Improving Communication in the Acute Psychiatric Setting Through a Collaborative Behavior Plan: A Quality Improvement Initiative

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Abstract

Effective provider-patient communication is essential in acute psychiatric inpatient care. Communication breakdowns in these settings can lead to a lower quality of care and increased coercive measures such as the use of seclusion and restraint. Thus, a Collaborative Behavior Plan (CBP) was developed for a quality improvement (QI) project piloted on a single unit of an urban psychiatric hospital. Nurses were trained to help newly admitted patients fill out a CBP that identified their personal triggers, warning signs of escalation, preferred coping strategies, and requests for staff support during crisis. The specific aims of the project were a 50% CBP completion rate from patients admitted during the implementation period and 70% of nurses endorsing improved communication from the tool. Pre- and post-implementation surveys assessed nurses' receptiveness to the CBP and their perceptions of its effectiveness in improving communication. Ultimately, the results of this initial QI project fell short of the specific aims, with 28% of patients completing a CBP and 60% of nurse respondents rating the tool as somewhat effective. Barriers included timeframe (one month), staff ambivalence, the lengthy admissions process, and competing demands. Strengths of the project were the structured, unit-wide training, and the facilitation of qualitative feedback from nursing staff. Future projects may optimize results by incorporating nurse and patient feedback early in the development process, recruiting support from interdisciplinary team members, and leveraging technology to improve access to crisis plans.

Keywords: inpatient psychiatry, patient-provider communication, de-escalation techniques, patient-centered care, coercive measures

Problem Description

Effective communication is a critical component of all healthcare settings and is especially important in the acute psychiatric environment. Communication breakdown in the inpatient psychiatric setting can negatively impact quality of care, patient satisfaction, and the safety of both patients and staff (Yu et al., 2023). Despite efforts to provide safe treatment, patients in these settings often report re-traumatization and a lack of autonomy (Butterworth et al., 2022). Although guidelines for inpatient psychiatry recommend using the least-restrictive measures to resolve incidents, the system remains overly reliant on coercive measures (CM), which include seclusion, chemical restraint, and physical restraint (Butterworth et al., 2022). CM carry significant psychological and physical risks and hamper patient care (Butterworth et al., 2022).

A comprehensive needs assessment conducted at a large urban inpatient psychiatric facility emphasized the importance of effective communication. Conversations with psychiatric providers at the facility identified three main factors impacting care and communication: time constraints, patient symptom severity, and a reactive response system to behavioral incidents. Time constraints were cited as a barrier to communication between patients and providers as well as within the interdisciplinary treatment team. The severity of patients' symptoms was also noted to influence their ability to collaborate with their care team, though this improved with stabilization on medications. Notably, communication processes related to individual patient needs and crisis plans were created with little involvement from the patient and described as "reactive," meaning they were only implemented after CM were used.

Proactive patient-provider communication that involves the patient in decision making shifts the focus from the patient's illness to their wellbeing and recovery. Therefore, inpatient psychiatric care settings must prioritize improved, proactive patient-centered communication.

Available Knowledge

Patient-centered care is associated with improved appraisal of patients' own mental and physical health (Yu et al., 2023) and does not require additional time or resources (Rosen & Stoklosa, 2016). Shared decision-making, a component of patient-centered care, has been shown to play an important role in treatment (Storm et al., 2019). For example, joint crisis plans in acute psychiatric settings empower patients and support collaboration with providers (Goulet et al., 2024). Additionally, patient involvement in care during inpatient psychiatric stays is one of the core components associated with eliminating restraints (Bausman et al., 2024). In countries with low rates of non-medical mechanical restraints, patient-identified triggers are among the specific factors that contribute to not needing mechanical restraints (Bak et al., 2015).

Seclusions and restraints in the inpatient psychiatric setting negatively impact both patients and nurses (Yurtbasi et al., 2022). Further, both patients and staff support the adoption of more patient-centered care in inpatient psychiatric setting (Berg et al., 2023). Patients with impaired communication at admission due to language barriers, behavioral dysregulation, or other contributing factors, are at increased risk of CM during hospitalization (Cole et al., 2022). Thus, the establishment of collaborative communication early in the admission process may provide additional support in such instances.

In the existing literature, projects aimed at decreasing CM in the inpatient psychiatric setting have typically focused on reactive techniques such as debriefing after the use of CM (Eblin, 2019; Griffin, 2021). Although there is limited literature on the use of proactive, patient

co-authored communication plans, recent quality improvement projects show promise (Hajaj, 2025). This is aligned with existing research supporting patient engagement and individualized planning in CM prevention (Gooding et al., 2020; NASMHPD, 2006; Kaur & McNamara, 2025).

Rationale

The current project was based on the Six Core Strategies, an evidence-based practice to reduce the use of CM (NASMHPD, 2006). Specifically, the Six Core Strategies supports the use of CM-reduction tools such as relevant admissions assessment questions, the creation of individualized safety plans that include unique patient triggers, and self-management strategies (NASMHPD, 2006). Planning documents, such as psychiatric advance directives, are typically well-regarded by patients (Braun et al., 2022).

The current QI project was implemented on a single unit in an inpatient psychiatric facility. The specific unit was chosen for its low acuity, with the rationale that the patients on the unit would be most able to engage in collaborative proactive crisis planning. The intention was to implement one Plan-Do-Study-Act (PDSA) cycle of a communication tool on the unit. Information learned from the initial pilot could then be used in subsequent PDSA cycles on additional units (Institute for Healthcare Improvement, n.d.).

