph.D., Katherine Meyer, Ph.D., and WRCH PBS Leadership team on 2/20/2020.

FW-TFI Walkthrough Tool
**Purpose**
• The Walkthrough Tool is a component of the Tiered Fidelity Instrument (TFI), the purpose of which is to provide a reliable, efficient measure of staff and patient awareness and application of the core features of hospital-wide positive behavior support.
• Assessment will serve to measure progress and implementation fidelity.
**FW-TFI Walkthrough Tool**

- At each assessment point, a set number of staff (10-15 total) and patients (3-5 total) will be interviewed on each unit (10).

To ensure representation from different disciplines/positions and shifts (1st and 2nd), the staff surveyed on each unit will include the following targets as outlined below:

<table>
<thead>
<tr>
<th></th>
<th>1st Shift</th>
<th>2nd Shift</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHW</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>RN</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Rehab/OT</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Psych/Psych</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry/Medicine</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (housekeeping, peers, etc.)</td>
<td>optional</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FW-TFI: Walkthrough: Staff**

- What are the HW-PBS values/behavioral expectations?
- Have you coached any of the HW-PBS expectations to patients in the past 2 months?
- Have you noticed or acknowledged patients for displaying any of the HW-PBS expectations in the past 2 months?
- Have others noticed and acknowledged you for implementing PBS or the HW-PBS expectations in the past 2 months?

**Walkthrough Preparation**

- **Informed Consent:** Prior to starting the interview, staff and patients should be notified of the following information:
  - We are doing a survey as part of an effort to roll out a hospital-wide initiative on positive behavior/culture change. It is purely voluntary to evaluate your performance, or that of your unit.
  - Your participation will help us assess progress of the program; the questions being asked are in no way intended to evaluate your performance, or that of your unit.
  - Participation is completely voluntary. Your decision to participate or decline to participate will have NO impact on your employment (or performance evaluation, etc.
  - (FOR PATIENTS: will have NO impact on your treatment or discharge)
  - Responses are anonymous. We are not recording any identifying information, so the information you share will have no way of being traced back to you.

**FW-TFI: Walkthrough: Patients**

- What are the HW-PBS values/behavioral expectations?
- Have staff coached you on any of the HW-PBS expectations in the past 2 months?
- Have staff noticed and acknowledged you for displaying any of the HW-PBS expectations on unit in the past 2 months?
- Have staff noticed an acknowledged you for displaying any of the HW-PBS expectations off unit in the past 2 months?

**WRCH Staff- Walkthrough Baseline**

- 89 total requests
- 70 participated
  - 44 MHW/RN (62.9%)
  - 17 Clinical Staff (24.3%)
  - 9 Leadership Staff (12.9%)
- Total Hospital Pool: 603
  - 437 MHW/RN (72.4%)
  - 125 Clinical Staff (20.7%)
  - 41 Leadership Staff (6.8%)
- 1st shift: 48 (68.6%)
- 2nd shift: 21 (30%)

**Values/Expectations Named**

<table>
<thead>
<tr>
<th>Respect</th>
<th>Responsibility</th>
<th>Safety</th>
<th>Communication</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Wide</td>
<td>35.0%</td>
<td>31.8%</td>
<td>34.0%</td>
<td>35.0%</td>
</tr>
<tr>
<td>MHW/RN</td>
<td>28.0%</td>
<td>35.0%</td>
<td>34.0%</td>
<td>35.0%</td>
</tr>
<tr>
<td>Clinical Staff</td>
<td>31.8%</td>
<td>31.8%</td>
<td>27.0%</td>
<td>32.0%</td>
</tr>
<tr>
<td>Leadership</td>
<td>31.8%</td>
<td>31.8%</td>
<td>14.1%</td>
<td>44.1%</td>
</tr>
</tbody>
</table>

- Avg number of expectations: 1.08
  - 0: 30 (41.4%)
  - 1: 5 (6.6%)
  - 2: 5 (6.6%)
  - 3: 5 (6.6%)
  - 4: 5 (6.6%)
Coached Expectations

Noticed and Acknowledged Others

Others Noticed and Acknowledged Me

WRCH Patients - Walkthrough Baseline
- 29 patients asked: 20 participated, 9 declined
- Average Length of Stay: 23.7 months (Range: <1-72 months)
- Average number of expectations: 0.4
  - 0: 14 (70%)
  - 1: 4 (20%)
  - 2: 2 (10%)

Taught Values (Patients)

Values Noticed On Unit (Patients)
Values Noticed Off Unit (Patients)

Outcome Data Variables

- Restraint and Seclusion Use (restraint database)
- Patient Assault (incident database)
- Staff Injury (IA data)
- Patient Engagement (MHIS Recovery-Skills group data)
- Length of Stay (UM Admission/Discharge data)
- Consideration of Staff Satisfaction/Retention variables
- Other data sources specific to implementation process (e.g., Concierge area).

Potential Initial Positive Impact?

Thank you!

- Email contact: Meredith.Ronan@state.ma.us

References