**Emergency Involuntary Procedures (EIP) Work Group**
**Department of Mental Health**
**280 State Drive, NOB 2 North**
**Waterbury, VT 05671-2010**
***Draft***
**August 11, 2017 – 10:30am – 12:00pm**

**Attendance:** Emma Harrigan, Mourning Fox, Karen Barber; DMH, Karen Crowley; VCPI, Jackie Leman; Devon Greene; VAHHS, Ward Nial; Michael Sabourin, Cathy Rickerby, Laurie Emerson; NAMI, Anne Donahue; Counterpoint. Scott Perry and Alisson Richards; VPCH, Rob Scott; VA.

**Phone**: Jan Sherer, Springfield; Linda Cramer, DRVT; Stacey Ward, UVMC; Sherry Providence; BR.

**Introduction:** Introductions took place around the table. Review of agenda.

Karen brought to everyone's attention that it is time to work on the Annual Report to the Commissioner. This review committee is tasked with the annual report, and feedback from people not on the committee is welcome as well.

The report is about summarizing the advisory work to the Commissioner along with any ideas people would like added.

- Six Core Strategies – encourage DMH to support and sustain this.
    - It was recommended that a new training needs to happen. Karen is working with the different sites to put together an opportunity to not only train but a train the trainers, along with peer reviews of the other programs.
    - Question if data can be looked at to see if with the implementation of Six Core Strategies, has there been a decrease in EIP's?
    - Comment that the training is more targeted towards leadership in considering different ways to support staff and they are bringing back elements to all staff from these trainings.
- Non-compliance at the meetings of Members – the expectation is that all of the hospitals will attend. There only needs to be one DA representative. UVMC commented that there is high acuity at UVMC right now and following the Six Core Strategies model of leadership presence, that takes priority.
- Root cause and analysis – needs to have consistent reporting. What has been reported and what has not?

Comment: DMH gets the CON's for the individuals in the Custody of the Commissioner, on a psych unit. On an aggregate level, we get the total hours of seclusion and restraint for all patients regardless of their legal status.

Q – Who responds to this data?
A – The clinical staff at DMH works with the hospitals around alarming trends, placements, etc.

Q – What about data from MTCR? Is that collected?
A – MTCR does not allow seclusion and restraint.

- Staff safety and patient safety are highly interrelated. Does the group want to make recommendations for the VOSHA findings at VPCH i.e. PPE, shin guards, arm guards?

Comment: It may be worth considering whether PPE is in conflict with the Six Core Strategies, and would be a good topic for the committee.

Karen stated that she would be happy to share an overview of what is in the Six Core Strategies and also should be an item on the Agenda for the meetings.

**Data Review**
**Link:** http://mentalhealth.vermont.gov/sites/dmh/files/documents/Committees/EIP_Report_2017-08-11.pdf

The question was asked there was a way to look at the administration of psychotropics (i.e. Haldol, Clozaril), which ones are used most frequently? DMH does receive dosages through the CONs but it is not data that can be queried, we don't have enough data. The rule doesn't require that level of detail.

Comment – It is difficult as there are only a handful of medications you can use (2-3 injectable) and it is very subjective.

A discussion arose about the side effects of these medications and the tracking of adverse reactions.

Comment – The primary concern of the hospital is the individual. We look at any medical risk factors, allergies and we take that very seriously.

Comment – There is a rule in Vermont around emergency involuntary medications, it is required that the RN document the patient every 15 minutes for an hour after the injection.

There was a question about the census and the data is being based on 149 total adult patients.

There was a question about Page 6 ***Aggregate Procedures: Type of Procedure by Unit*** as there were some hospitals that had blank data. All hospitals understand that if an EIP happens, a CON must be reported. After a brief discussion, Emma will add a 0 where the blank data was.

There was a discussion around the data that 5 folks had 21+ Procedures. The information cannot be shared without the possibility of identifying that individual.

Q – What is an Episode?
A - Seclusion and Restraint – this is listed as one episode and as a procedure it would be considered two procedures.

There was a discussion regarding the National Average and if Vermont is higher than the average. Page 11 of the data review shows that Vermont is, for the most part, staying under the National Average.

Q – How many Units and beds does RRMC have?
A – RRMC has two units. The South Wing has 6 beds and the General Wing has 17 beds.

**VPCH Presentation**

EIPs - we pay close attention to all of them. An event happens that leads to an EIP, the documentation is incredibly important. Our documentation requirements are quite detailed and extensive so that RNs and Docs are prompted to think carefully before they are involved in an EIP. The most important part of the documentation is the justification of what lead up to the EIP, was there an immanent risk and the intervention was justified? We spend a lot of time paying attention to that. Coaching and feedback is given if the documentation needs to improve. Precise wording is important. We train people to use specific behavioral language to describe as clearly as possible what happened.

Charge Nurse reviews the documents on unit and they are reviewed the next morning by quality staff. There are weekly meetings that includes the CEO, MD, nurse manager, director and more and they review all documents and what we call high risk project notes (events that posed a partial risk but didn't lead to an EIP). We decide what needs to be done, if anything to follow up. We review each one and make individual changes to their treatment plan if there is a high-risk event of EIP. The idea is to prevent an EIP.

Then every high-risk event/EIP is reviewed by that individual's treatment team the following morning and they summarize/analyze the event, see what the contributing factors were and decide if the treatment plan needs to be changed.

Presentation was done by Ms. Wagner
**Link:** http://mentalhealth.vermont.gov/sites/dmh/files/documents/Committees/EIP/VERMONTEIP_AUG_2017.pdf

Comment: Thank you for sharing.