The intervention was developed assuming nurses would support the tool and use it at admission. This assumption was informed by conversations with stakeholders, and the identification of a similar collaborative proactive crisis plan on the facility's adolescent unit. Thus, a collaborative behavior plan (CBP) was developed based on these tools, stakeholder feedback, and site-specific context.

Specific Aims

The primary aim was to improve communication between care staff and patients on an inpatient psychiatric unit by achieving a 50% completion rate of CBPs upon admission to the unit. The secondary aim was for 70% of post-survey responses by tool-trained nurses to indicate improved communication through the CBP. The project's implementation period was to last one month.

Context

This QI project took place at an urban psychiatric hospital providing acute stabilization. The facility provides a range of services, including crisis stabilization, inpatient care, and care coordination. The hospital is equipped with four adult inpatient units with a total of 85 beds, and one adolescent unit with 22 beds. Upon admission to the facility, patients first stay in the psychiatric emergency department and then are admitted to a specific unit based on their diagnoses, symptoms, and level of acuity.

The QI project was implemented in a 23-bed unit that serves adult patients with the lowest-acuity needs in the facility. Patients on the unit carry diagnoses including major depressive disorder, bipolar disorder, borderline personality disorder, polysubstance use, and psychosis. During their stay, patients typically engage in treatment planning to some degree. For example, they may choose between medication options, advocate for themselves during care coordination, or collaborate on discharge planning.

Patients on the unit have varying diagnoses and were predicted to differ in their willingness to engage with the project. Patients' legal statuses were also predicted to play a role, as patients with involuntary holds tend to be less engaged in treatment. Additionally, staff buy-in was predicted to play a large part in project implementation (Svensson, 2022).

This project was a continuation of a recent QI project at a nearby inpatient psychiatric facility that showed improved staff-patient communication using a similar tool (Hajaj, 2025).

Interventions

The CBP was adapted from the tool by Hajaj (2025) to improve communication on an acute psychiatric unit (Appendix 1). The development of this brief, structured tool was informed by multiple sources. Prior literature highlights the critical role of communication in delivering patient-centered care and reducing the use of CM. The team reviewed existing, longer-form communication tools, including a previously implemented mental health passport developed through a quality improvement initiative (Cole et al., 2022; Hajaj, 2025). Additionally, the team examined current practices at the project site, including the list of identified triggers and concerns on the child and adolescent unit (Appendix 2) and the post-incident debrief tool on the adult unit (Appendix 3). These existing resources informed the adaptation of the CBP for the current study. The CBP consisted of five questions exploring patients' triggers, warning signs, strategies to reduce distress, and actions that could worsen distress.

The CBP was incorporated into the nurses' existing workflow for unit admissions (Appendix 4). Nurses were trained on the standard operating procedures and use cases for the tool (Appendices 5 and 6). The CBP and its patient disclosure statement (Appendix 7) were to be included in the intake packet given to all patients upon admission to the unit. At intake, nurses were to collaborate with patients to complete the CBP, enter their responses into the electronic health record (EHR), and provide patients with a copy of their CBP. The unit support staff were to conduct weekly chart reviews for CBP completion and inclusion in the EHR. The assistant nurse manager (ANM) posted information in the nursing station about the CBP.

Study of the Interventions

To measure the impact on patient-provider communication and likelihood to adopt the tool moving forward, nurses were asked to provide voluntary feedback (Appendix 8) through a pre-intervention and post-intervention survey. The pre-survey collected baseline data on nurses' attitudes towards a CBP (Appendix 9). The post-survey, given after one month of CBP implementation, explored nurses' perceptions of the tool, the ease of incorporating it into the workflow, and whether they would recommend it moving forward (Appendix 10). Project leads also collected baseline data on the unit's behavioral incidents in the month prior to implementation and as well as comparison data during the implementation period.

Measures

This project investigated a combination of outcome and process measures to examine CBP implementation and determine its impact on unit communication.

The primary process measure was the percentage of nurses who completed CBP training. Project leads tracked the number of tool-trained nurses, with a goal of at least 70% of day shift nurses completing the training prior to implementation. Additionally, completion of pre-intervention and post-intervention surveys was also tracked, with a goal of 70% of tool-trained nurses completing both.

The primary outcome measures were the percentage of patients completing the tool and the percentage of nurses reporting improved communication from the CBP. Additionally, the number of behavioral incidents on the unit were tracked for one month before the intervention and the month of the intervention to assess if the CBP was correlated with a decrease in behavioral occurrences.

Analysis

Data from pre- and post-intervention surveys were collected through Microsoft Forms and analyzed through Excel. The two primary process measures, i.e., nurse completion of training and surveys, were tracked throughout the project and analyzed as percentages after project completion. The two primary outcome measures, i.e., patients' CBP completion rates and nurses' survey reports of improved communication, were also tracked throughout the project and analyzed as percentages after project completion. CBP completion data were graphed to examine variance throughout the intervention period. Additionally, data on the use of CM were compared between the month prior to the intervention and the month during the intervention.

Ethical Considerations

A request for determination was submitted to the Oregon Health & Science University (OHSU) Institutional Review Board (IRB), confirming the project did not constitute human subjects research. Ethical considerations included potential staff burden and involvement of a vulnerable population. To mitigate risks, participation was voluntary; participants received a disclosure of risks and benefits, and no protected health information was collected. Additionally, staff surveys were anonymous, and the CBP was integrated into the existing workflow.

Results

This QI project was planned as a one-month implementation, with surveys available for two weeks prior to the intervention and two weeks after the intervention. Early in the implementation period, support staff reported confusion about data tracking procedures. After clarification from the ANM, support staff began storing CBPs in binder at the nursing station to improve tracking. Project implementation was extended to seven weeks to account for initial challenges in data collection and norovirus outbreaks that halted admissions.

