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TRAINING SOLUTIONS LLC

Maximizing Integration

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8-Step Suggestion For Aegis Integration

When engaging The Aegis System™, it may be timely to evaluate the inner-workings of your organization. An organization must know its vital signs to maximize integration. The National Technical Assistance Center for State Mental Health Planning's publication of six core strategies for positive cultural changes that reduce the need for the use of restraint is incorporated below (Huckshorn, 2005). The following points are also influenced by Suess's (2008) "Lessons Learned From 30 Plus Years of No Physical Intervention." This 8-step format is a product of knowledge gleaned from many successful Aegis integrations. It is not an exhaustive framework for integration, but a helpful starting point for thinking seriously about engaging The Aegis System™.

Step 1: Create a Committee

Establish a multidisciplinary group that includes leaders from various areas of the organization. The effectiveness of this body of leadership will determine whether or not positive cultural change will occur. The overall vision and action plan for positive change is spearheaded by leadership. Leadership needs to own the macro factors that will determine whether a positive impact is achieved. From a macro perspective, leadership's ability to clearly define the model of care and demonstrate their experience with that model will have a significant impact. While organizing this committee, it may be timely to assess internal expertise. Front line professionals that have tenure with the organization can often feel underutilized. Including such staff in the committee may contribute greatly to the conversation.

Step 2: Establish a Clear Goal

With this committee, clearly identify a tangible goal with an established timeline (i.e. cut restraints in half and eliminate injuries within two years). Level set this goal to the population served vs. comparison to other organizations. This may be the time to clarify the organization's definition of restraint. There is no consensus in literature or various state and federal guidelines, so it is prudent that each organization establishes their own definition (which may come from the chosen training vendor). It may be necessary to articulate a distinction between manually applied restraints vs. chemical restraints vs. mechanical restraints and align this definition to state regulation and accreditation standards (if applicable). It should also be clear what an "escort" is and seclusion should not be lumped into the definition of restraint.

Step 3: Collect and Review Available Data

Process all incident reports and available data pertaining to incidents of restraint and near misses. Be sure *not* to look at frequency of incidents by itself but across the number of different clients. Also look for correlations in rates of staff turnover to trends in incidents of restraint. It may be prudent to do surveys and/or meet with key staff to gather information. Allow staff comments to stimulate future discussion. Include input from the population served, parents, legal guardians and members of the greater community. It is suggested for organizations to have separate incident forms pertaining to the use of restraint vs. general critical incident forms that can skew data and make review more challenging. Establishing a baseline with data collection will become a necessary starting point to track progress.

Metrics to consider:

- Number of physical interventions used, organized by type per each department or area
- Number of injuries to clients and type
- Number of injuries to staff and type
- Number of workers compensation claims/days away from work
- Property damage resulting from incidents of restraint (*Note: Monetary figures should never be used to justify the use of restraint; property damage must directly result in a safety concern for physical intervention to be considered an appropriate response*)
- Injuries to bystanders or others involved in the incident that were not restrained
- Number of non-physical interventions where de-escalation was achieved that could be categorized as a near miss

Step 4: Assess and Confront Potential Barriers

Anticipate micro barriers at point of care and macro barriers across the organization. Plan to confront these barriers while pushing for positive change. Factor the contagion effect while taking this initiative. Lean on internal resources and consult with the chosen training vendor to confront potential barriers. Assess:

- Limits to financial resources
- Limits within the physical space of the facility (such as limited access to stimulus-reduced space when escalated)
- Operational limitations on the ability to provide staff with autonomy
- Staff to client ratios
- General barriers within workplace culture:
    - Absence of a pro-active approach to crisis and/or reactivity to clients
    - Lack of client rapport
    - Lack of cohesive staff teams
    - "Because I said so"
    - Consistent power struggling with clients
    - Excessive staff burnout
    - Client vs. staff dynamics
    - Lack of positive regard for clients
    - Excessive "street language"
    - De-personalizing language (as a mechanism to maintain emotional barrier between client(s)/staff and amongst colleagues)
    - Avoidance of or failure to follow through with individualized client support plans
    - Lack of positive reinforcement of clients (Friman, Jones, Smith, Daly, & Larzelere, 1997)
    - "Code of Silence" or "report at your own risk"
- Resistance to change, which may correlate to staff tenure and create a contagion effect with:
    - Early adopters excited about change
    - Neutral staff
    - "Laggards," whose resistance to change may be overt or covert (Barwick, Boydell, Stasiulis, Ferguson, Blasé, & Fixsen, 2005)

- Collective attitude towards restraint, current CI model and current P&Ps pertaining to crisis
- Collective attitude towards population served
- Ability to implement and maintain consistency with individualized support planning, which is significant towards reducing the number of restraints and critical incidents and may include:
    - Individual client history addressed in a check-list fashion
    - Additional risk factors flagged, such as, but not limited to: physical health, prescribed medications (such as lithium), trauma history, pertinent psychological history, current diagnoses, etc.
    - De-escalation strategies may be prescribed in context specific to the individual (i.e. gearing strategies more towards co-regulation or self-regulation)
    - Supervision interventions and/or manipulation of staff ratios and gender specificity in relation to individual clients
    - Physical intervention may be prescribed in context specific to the individual (i.e. which level of hold is appropriate; another great intention of having holds arranged in a tertiary design)
    - Plans to manage the duration of an incident specific to the individual client
    - Clinical observation/report/shift change notes from staff that include trends in behavior (i.e. seeking behavior or patterns of behavioral escalation at specific times of day or staff changes)
    - This individualized support plan may be communicated to parents or legal guardians for input and buy-in
    - Individual support plans for clients that have been held in restraint should look different from those that have not

