Shadow Mountain at Riverside A.C.E. Treatment Protocols

Overview of Philosophy:

Welcome to the Attachment/Trauma based A.C.E. unit at Shadow Mountain Behavioral Health Systems at Riverside.

At Shadow Mountain Riverside, we treat children and families, not diagnoses and although we use attachment principles in our treatment, we provide a more holistic treatment than just attachment. Our first job with children is to provide psychological and physical safety, by increasing the structure of their lives and by helping the children regulate their emotions. Our second job is to be curious to what the child is telling us through behavior and help the child put those feelings into words and verbalize. We help children tolerate anxiety and negotiate closeness adaptively so that they can express their needs more adaptively. We help parents be attuned to the child and meet the children's needs at the developmental level that they are expressed. Shadow Mountain at Riverside also does not change a child to fit a family, but rather help families understand who they are as individuals and as family systems. At Shadow Mountain Riverside we expect our outcomes be the unexpected.

Description of processes

Prior to admission

The family or current provider is asked to complete the following rating scales prior to admissions: Child Behavioral Check List (C.B.C.L.), Teacher Report Form- Child Behavioral Check List (TRF-CBCL), Sensory Profile, Parenting Stress Index, and Overt Aggression Inventory. If no testing has been completed within the last year or previous testing indicates likelihood of significant learning problems or processing problems a referral to one of our testing consultant will occur. Information from the Primary Care Physician will be obtained including chronic diagnoses, most recent physical exam, and acute medical issues. Date of most recent eye exam and if patient wears glasses is requested. We request an eye appointment me completed prior to admission if not up to date.

Parents/caretakers are given in-depth information about A.C.E. Program including parent participation requirements, Dyadic Developmental Psychotherapy Model and articled related, and Program Guidelines. One of our therapists then meets with the child and parent in person (if possible due to distance of travel). If not able to complete a face to face assessment the therapist will speak with the caregiver by phone. If child is in state custody the worker and supervisor must commit to finding a permanent placement and identified caregiver to be involved in the attachment treatment.

After Admission

Admission to the program is a very sensitive process. When the child is brought to the unit the staff that are working directly with the child meets the child and helps the child to the unit. All of the children on the unit are aware of the new child's admission and have completed a group of welcoming the new

child. Once the child is on the unit each child is able to come up to him/her and introduce themselves to them one at a time. The child remains close to the staff at all times during the first few days of admission. It's the staff's responsibility to ensure the child feels physically and psychologically safe in the very beginning. This also allows the child to experience the adults ability to care and meet the child's needs. The first night is also a very importance time for the staff to spend time with the child ensuring they feel comfortable sleeping in their new environment. The families are welcome to call the child in the evening to reassure both the child and family.

Family

If no IQ testing was completed in recent history one will be completed. Within the first two months a Block Task with child and each identified caregiver will occur. This task is videoed and assessed by therapy and psychiatrist and then reviewed with the parents. Dr. Dan Hughes Questionnaire for Parent Reflection is completed by each identified caregiver (caregiver may complete during session or take home and return to therapist). At least two individual therapy sessions, one parent therapy session, and one parent/child family therapy session videotaped within the first six months of treatment which is reviewed by the therapist and psychiatrist for consultation.

Completion of case assessment at one, three, six, nine, and twelve months from admission (This includes assessment regarding needs for Systems of Care, marriage counseling, individual counseling of the caregiver, whether or not patient will return to previous providers, type of providers that patient and family should be matched with upon outpatient.)

If there are significant identifies on the Sensory profile or Speech and Language assessment a referral will be made. A current Individualized Education Program will be in place and update complete before discharge.

Treatment Planning:

Upon admission the treatment plan is established that includes the goals, objectives, interventions, diagnosis, medications, and discharge plan. This is a working document that changes based on the child and families needs. These needs are identified from the client developmental history, treatment history, current problems and/or symptoms, the ongoing treatment on the Units and Assessments utilized in treatment. These are updated every two weeks.