Of the nurses assigned the training (n = 36), 77% completed it. Pre-survey completion rates were 44% (n = 16) and post-survey completion rates were 27% (n = 10). Overall, patients' CBP completion rates were low (Appendix 12). Of the patients admitted to the unit during the project implementation period (n = 69), only 28% completed a CBP. Although the goal was to offer the CBP to all eligible patients at admission, 13% were not offered it, typically due to nighttime admissions and intra-facility transfers. CBP completion rates improved with process improvements and reminders from the ANM (Appendix 13).

Half of the nurses who completed the post-survey listed improved patient-nurse communication as one of the top three benefits of the CBP, and 30% described it as beneficial in their free-text responses. Responses to these two questions, after accounting for repeat endorsements, indicate that 60% of nurses felt the CBP improved communication.

Nurses' post-survey free-text responses provided additional context. Qualitative analysis, loosely informed by Grounded Theory (Chun Tie et al., 2019), identified three primary challenges: patient fatigue during the admission process; difficulty accessing completed CBPs; and competing nurse responsibilities. These findings were corroborated by the ANM.

Lastly, there were no improvements in behavioral incidents during implementation. There were four behavioral incidents prior to the intervention and eight incidents during the intervention. The relationship between these numbers and the intervention is unclear.

Summary

The results of this initial QI project fell short of the specific aims, with a 28% completion rate of the CBP and 60% of survey responses describing the tool as somewhat effective. While nurses indicated that the tool had potential to improve patient–provider communication, they felt the clinical context did not support implementation under the circumstances. Key strengths of the

project were the structured, unit-wide training, and the facilitation of qualitative feedback from nursing staff. Identified barriers included timeframe (one month), staff ambivalence, and competing demands.

Interpretation

With limited use of the CBP, it was difficult to detect meaningful improvements in communication or decrease in rates of CM. Because patients are vulnerable to re-traumatization with the use of CM, and proactive communication tools have been shown to enhance patient empowerment, we anticipated strong patient participation (Butterworth et al., 2022; Bausman et al., 2024). However, of the patients offered a CBP, nearly 70% declined to complete one. Fatigue after extended time in the ED and long admission process likely impacted participation. Finally, the lack of integration of the CBP into the EHR limited its accessibility and usability; these barriers were further emphasized in qualitative feedback from nursing staff.

Nurses' perceptions of improved communication were modest, with 60% of post-survey respondents rating the tool as somewhat effective for communication. Although the CBP was incorporated into the nursing workflow, it received varying support from staff. Survey responses suggest nurses felt they had insufficient time to help patients complete the tool. Therefore, implementation by another team such as social work or counseling may be more appropriate. For example, integrating the CBP into counseling groups could provide patients with dedicated time and support to complete the tool. Additionally, participation reminders from the ANM appeared to improve completion rates for CBPs (Appendix 13), the training module, and surveys. Training completion rates were the only metric to achieve the intended goal, likely in part due to being made mandatory.

Limitations

This project was developed with input from the unit's psychiatric providers and ANM. Initial consensus from all involved parties, especially nurses and support staff, would have improved the project's feasibility and acceptability (Van Nostrand et al, 2025). With inclusion of project skeptics during initial phases, project design could have addressed concerns apparent in post-surveys (Jeffers & Anderson, 2025), potentially yielding higher CBP completion rates.

Given the low completion rates of pre- and post-survey qualitative sections (50% and 31% of all nurses, respectively), it is unlikely that we achieved optimal theme saturation (Saunders et al., 2017); more responses would have likely revealed additional themes.

In the initial project design, CBPs were to be uploaded to patients' EHRs. However, support staff ultimately kept CBPs in a physical binder to improve data tracking (see Results). Post-survey responses indicated that nurses wished CBPs were accessible in patients' electronic charts; it is possible that they would have found EHR-integrated CBPs more useful.

Lastly, as this is a QI project, its results are not generalizable beyond the current setting.

Conclusions

Historically, inadequate communication in inpatient psychiatry has contributed to patients' experiences of isolation, reduced autonomy, safety concerns and the potential for re-traumatization, particularly in the context of CM (Rosen & Stoklosa, 2016; Butterworth et al., 2022). Evidence suggests that strengthening patient–provider communication in inpatient psychiatry can improve quality of care, patient satisfaction, and rates of CM (Goulet et al., 2024). In this project, low patient participation and nurse survey response rates limited evaluation of the CBP's impact. Similar QI projects without these limitations have shown promising results (Hajaj, 2025). Future projects may optimize results by including interdisciplinary team members, incorporating patient feedback, and leveraging technology to improve access to crisis plans.

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Appendix 1: Collaborative Behavior Plan

Collaborative Behavior Plan

What are situations where I can become overwhelmed or upset?

Examples: physical (hunger, pain), environmental (noise, med changes), social (conflict, misunderstanding), etc.

What are some warning signs that I am getting upset?

Examples: talking louder/faster, talking more quietly/withdrawing, muscle tension, eye contact, etc.

When I am in crisis, what can staff do to help me?

Examples: two-staff approach, provide active listening, offer me choices/support, give time to cool off, etc.