Step 5: Evaluate Policy and Procedure

Identify which staff are to be trained in physical intervention (vs. de-escalation only) and what the ratio of hours spent on de-escalation vs. physical intervention should be (1 to 1 is a bare minimum). The chosen de-escalation model should be thought of as a common thread across the organization, but not all staff need to be trained in physical intervention. Deciding which staff are to be certified in the use of restraint is a weighted decision that may impact outcomes. For example, in some environments, having everyone trained in the use of (benevolent) restraint may increase the safety climate. In other environments, having select or more experienced staff trained in the use of (benevolent) restraint may do more to encourage de-escalation and lessen the frequency of hands on incidents.

Some diligence may be required to make sure training is in alignment with existing P&Ps. The chosen vendor should be able to support this process. Eliminating grey areas in policy will be helpful towards better mitigating incidents of crisis. P&Ps may need to be adjusted to better align with individual support planning. Increased scrutiny of incidents from the most senior level of the organization is encouraged, which reinforces the reality that each restraint is important.

Maintaining adequate client to staff ratios is important as case study has revealed a correlation between this and the frequency of critical incidents (Friman, Jones, Smith, Daly, & Larzelere, 1997). Inadequate staff to client ratios will likely increase the number of incidents and resulting complications. It may be timely to look at hiring practices from recruitment to pre-hire staff training. Some organizations experience positive results by investing in significant staff training before staff has any client contact.
It is strongly encouraged to draft policy and procedure that empowers front line staff with decision-making capabilities within the operational structure provided. This is needed to maintain adequate responsiveness during crisis and to provide staff with the autonomy needed to prevent behavioral escalation. When staff believe they are restricted by explicit or implicit time/cost limitations, they become hyper focused on control of clients and ensuring their compliance vs. clinical support. This leads to coercive interventions and reactive staff behavior. This dynamic increases power struggles and conflict that leads to more

frequent incidents of behavioral escalation. Furthermore, staff caught in this dynamic are more likely to turn-over (Thompson et al., 2008; Carter et al., 2008).

Step 6: Publish the Plan

Summarize and outline the plan with a firm timeline in place. Publish the plan in hard copy or digital form. Distribute to all staff to formally roll out this initiative. Open up lines of communication with staff that values their input without framing staff involvement as an evaluation of the decision to initiate change.

Step 7: Put The Plan Into Action

Execute your initial round of trainings in as short a time frame as possible. Plan to complete initial staff trainings in separate areas or quadrants where staff are more likely to be doing team interventions together. Complete these areas/quadrants as stepping-stones, before moving on to other areas. Anticipate staff refresher trainings down the line.

Creative thinking often reveals ways to maximize time committed to training. Breaking training into modules or highlighting certain aspects at staff meetings or in-services has proven to be effective in some organizations. Create space for mandatory and/or elective practice times for staff to meet with certified Aegis Trainers to practice techniques, review de-escalation strategies and talk constructively about concerns from point-of-care.

Some organizations have experienced great success with redefining aspects of their clinicians' role (LPC's, psychologists, etc.) to include more staff development. This provides more "behavior specialists" on site and encourages investment in staff development. Skilled professionals feel like they have more command over the situation at hand and are less likely to compensate or react negatively (Suess, 2008).

Training, through the lens of workforce development, should be thought of as a platform to maintain the model of care. Investment in training is a measure to ensure quality and employee satisfaction. Interaction with staff in the classroom or training space maintains supervision of staff. Crisis intervention training is an opportune time to evaluate competencies and further staff development with a strength-based approach.

Step 8: Monitor Outcomes and Invest in Debriefing

Continue to review data and respond to trends. Identify milestones for formal review. A positive impact should be trending after the completion of staff training, but it may take longer to see empirical results. One to three years is a safe window, depending on the environment. Investing in a more formalized debriefing process is an effective way to monitor outcomes and better mitigate critical incidents.

Using effective debriefing techniques after each incident encourages the psychological repair of everyone involved. Supportive debriefing is an opportune time for leadership to strengthen their rapport with staff. Debriefs also present an opportunity to coach staff and encourage their professional development through critical incidents. It is safe to assume that a staff person's confidence in their ability to intervene will only be positively or negatively reinforced by the incident that transpired; this may significantly impact future outcomes and post-incident procedure should be attentive to this.

Effective debriefing is part of utilizing assessment and prevention tools. Policy & procedure must be in place to detect abusive or negligent practices and ensure immediate responsiveness with corrective action. Such P&P may be placed within the debriefing process. Debriefing, in combination with incident reporting, is the primary way that data is aggregated. Over-reporting and over-communicating any incident, or near miss, should be commonplace across the organization (Thompson et al., 2008). This ensures there is data available to inform practice. Data collection and responsiveness to trends in data is a vital sign of effective organizations.

REMEMBER:

Each person is unique

Every restraint is important

Agency culture is a critical factor

Approach to crisis needs to be data-driven (Carter, Jones & Stevens, 2008)

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