The Treatment Team meets weekly to discuss the child's treatment. The Treatment Team includes the treating Psychiatrist, Licensed Therapist, Registered Nurse, Staff that work directly with the child, School Teacher, Discharge Planner, Case Manager, Speech or Occupational Therapist, Parent, and Child.

Treatment Techniques Used:

The primary concept of treatment is based on Dyadic Developmental Psychotherapy (DDP) created by Dr. Daniel Hughes. D.D.P. is a treatment approach to trauma, loss, and/or other dysregualting experiences that is based on principles derived from attachment theory and research. D.D.P. also incorporates aspects of treatment principles that address trauma. It is a family centered, with the child's attachment figures actively involved.

The central therapeutic process of Dyadic Developmental Psychotherapy is *attunement*. Attunement is an affective process in which two people are in emotional sync, communicating verbally and nonverbally in a responsive and affectively sensitive manner. The basic "attitude" used in Dyadic

Developmental Psychotherapy is creating as healing **P.A.C.E.**: being playful, accepting, curious, and empathic.

For parents, the framework within which they must operate is to create a healing. **P.L.A.C.E.**; being playful, loving, accepting, curious, and empathic. Taking this "attitude" in working with children with attachment disorder helps to insure that the client is not alone while entering a painful experience.

The **(A.C.E.)** program name was created from part of the acronym of the P.A.C.E. model.

Discharge Planning

We begin to identify early in treatment what potential outpatient supports will be needed for both the child and family. If the child or family has a referring therapist, or doctor they are involved throughout the treatment process and will be referred back to them upon discharge. We attempt to assure the outpatient therapist that they return to is trained in attachment therapy and has some experience in the model we utilize. If Occupation or Speech/Language treatment is needed a referral and appointment will be made. We complete a face to face (if possible due to distance of travel) school transition meeting with the child's original school before discharge. To ensure continuity of care we want to ensure all the assessments, evaluations, interventions used continue to be utilized with the child including the school setting. We have found that the schools truly appreciated and the child benefits from this meeting.

<u>Safety/Risk Management Plan:</u>

Staffing/Hand off Communication:

We use a rotation of staff and shifts. There are two mental health techs (MHT) for every 8 children on each unit. During all shifts, the staff ensures patient safety by doing every 15 minute checks and documenting the patient's wellbeing and location. The nursing staff makes unit rounds throughout the shift to ensure that the checks are being completed. The nurse signs the 15 minute check sheets upon completion at the end of each shift. The staff and nurses are able to communicate via radio and telephones on the units for patient emergencies. Staff exchange shifts which consists of a 30 minute time period where nurses hand off report to the oncoming nurse and techs hand off a report to the oncoming tech of how each child has been doing that day and if any interventions need to be continues during that shift. Specific patient precautions are confirmed. The nursing staff also completes a shift report where they update the oncoming nurse regarding patient precautions, wellbeing, new medications or special treatment interventions initiated during the last 24 hours. Any time a patient is off of the unit with anyone besides their MHT, whether, physician, nurse, therapist, the 15 minute checks are maintained by the person that they are with.

Staff attends a mandatory Unit Meeting once a week. The meeting includes all direct care staff that work on that unit, the therapist, psychiatrist, and nurse. The purpose of this meeting is to openly discuss any issues that pertain to that unit. This could include unit structure, consistent with the schedule or constantly with how we are intervening with a child, staffs own response or feelings regarding a child, possible transference that could be occurring, or any unit changes. This meeting is very helpful in how the unit remains healthy as a team to ensure the best possible treatment of the child.