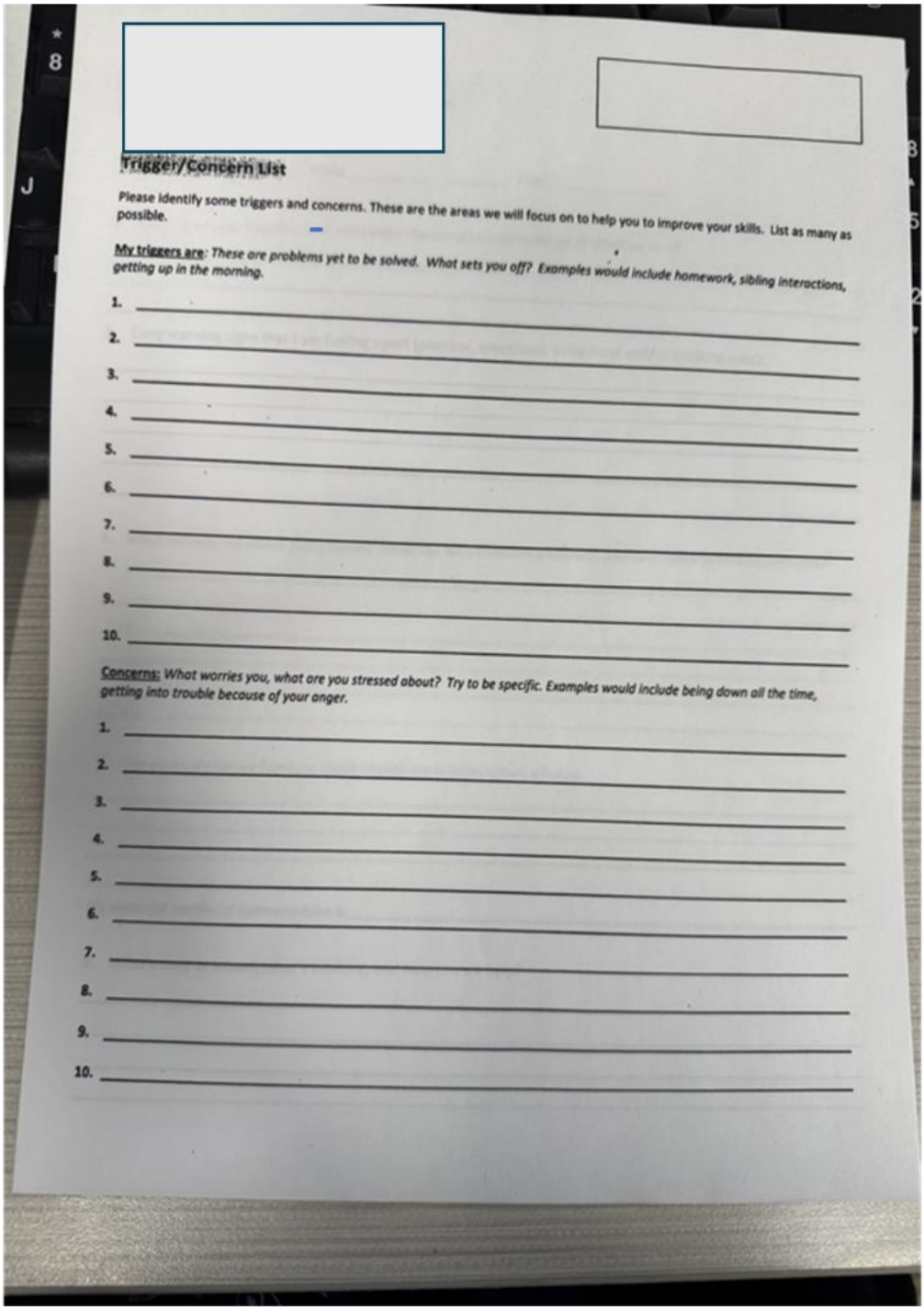
When I am in crisis, what should staff avoid?

Examples: Please don't get close to me, raise your voice, or tell me to calm down.

When I am in crisis, how can I help myself?

Examples: Take deep breaths, listen to music, walk around the unit, call a loved one, etc.

Appendix 2: Triggers and Concerns List (Adolescent Unit)



Trigger/Concern List

Please identify some triggers and concerns. These are the areas we will focus on to help you to improve your skills. List as many as possible.

My triggers are: *These are problems yet to be solved. What sets you off? Examples would include homework, sibling interactions, getting up in the morning.*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Concerns: *What worries you, what are you stressed about? Try to be specific. Examples would include being down all the time, getting into trouble because of your anger.*

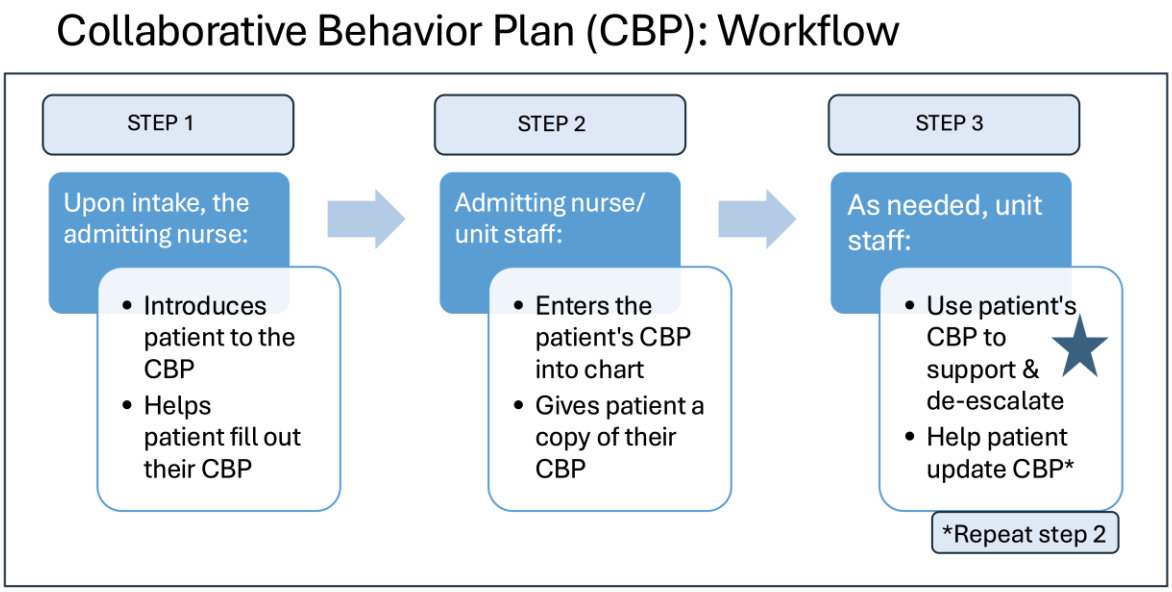
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Appendix 3: Existing Debrief Questions (Adult Unit)

