VPCH Advisory Committee

January 28, 2019

Attendees: Karen Barber, Emily Hawes, Stephanie Shaw, Scott Perry, Alisson Richards, Greg Tomasulo, Jeremy Smith, Michael Sabourin, Cathy Rickerby, Diane Bugbee, Zack Hozid, Jackie Leman

General Hospital Updates:

Dr. Richards: spike of acuity, two beds closed for almost two months. A couples of patients that struggle with intermittent assaults against other patients and staff. Put them on a unit with less people and stimuli. Helped avoid 1:1s and 2:1s. Lots of leadership involvement and clinical conferences trying to problem solve. Goal is always to keep people safe and start to reintroduce patients onto that unit.

Q: have these patients been here a long time?

A: One, yes. Second one, yes – an interstate transfer.

Overall the hospital has been okay, not to acute other than that unit.

Q: do you think the violent stems from internal stimuli or rules?

A: Most of it is likely internal, although of course not wanting to be here doesn't help. *Dr. Tomasulo* – other psychologist has been looking at the variables very closely and any external ones identified, they are working on changing when possible.

Medical staff: two part-time physicians that are getting to retire in June. Going to start looking for a full-time staff at UVMMC for this position for hopefully a July start. Dr. Malloy and Dr. Novas-Schmidt

Stephanie Shaw: risk assessment policy and procedure changes – going through handouts: new suicide and risk assessment policies and the tools that go along with them (see attachments). Been using Broset for 6-8 months. Seems to have provided a standardized language. Have the same hopes for the Columbia, which goes live Feb 1st.

Joint Commission requirement to have an evidence-based tool. This is just the tool nursing will be using, it won't change psychiatrist assessment.

Q: re: Columbia – if they say yes to 1 and 2 and you go to 6, do you explore cutting yourself, if that's associated with trying to deal with pain or if they were trying to hurt themselves.

A: yes, the nice thing about this tool is it standardizes the language we use to start these discussions.

Q: is there a question that pertains to why they cut themselves?

A: no, this tool is specifically designed for suicidality. *Dr. Richards*: the psychiatrist assessment is looking deeper into things like that. *Scott Perry*: this isn't intended to capture everything, this is just focused on self-harm

Q: do you wait until a certain level of stability? Do you ask at different points throughout the stay?

A: this tool is meant to be used once per shift. *Dr. Richards*: upon discharge there is another risk assessment that looks at the whole person and what their risks are (like upon admission). The idea is this is all used together. Physician notes are where the tool's findings are flushed out and captured. These are narrow windows that the tool is looking at.

Q: Broset – if it is a well-known behavior, don't score. Why?

A: the goal is to score changes and show risk.

Dr. Richards: idea is to integrate nursing and physician assessments and help guide how we respond to changes and update the treatment plan.

Q: if someone has a well-known behavior, where would it go? Like someone was confused a lot. How do you know if a behavior is well known?

A: Say we pick confused; the physician's note will summarize that and deal with it in their treatment plan. And there may be other measures we bring in from psychology.

Q: what does well-known mean? How do you know what someone's baseline is?

A: We looked at a lot of different tools and while certainly there are times someone might not know the patient super well, but most do know them or are oriented at shift change. You could always go to the charge or other people to find out if the behavior is baseline or a change.

Stephanie Shaw: do you think it should be defined? And if so, what should it be?

A: seems like a good idea but is it really? It's nice to have this but how functional is it?

Dr. Tomasulo: we chose this because there is a lot of research, this is a tool used by hospitals throughout the world and research shows if people use it the way we are you can better predict than without.

Q: might want to have a no response option.

A: because they are standardized tools that are copyrighted, we are limited as to what we can do, but agree that a no response option would be helpful. We understand not everyone is going to fit into these boxes. This isn't the end all be all of our assessments.

Q: is there a way to ask these six questions using different words so they don't hear the same thing three times a day?

A: sure. And they are doing it now.

Q: is any data collected from this?

A: it has been really integrated into treatment teams – the teams meet daily to review the scores. The higher the number helps the team prioritize what needs to be dealt with sooner. The tool allows them to see a pattern and get the team together formally sooner.

Q: does the treatment team include a family member or friend?

A: yes.

Q: how many are there?

A: how many patients want that. We haven't counted it. We often set them up based on availability of family members.

Q: another hospital I dealt with really encouraged it. Got a card with contact info as an invite. That template was my invitation.

A: good idea. We'll write that down and think about it more.

Q: is open dialogue still an initiative?

A: yes, we do try and utilize those principles on the patients to the extent they allow. We are sending three people in open dialogue training as we speak. We're inviting family members and outside providers in for network meetings.

Q: who does the training here? Are family members included when you meet with a patient and use open dialogue?

A: Greg is one of the trainers. Yes, when it is possible, we include family members and friends.

Q: how many family members have come in this past month?

A: I don't know that information for the whole hospital.

Q: I assume it doesn't work on the phone?

A: we've tried in the past, we try and be flexible. We have done Skype, try and do what we can.

Stephanie – Primary Nursing: one nurse is assigned a group of people and they do every aspect of care – more holistic vs. task-orientated. Helps people build relationships with their teams. Been doing for about two months. Staff and patients seem to like it. We did a lot of prep work and practice assignments to get ready. Move towards person-centered approach, helps build trusting relationships.

Q: 12- or 8-hour shifts currently?

