

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

August 12, 2016 – 10:30am – 12:00pm

DRAFT Minutes

Attendance: Jaskanwar Batra, Karen Barber, Emma Harrigan, Mourning Fox; DMH, Anne Donahue; Counterpoint, Scott Perry; VPCH, Paul Capcara; CVMC, Linda Cramer; DRVVT, Laurie Emerson; NAMI, Stacey Ward; UVMC, Michael Sabourin

Phone: Jan Sherer; Springfield, Suzanne Leavitt

Introduction: Introductions took place around the table.

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 EIPs for Involuntary Patients Adult Psychiatric Units by Type of Procedure: There were a total of 178 procedures, with a decrease from April and May.

Comments:

Linda – She had read in a chart about something called a J-hook, to a standing wall hold and was wondering what it was. Paul C. stated that it is a type of hold and is counted as a manual restraint, CPI hold. He did state that it is not typical though to give an injection while standing.

Anne – Saw something about putting bags put over patient’s head? It is being used in ED’s, Police, Ambulance. It was clarified that it is a net to reduce spitting and was wondering if this was being used on inpatient units. Dr. Batra stated that he had not heard anything about this being used on inpatient units.

Page 4 – Aggregate EIPs for Involuntary Patients Youth Psychiatric Units by Type of Procedure. There were a total of 9 procedures in this quarter.

Page 5 – Aggregate EIPs for Involuntary Patients Psychiatric Units by Type of Procedure. The trend is still holding from adult procedures with a decrease overall from April through June, except mechanical restraints.

Page 6 – Aggregate EIPS for Involuntary Patients Adult and Youth Psychiatric Units by Type of Procedure, broken out by hospital unit. Overall there were a total of 187 procedures, 116 total episodes, and total hours were 78 for the quarter. The same trends seem to be holding. One

individual on Tyler 2 had quite a few procedures but we would need more clarification from Sherri at BR and will ask for feedback.

Page 7 – Aggregate EIPs for Involuntary Patients Procedures Per Patient, Adult Psychiatric Unit. There were 117 or 76% of the individuals did not receive an EIP during this quarter.

Comments:

Michael S – asked if DMH was keeping numbers on the ERs usage of seclusion and restraint. Dr. Batra stated that we do not get information on this. Michael stated that the information is biased.

Anne – asked the question if DMH was doing any planning to begin collecting the information from the ERs since there is a statutory obligation to monitor the care in the ERs. Dr. Batra stated that the best person to answer would be Commissioner Reed but that we did ask the Hospitals for that information and didn't get anywhere. They don't feel like they have to share that information.

Karen – They feel they are under no legal obligation to provide that information to us.

Anne – In order to fulfill that statutory obligation, it looks like you would need to approach Legislature to make the ERs provide that information. Dr. Batra stated that is something for Commissioner Reed to answer.

Page 8 – Aggregate EIPs for Involuntary Patients Episodes Per Patient (Adult). This is the estimation of what we could call an episode. We can see that the trends seem to hold, same with the 1-2 episodes during the time period and smaller percentages for 9-10, 11-12.

Comment: Anne – Do you have the percentage for no EIPs? Emma stated that it would still be the 76%.

Page 9 – EIPs on level 1 Units (electronic bed board per 1000pt hours) – overall during this time period we have seen a decrease on all 3 units/hospitals with the exception of RRMCC which has gone up about .5 hours over the year. Emma will reach out to RRMCC to get a sense of the story behind the numbers.

Comments:

Michael – Why the discrepancy? Why is the Retreat's numbers higher than other facilities providing the same services?

Dr. Batra stated that it is all dependent on who goes into the units. Yes, they are a bit higher, but from our experience, take some of the most acute patients.

Paul stated that VPCHs numbers are remarkably low and is surprised at how well they are doing.

Anne stated that she thinks the Retreat has less space, is less well designed and they have less decompression space.

Linda stated that Anne is absolutely right. Also when using ALSA, which has been full, this seems to be the worst thing for people because of the way in which people are escalated and escalate each other.

Anne stated that she has fought using ALSA from the beginning as she believes it is extremely escalating. Technically they are in compliance using ALSA but philosophically it violates seclusion.

Linda asked if there was a way to determine how many EIPs happened in ALSA versus the general unit. Emma stated there were no patient location indicator on the CON. Emma felt we should bring it as a discussion to BR and have Sherri comment on this.

Dr. Batra stated that he suspects you would get a higher rate but at the time they are posing a danger to themselves and others.

Anne stated that this could give important information if it is valid of increasing negative outcomes.

Dr. Batra stated that we should address these specific topics with the Retreat.

Page 10 – EIPs Rate of Seclusion or Restraint – these have the updated Joint Commissions national averages for the time period. The red line is the national average, the green line is our rate each quarter. The combined rate of VT is below the national average.

Page 11 – EIPs Rates per 1,000 Patient Hours All Units and Legal Status on Psychiatric Units – this was requested at the last meeting to report the total number of procedures each quarter so you can see the change over time. Emma has set up a score card.