MILIEU SAFETY PLAN:

1. *RELEVANT BACKGROUND*
2. *CHALLENGING BEHAVIORS IDENTIFIED (i.e.: Violence, Self Harm, Elopement, etc...)*
3. *CUES for CHALLENGING BEHAVIORS (how does this patient appear when escalating?)*
4. *IDENTIFIED TRIGGERS (what circumstances or events may result in this patient escalating?*
5. *PREVENTATIVE INTERVENTIONS (what helps prevent escalation? List safety precautions for staff - i.e.: 2-staff approach, etc.)*
6. *RESPONSIVE INTERVENTIONS (what helps this patient deescalate?)*

Appendix 4: Staff Training Workflow



Appendix 5: Standard Operating Procedure

Standard Operating Procedure

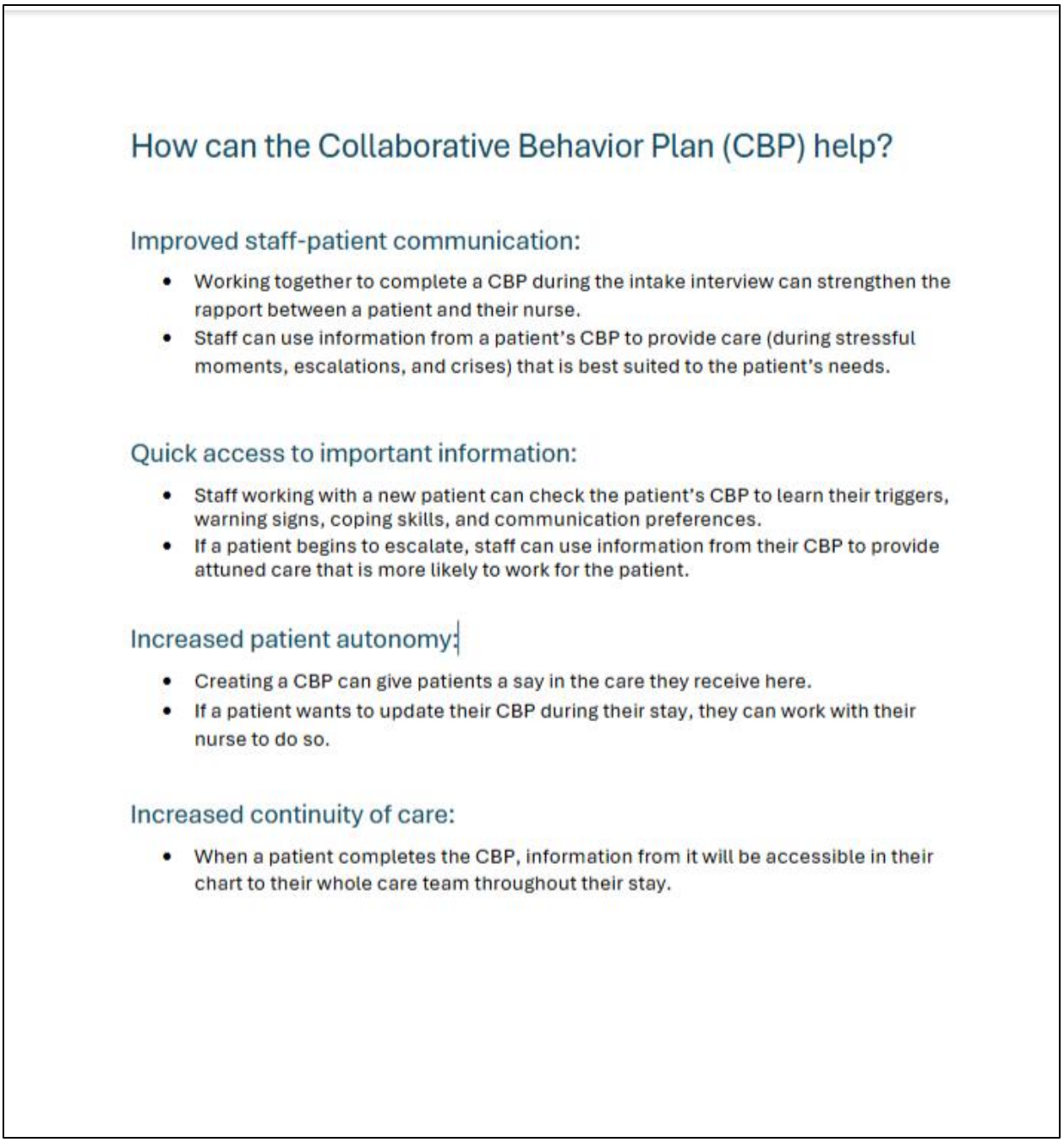
Implementing the Collaborative Behavior Plan (CBP) to improve communication