Levels of observation/Precautions:

If necessary, a physician may authorize a patient to be placed on special precautions of observations, which include 1:1 observation, Line of Sight (LOS), Sexually Acting Out (SAO), Assault, Absent Without Leave (AWOL), or Suicide Precautions (SP). If 1:1, the only responsibility that the staff person has is to be within one arms length of that patient. All precautions involve line of sight while the patient is awake and the 15 minute checks resume once patient is asleep. Staff remains vigilant for possible signs that a patient may need to have special precautions added. If a patient is assaultive, acts out sexually, and/or is at risk for elopement or suicide, the nurse is summoned and may initiate special safety precautions. The nurse then notifies the physician for an order to maintain the patient on any needed special precautions. Patient safety is at the forefront of daily milieu management. Once admitted to Riverside patients belongings are respectfully searched for sharp objects, anything that could become an instrument of self harm of aggression for other patients. A client inventory is completed of all their belongings. Children regularly go on passes off campus with their caregivers and if any new belongings are brought back to the campus it will need to be checked in with the nurse and therapist to ensure safety and documented in their inventory.

Incident reporting:

If an unusual occurrence happens, an incident report is completed. Unusual occurrences include but are not limited to the following: Unsafe boundary issues, contraband/controlled items found, elopement attempt, harm to peers, harm to staff, broken or malfunctioned equipment or furniture, medication variances, physical abuse by staff, recreational injuries, restraint or seclusion, self harm, suicidal gestures or threats, and medical complications. Each incident is reviewed and addressed by members of the treatment team. The physician, therapist, and parents are notified and as each situation warrants. After review the reports are forwarded promptly to the risk manager for performance improvement record keeping. All incident reports are followed up with evaluation of the outcome.

All patients and families have access to a supply of grievance forms. They are encouraged to complete a grievance if they are not satisfied with their care or feel they are not being treated fairly. Nurses, therapist, or physicians may assist a patient that is unable to complete a grievance on their own. Grievances are addressed in a timely manner, and then forwarded to the patient advocate. Some grievances are addressed personally by the patient advocate. Patient emotional and physical safety is considered at all times.

Environment of Care:

The facility is a secure facility with magnetic locks that will release in case of emergencies. Employees have badges that will allow entry through the locked areas. The facility maintenance staff provides routine inspection standards according to Joint Commission and Department of Human Services requirements. The facility is cleaned and disinfected daily by a janitorial service. Infection control standards are maintained under the supervision of a certified Infection Control Nurse. Chemicals used in cleaning or disinfecting are kept locked away from patient access and are listed in the Material Safety Data Sheet (M.S.D.S.) kept in each nursing office. Sharps containers are used for storage of used sharps where appropriate in patient care. The milieus where patients program, sleep and have recreation are cleaned daily and kept in safe working order. Any items that could bring potential harm to a patient are kept locked away from patients. The Center for Disease Control (C.D.C.) hand hygiene method is used throughout the facility by staff and patients. The organization promotes the Joint

Commission National Patient Safety Goals in training and in all aspects of patient care. All units are inspected routinely and randomly for potential risks to patient safety. Staff and patients are encouraged by use of friendly contests and competitions to keep their units safe and aesthetic. When a unit wins the prize they get an ice cream party for keeping the cleanest environment. Fire, medical emergency and severe weather drills are coordinated and performed on a routine basis. Fire Alarm and Sprinkler systems are maintained and routinely tested and inspected according to standards set by regulating bodies. The city has a 911 service that is easily contacted in case emergency. Data is kept for performance improvement in the environment of care.

Evaluation, Outcomes, Follow Up:

At discharge every child completes a satisfaction survey. This data is compiled on a quarterly basis and reported and reviewed by the medical staff. If the child remains in our state we are able to track the client success through the Oklahoma Health Care Authority. Success is measured based on if they child remains in the community or has to be re-hospitalized. We are able to track what services the client continues to receive in the state. If a child is re-hospitalized we look at why the child was hospitalized, how long they remained in the home, and what we can do now to assist the current provider.

At discharge Confidentiality releases are signed to the outpatient providers to ensure we can follow up with the clinician of how the child is doing, provide any clinical information, assessments, and testing while here, and are available for a consultation on the case if needed.