Anne asked if we could go any further back. Emma has a request out to the hospitals.

Hospital EIP Discussion

VPCH – could not come today as they are with the Joint Commission

CVMC – Paul stated that CVMC is well on their way to eliminating Seclusion & Restraint. They have not had an episode at CVMC for the past 4 months. There were 2, one minute holds to give an antibiotic to an elderly woman, but this was not involving a behavioral issue.

Paul stated that the lack of EIPs is not due to the lack of accepting patients that are acute, but it has a lot to do with increased staff training. They have put a real emphasis on training and also

focusing on not using any kind of EIPs. Secondly, the environment of care has been made more safe. In the last 12 months, CVMC has been the lowest in the state besides Windham center.

Comments:

Linda – stated that she was very impressed with Paul/CVMC. She was on the unit last week for a meeting when a patient came in. She stated they are definitely not cherry picking. This person was very threatening but the staff worked patiently with her. There were no hands on. Paul came out on the unit and directed what was going on.

Laurie – It would be good to share best practices with everyone. Training is key.

Paul stated that doing the Six Core Strategies has been a great help. In addition, Paul stated that staff fear is the biggest obstacle. You need to create an environment of care where there is not a lot of dangerous items in it. They constantly say out loud, are you safe, are other patients safe. Sometimes it can take a great deal of time to deescalate someone but we are constantly reminding ourselves, we are safe, you are safe. They have created a behavioral support team with a high degree of training, and they work together as a team. It has made a huge difference in the past year.

Paul stated that the person Linda was talking about, actually apologized to the staff the very next day.

Anne stated concerns about apples to oranges, within a single hospital it is easier to do pre-Irene/Post-Irene continuum. The issue of more or less difficult patients, specifically involuntary patients in the care and custody of the Commissioner, do you have a sense compared to 7-9 years ago? All of the designated hospitals that are not Level 1, has significantly reduced percentage of patients they admit that are involuntary. Do you have that as a data point from the last couple of years.

Paul stated he has only been at CVMC for one year. CVMC typically has 1-4 involuntary patients at one, usually 3-4 out of 14 beds. Their average is about 12 patients.

Anne wanted a little more specific information regarding the safe environment of care as historically there is tension between a comforting, positive recovery oriented setting and a really safe setting.

Paul stated that the furniture is quite attractive, but designed to be safe, selecting items that one is not able to turn into a projectile and over the door alarms. It was asked what an over the door alarm was. It has to do with protecting against the likelihood of someone fatally hanging themselves. The alarm makes it so there is no possibility of someone looping anything around the door.

Anne asked about the progress on the balcony at CMVC.

Paul stated that it is about ¾ completed and should be done in about 3-4 weeks. This makes it so all patients can get outside and get fresh air.

Stacey stated at UVMC the outdoor porch finally got its approval. There were some barriers but it is on the next construction agenda.

Stacey asked if anyone has experienced patients with increased medical acuity, some requiring total nursing care, IV's, etc. She stated that if the patients are medically sicker, this could cause less EIPs and could impact data.

Paul stated that it is more staff intensive with patients that have a higher medical acuity but on the flip side, it has some benefit for the other patients. It puts staff in a caring role and this in turn builds some respect with the other.

Stacey mentioned that UVMC has a new visiting policy. All family and whatever supports the patient has identified can come whenever, can stay overnight. It has been really positive and staff are doing a great job maintaining this. They also put in lockers for people staying over to leave their personal items.

Dr. Batra stated that it was remarkable.

Paul stated that he will be revisiting this option at CVMC.

Laurie was wondering if there was a common training that all hospitals are doing for de-escalation. Paul stated that all hospitals are different but UVMC, CVMC and VPCH use ProAct.

Laurie – sharing with law enforcement around the training would be helpful.

EIP Work Group Expectations in the Administrative Rule

Karen Barber started off with what membership is needed for the work group. Dr. Batra is going to check in with Christie Everett (DA) to see if she will be the membership needed for the Designated Agency piece.

L&P – that will be Suzanne Leavitt.

Need a Peer and a person living mental health experience. Some options given were: peer organizations, VAMHAR, VPS, Another Way, Pathways, etc.

There was some discussion on the definition of Person with lived experience. There is no specific definition. There is a new meaning, family members could be the lived experience, it creates a different meaning of a term that generally speaking is not meant that way.

Laurie stated it might be good to have someone with experience of EIPs.

Stacey stated that they have one person with lived experience on their Seclusion & Restraint committee at UVMC and they can ask that person. Laurie from NAMI will also ask some people as well.

Karen mentioned there may be a privacy issue and Michael stated that part of the meeting could always go into Executive Session for privacy.

There is also a Functional responsibility for an external review, oversight and annual report to be provided to the Commissioner as it doesn't make sense for someone from DMH to write it and then present it to the Commissioner.

Emma stated that possibly VCPI might be a good option for this.