A Quality-Improvement Initiative at Unity Center for Behavioral Health

Effective October 1st, 2025 through December 1st, 2025

1. **Ensure each patient is given a Collaborative Behavioral Plan during their intake on Unit 1E.**
    a. To ensure the patient is provided the form, the CBP form will be included in the folder that every patient receives upon admission to the unit.
    b. The CBP form will be embedded into each patient chart by the assigned nurse.
2. **Prioritize the completion of patient demographics, admission consents, and all other necessary intake forms PRIOR to filling out the CBP.**
    a. The CBP is **voluntarily** completed by the patient. It is ideally completed in collaboration with the nurse who admits them to the unit.
    b. The patient should be *encouraged* to complete the MHP during their unit intake with the nurse.
        i. A completed CBP is preferable. HOWEVER, in the case the patient cannot complete the CBP at the time of admission due to altered mental status or other factors, they can bring the form with them onto the unit and continue to complete it there.
3. **Ensure the 1E admitting nurse takes the patient's completed CBP and enters the information from it into the patient's chart.**
    a. This metric will be tracked by the Quality Improvement team lead.
4. **Unit 1E staff will provide the patient with the original copy of their CBP, for the patient to keep and reference.**
5. **If the patient wishes to update their CBP or discontinue it at any time, their assigned nurse will assist in this process.**

Appendix 6: Use Cases for Staff



Appendix 7: Patient Disclosure Statement

This form is part of a quality improvement project led by PMHNP students at Unity Center for Behavioral Health.

The goal of this project is to improve communication between patients and healthcare workers through a new tool called the Collaborative Behavior Plan (CBP). It involves filling out a one-page plan to tell staff about your care needs and how to best support you during your stay here.

Your Choice to Join:

- Your participation in this project is completely your choice.
- You can decide not to join, or if you join and then change your mind, you can leave project at any time. This will not affect your care here.

What Will Happen:

- If you decide to participate, we will ask you to complete the Collaborative Behavior Plan on your first day on Unit 1E.
- Staff will make a copy of it to keep in your chart during your time here.
- This helps your healthcare team learn more about your needs and take better care of you.

Benefits:

- Your participation will help us learn how to provide better care for you while you are here. It also may help improve care for other patients in the future.

Keeping Your Information Safe:

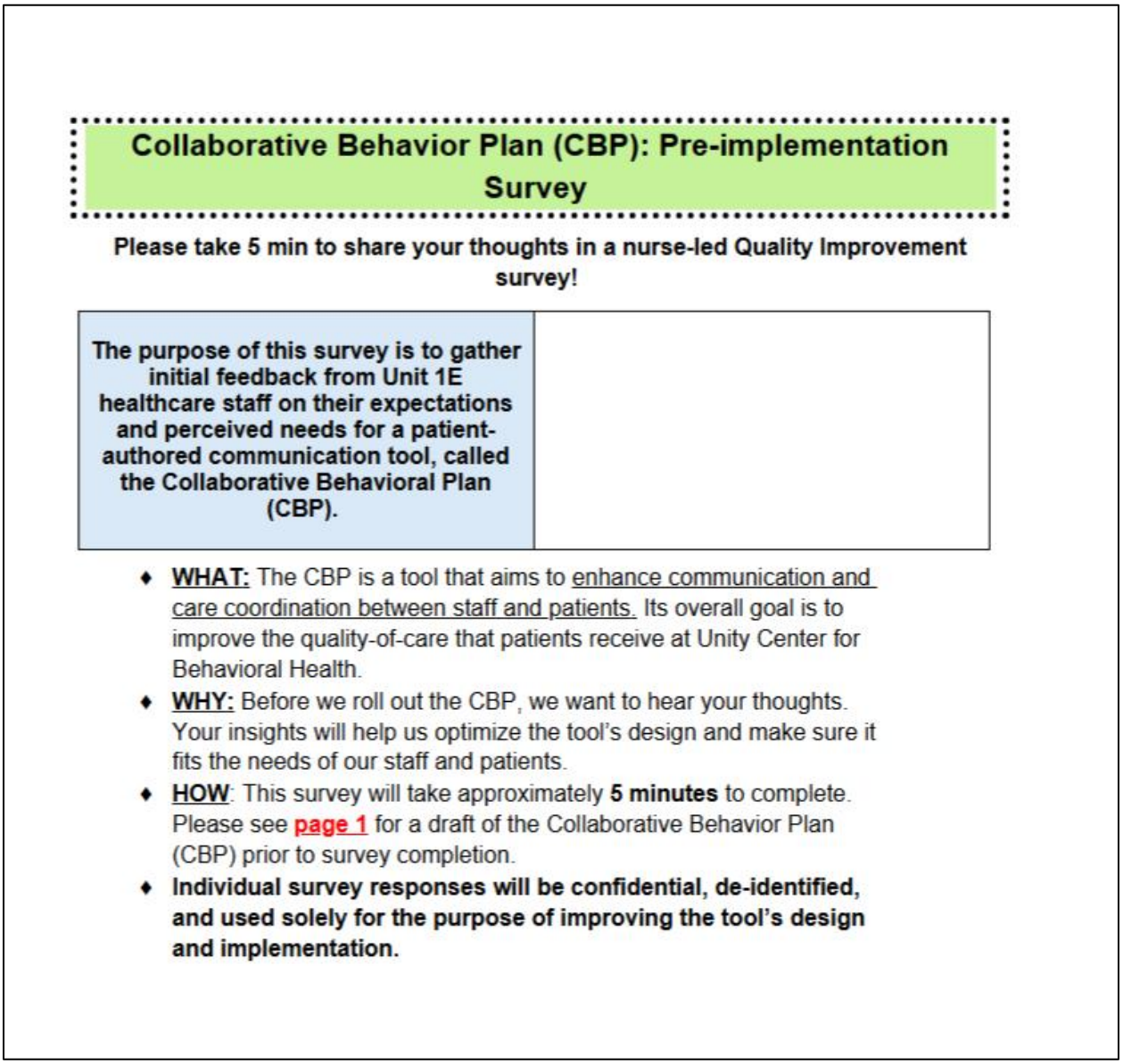
- All information you share with our staff will be kept private.
- Your information is 100% protected; your safety and privacy are our priority.

