

Emergency Involuntary Procedures (EIP) Work Group
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010

May 13, 2016 – 10:30am – 12:00pm

DRAFT Minutes

Attendance: Emma Harrigan, Nick Nichols and Frank Reed; DMH, Anne Donahue; Counterpoint, Jeff Rothenberg and Scott Perry; VPCH, Lynn Jones; VCPI

Phone: David Mitchell; VPCH, Katharine Monje – UVM, Sarah Sherbrook, VPCH Sheri Providence, Eileen Glover; Brattleboro Retreat, David Mitchell; VPCH

Introduction: Introductions took place around the table. Minutes approved from February.

Report to the Emergency Involuntary Procedures Review Committee (Statewide Data Review): Emma Harrigan reviewed the document with the members. She noted the following:

Page 3 – Aggregate Emergency Involuntary Procedures for Involuntary Patients Adult Psychiatric Units broken out by type of procedure; January had a total of 63 procedures with the majority being manual restraints. February had a total of 81 procedures with the majority being manual restraints, and March had a total of 128 procedures with the majority being manual restraint, an upward trend.

Page 4 – Aggregate Emergency Involuntary Procedures for Involuntary Patients Youth Psychiatric Units broken out by type of procedure; During this time period there were 12 procedures, 2 in the month of January, none in February, and 10 in March.

Page 5 - Same information from pages 3 and 4, combined.

Page 6 – Aggregate Procedures: Type of Procedure by Unit for Adult and Youth; majority of the units had less than 20 procedures during the waiter, Tyler 4 a little over 60, VPCH was less than 40 at 36 procedures this time period.

Page 7 – Aggregate Procedures: Procedures Per Patient, note that of the total adults included in the study (101) 72% did not receive an EIP in the time period. The next largest is 1-2 procedures per patient with 40% of all of those receiving EIPs, then 25% for 3-4 procedures, 10% 5 or more – occurring on level 1 units

Page 8 – Aggregate Procedures: Episode Per Patient – this is broken out by episodes rather than procedure, graph is missing information contained in the table for non-Level 1 units.

Page 9 – Emergency Involuntary Procedures on Level 1 Unit; BR Tyler 4 has had a decrease since baseline, VPCH 1.52 to .29 hours per 1000 patient hours, RRMC has had an increase although it appears to be outside their normal range of reported time of 4.02 hours.

Page 11 – Emergency Involuntary Procedures Rate of Seclusion and Restraint - additional rates per 1000 patient hours statewide going back to July-September 2014, less than the National overall; reported 0.86, the rate of seclusion dances around the national average .51 to .16 and the rate of restraint is consistently below the national average about ¼ total time.

Comments

Frank – asked the question to RRMC regarding last quarter, if there was any information they can shed on that rise in terms of acuity, outlier. Norm McCart can reach out to RRMC to get more information

Anne – Restraint national average, we separate out hands out versus mechanical, is that true with the national comparison? Our rate does include mechanical and hands on.

Jeff - Doing a more over time analysis of the information that is collected. Emma to look into this as Jeff asked.

Jeff - Whether there is a way to measure staff injuries due to assaults through workmen's comp – What do people think of that?

Emma – critical incident reports from hospitals related to staff injuries that meet a statutory threshold report to DOL and WC. Hospital associations have a very high threshold to meet, might not be a good indicator to compare. VPCH monthly dashboard reports on the number of injuries that are moderate or greater, with 5 per quarter at its highest. DA workgroup to discuss if there is a common measure the hospitals can agree upon to track against EIP.

Sherri – definitions should be agreed upon through DH group.

Catherine – Should be apples to apples, will give it some thought. It could be helpful.

VCPI – Update

See attached document for Overview

Comments

Nick - the past year's work was co-funded by DMH and hospitals. Is there a way to fund another year sharing responsibilities through multiple organizations?

Jeff – thinks it would be great to have Kevin available and train the trainer

Katharine - interested in train the trainer, something to look forward to.

Sherri – it all sounds good.

Nick – a thank you to Lynn for covering interim for VCPI.

Brattleboro Retreat

We have had a very successful first quarter of 2016 noting rates going down.

All unit increase in rates or numbers for EIPs is very patient/event specific.

Childrens unit – the unit has done a really nice job planning, talking about the previous 24 hour shift and involve the off shifts.

Adolescent in this quarter were lower than previous year - 23 individuals, 2 had two or more admissions and combined totals 22 events in those admission, finding some correlation with individuals staying for a long period of time or waiting for longer term placement. This is the most acute unit. We have added more outside space, courtyard divided into 2, added in Osgood building a therapeutic space – sensory room, movement room, it is getting them outside, off unit and using up some of their energy. Osgood has been back Level green privileges – starting to see some results.

Tyler 3 – Has been change in leadership staff in January, has had a destabilized leadership over the past year, 3 different nurse manager, right now they have a stable leadership team. Education department - all Tyler 3 staff attended end of March or beginning of April a full day of education around supporting therapeutic engagement skills, trauma informed care, and team building. They will do a lot of building around that.

Tyler 4 – one outlier; this person is having some challenging issues, transiting the next month into some outpatient care. Overall rates have gone down, even for people who have been the higher users.

In general, the units themselves review EIPs as they occur, update treatment plans, then certs of needs are routed to unit managers, quality reviews them and we have weekly meetings with quality, leadership and clinical and we talk about the EIPS of that week. if questions, support is given. in addition to that we look at quarterly aggregate data and present that as a whole. quality engineers on a quality level, can look how we look at data

The Children's unit is changing focus on positive behaviors. It is looking at focusing on the positive behaviors that they have, how do we move them forward, get them into a positive trajectory.

They are changing their policy about S/R and decreased the length of time before new physician orders i.e. adult is 2 hours vs 4 hours, adolescents it is 1 hour instead of 2, children 30 minutes instead of an hour

Question: Jeff - Which groups do the social workers lead? They lead the more process oriented therapeutic groups twice a day, monitored and audited.

Public Comments

Anne D. – commented on the website with the wrong location and contact. Let her know this has been updated.

Tracking of EIPs in ER? What is happening? Have not received any EIPS outside of hospital. Trying to reach an agreement but no headway yet?

Any other data on reduction in trauma, treatment efforts in EDs? There are no collectible data points on treatment in EDs, Frank or Fox can answer questions related to initiatives.

Jeff – Graph on page 11 – is there any way to go back further in time to pre Six Core Strategy?

Emma will bring it to hospital group to see if they can extend an additional years' worth of information.

Katharine – There is value in including previous quarter or comparison from time period the year before., just wanted to reiterate that.