Questions?

- If you have any questions about this project or what it means to join, please ask a staff member. We would be more than happy to help.

Thank you for participating in this important effort to improve care at our hospital.

Appendix 8: Staff Survey Participation Flyer



Collaborative Behavior Plan (CBP): Pre-implementation Survey

Please take 5 min to share your thoughts in a nurse-led Quality Improvement survey!

The purpose of this survey is to gather initial feedback from Unit 1E healthcare staff on their expectations and perceived needs for a patient-authored communication tool, called the Collaborative Behavioral Plan (CBP).	

- **WHAT:** The CBP is a tool that aims to enhance communication and care coordination between staff and patients. Its overall goal is to improve the quality-of-care that patients receive at Unity Center for Behavioral Health.
- **WHY:** Before we roll out the CBP, we want to hear your thoughts. Your insights will help us optimize the tool's design and make sure it fits the needs of our staff and patients.
- **HOW**: This survey will take approximately **5 minutes** to complete. Please see page 1 for a draft of the Collaborative Behavior Plan (CBP) prior to survey completion.
- **Individual survey responses will be confidential, de-identified, and used solely for the purpose of improving the tool's design and implementation.**

Appendix 9: Nurses' Pre-Survey

Collaborative Behavior Plan (CBP) Pre-Implementation Survey

Instructions: Please answer the following questions based on your expectations for the Collaborative Behavior Plan (CBP). Your responses will be used to improve the introduction of the CBP.

1. **How effective do you anticipate the Collaborative Behavior Plan will be in improving communication between healthcare providers and patients?**

   1 Not effective | 2 | 3 Neutral | 4 | 5 Very effective

2. **How useful do you expect the information provided by the Collaborative Behavior Plan will be for your daily interactions with patients?**

   1 Not useful | 2 | 3 Neutral | 4 | 5 Very useful

3. **How easy do you expect it will be to incorporate the Collaborative Behavior Plan into your routine practice?**

   1 Very difficult | 2 | 3 Neutral | 4 | 5 Very easy

4. **In what ways do you anticipate that the Collaborative Behavior Plan will help you perform your job? Please rank your top three:**
   - **Establish rapport with patient upon their arrival to the unit**
   - **Improved ability to de-escalate during crisis**
   - **Decreased need for seclusions and restraints**
   - **Improved patient-nurse communication**
   - **Improved patient satisfaction with care**
   - **Patient-centered care**
   - **Other: _____**

   _____

   _____

   _____

5. **What do you anticipate to be the main drawbacks or challenges of implementing the Collaborative Behavior Plan?**
   - **Additional time required of nurses in unit intake interview**
   - **Utilizing information from patients' CBP during moments of crisis**
   - **Utilizing information from patients' CBP in day-to-day interactions**
   - **Patients unable or unwilling to engage in CBP creation process**
   - **Getting information from the CBP into the patient chart**
   - **Unit-wide adoption and buy-in**
   - **Other: _____**

Thank you for participating in this survey. Your feedback is vital to guide the upcoming implementation of the Collaborative Behavior Plan (CBP) at Unity Center for Behavioral Health. Your insights will help us ensure the CBP effectively meets the needs of both staff and patients in improving communication and care coordination.

Appendix 10: Nurses' Post-Survey

Collaborative Behavior Plan (CBP) Feedback Survey

Thank you for participating in this survey. Your feedback is crucial in evaluating the effectiveness of the Collaborative Behavior Plan (CBP) in improving communication.

Please answer the following questions based on your experiences with the CBP. Your responses will be used to adjust and optimize the implementation of the CBP.

Post-Survey Questions

1. **Perceived Impact on Communication**
   - After using the Collaborative Behavior Plan, how effective have you found it in improving communication between patients and members of their healthcare team?

     1 2 3 4 5
     Not effective Neutral Very effective

2. **Utility and Relevance**
   - How useful has the information provided by the Collaborative Behavior Plan been for your daily interactions with patients?

     1 2 3 4 5
     Not useful Neutral Very useful

3. **Ease of Use**
   - How easy has it been to incorporate the Collaborative Behavior Plan into your routine practice?

     1 2 3 4 5
     Very difficult Neutral Very Easy

4. **Intervention Disposition**
   - Would you like to see the Collaborative Behavior Plan permanently adopted on Unit 1E and potentially used as a tool on other units?
   - Scale: YES or NO

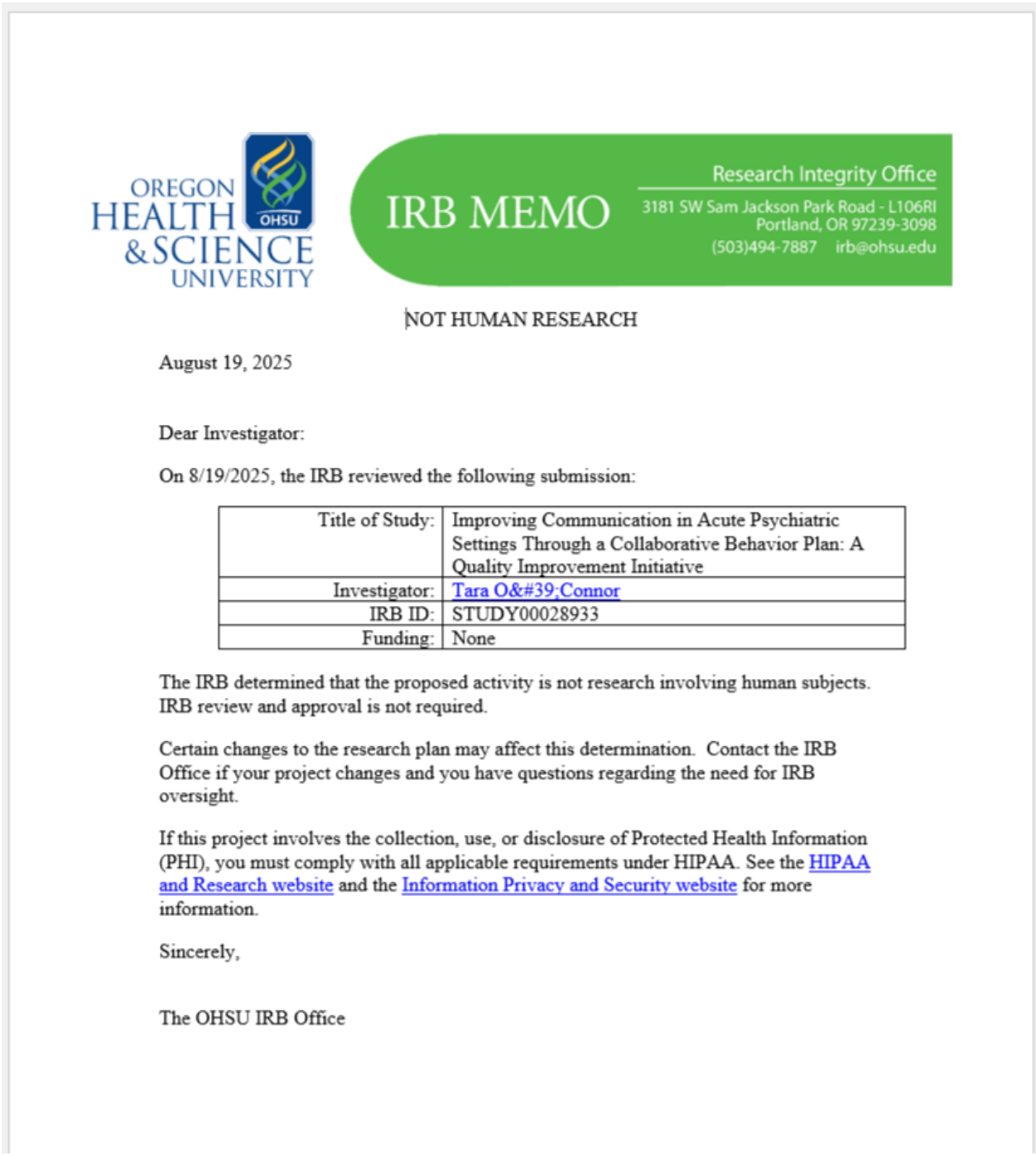
5. How do you envision the CBP benefiting [the unit] and other departments?
   - **Establishing rapport with patient upon their arrival to the unit**
   - **Improving care team's ability to de-escalate patients during crisis**
   - **Decreasing the need for seclusions and restraints**
   - **Improving communication between patients and their care team**
   - **Improving patient satisfaction with care**
   - **Supporting patient-centered care**
   - **Other:** _____

6. What concerns do you have about the CBP's adoption on [the unit] or other units?
   - **Requires additional time from nurses during unit intake interview**
   - **Feasibility of using information from patients' CBPs during crisis**
   - **Feasibility of using information from patients' CBPs in day-to-day interactions**
   - **Patients unable or unwilling to engage in CBP creation**
   - **Unit-wide adoption and buy-in**
   - **Other:** _____

7. **(Open ended)** Can you provide a specific example where the information collected on the CBP was beneficial or fell short?
8. **(Open Ended)** Based on your experiences with the CBP so far, what changes or additions would you recommend to enhance its utility and effectiveness? Are there any features that you believe could be improved?

Thank you for your time and insights. Your responses will help us refine and improve the Collaborative Behavior Plan to better serve both our staff and our patients.

Appendix 11: IRB Request for Determination



OREGON HEALTH & SCIENCE UNIVERSITY

IRB MEMO

Research Integrity Office
3181 SW Sam Jackson Park Road - L106RI
Portland, OR 97239-3098
(503)494-7887 irb@ohsu.edu

NOT HUMAN RESEARCH

August 19, 2025

Dear Investigator:

On 8/19/2025, the IRB reviewed the following submission:

Title of Study:	Improving Communication in Acute Psychiatric Settings Through a Collaborative Behavior Plan: A Quality Improvement Initiative
Investigator:	Tara O'Connor
IRB ID:	STUDY00028933
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the HIPAA and Research website and the Information Privacy and Security website for more information.

Sincerely,

The OHSU IRB Office

Appendix 12: CBP Completion Rates

Date Range:	11/7/2025	to	12/28/2025

Total Patients Admitted:	69
CBP Completed (count):	19
CBP Completed (%):	28%
CBP Not Completed (count):	50
CBP Not Completed (%):	72%

REASONS IF CBP NOT COMPLETED	
Patient Declined (count):	32
Percent Declined (%):	64%
Other Reason (count):	18
Other Reason (%):	36%

Total Patients Admitted:	69
Offered a CBP (count):	60
Offered a CBP (%):	87%

OF THOSE OFFERED A CBP:	
Completed (count):	19
Completed (%):	32%

Appendix 13: Completed CBPs Over Time