A: 8. We are exploring what scheduling models might work for this facility including 12-hour shifts. Both nurses and MHS positions. 12-hour shifts are the norm in healthcare. They are pros and cons to both. A lot of different models we are looking it.

Q: would this have the benefit of having MHS positions having some weekends off?

A: yes, that's the goal for more flexibility.

Q: relationships are important. And having the same MHS with a patient is important and I wouldn't want to change that.

A: we would still staff by unit.

These are all decisions that cannot ultimately be made by VPCH or even DMH but are a larger state-decision and would need to be bargained.

Emily Hawes:

In the midst of a time clock implementation – currently staffing is all paper. Hoping to have implementation complete and up and running by spring-ish.

Working on a privacy gap solution on the bedroom doors. In the process of taking down wooden barriers and putting in a brush like thing so there should be complete privacy when the door is closed. Done one unit so far.

Jeremy and Scott: review dashboard (see attached)

Two new categories added based on advisory member requests – number on court ordered meds, number of patient self-injurious incidents

Q: is 7 an average number for patients on court ordered meds?

A: probably about average, but we'd have to look into it; most people take court ordered meds voluntarily.

Q: is there a way to knock down lengths of stay? Forensic vs. non-forensic.

A: you only go into the count once you discharge, so you're not picking up those folks. We used to do the range of length of stay for everyone here.

Q: do you ever discharge patients to a hotel?

A: if someone wanted to, and that was safe, we would. We haven't had that happen in a while.

Q: if they are taking meds, how many days to get to take with them?

A: they generally stop at the pharmacy at discharge and get the next month's prescription. Maybe it would be helpful to have the social worker director to come and talk about what they do to set people up for success when they leave.

Q: number of self-injurious behaviors – do you really see people EEed with borderline personality disorder?

A: you certainly can. If someone is willing to go to the hospital, though, they don't come here.

Q: still doing sensory modulation?

A: yes, want to do a train the trainer

Q: since the suicide attempt in June 2018, have there been any not captured?

A: no

Q: didn't we have patient to visitor and visitor to patient?

A: maybe it happened once but its really a non-category. If we had such a thing we would mention it.

L&P did an unannounced survey in November as a result of a patient complaint. The patient discharged from the hospital and complained about insufficient medical care. L&P went through 3-5 charts and interviewed staff for one day. There were no findings. They noted that they appreciated the changes in documentation, making it more humanistic.

Q: how many grievances? How many "settled in favor"?

A: Scott will bring a summary.

Q: in terms if medical care, what can be expected?

A: We contract with two physicians with CVMC and they consult with nursing and psychiatry.

Q: can you use a c-pap machine here?

A: yes, we have one patient using one currently

Q: can we have a safety council update?

A: yes, one of the reasons we brought the risk assessment policies here was to show the work they are doing. We can make sure we are formalizing what types of things the safety council is working on, so you know.

Emily Hawes:

Visitor – Jackie and Kathy have some comments and concerns for feedback, will get those to Stephanie; Emily: will finalize in May.

Review charter: like it's non-exclusionary; how do we make more people aware of meetings? Will finalize in March.

Act 114 questions – who is asked for input? Refer to state standing committee to flush out more, maybe hear from Flint Springs

Emily: Trauma informed response to high risk events – at the last meeting there was discussion on what is the response when there is a significant incident. What's the response for the person who experienced it, the other patients, and the staff? Put on March agenda.

DMH Update: Legislative session has started, busy with budget testimony.

Vermont Psychiatric Care Hospital

Reporting Category	18-Jan	18-Feb	18-Mar	18-Apr	18-May	18-Jun	18-Jul	18-Aug	18-Sep	18-Oct	18-Nov	Dec-18
Effective Treatment												
Average Length of Stay (based only on patients who have been discharged)	106	105	105	112	104	105	104	103	103	103	102	102
Admissions	8	3	3	8	6	5	6	9	4	4	5	6
Discharges	5	3	3	9	5	5	8	9	4	3	10	2
Current Patients: male	13	15	15	15	16	17	16	15	16	17	13	13
Current Patients: female	11	10	10	9	9	8	8	7	7	7	6	7
EE/ Warrant Admission	6	2	2	6	5	4	3	5	3	4	4	5
Forensic Admission	2	1	1	2	1	1	3	4	1	0	1	1
# of Patients on Court Ordered Medications											7	7
Patient Care												
Elopements	0	0	0	0	0	0	0	0	0	0	0	0
Percent of individuals hospitalized who did not receive emergency involuntary procedure	71%	80%	76%	80%	76%	75%	88%	83%	70%	83%	64%	82%
# hours of seclusion and restraint per 1,000 patient hours	1.96	0.55	0.72	0.4	0.93	0.42	0.69	0.87	0.63	0.66	1.37	1.19
Safety												
Staff to Patient event: no injury	0	0	0	0	0	0	0	0	0	0	0	0
Patient to Patient event: no injury	4	4	2	3	1	5	2	3	7	4	2	3
Patient to Patient event: minor injury	0	0	1	0	0	0	0	0	1	0	1	0
Patient to Staff Assault: no injury/ unknown	1	0	2	0	7	6	0	2	6	3	3	3
Patient to Staff Assault:minor injury	3	0	1	1	11	2	0	4	1	1	7	3
Patient to Staff Assault: moderate injury	5	0	0	0	2	0	0	0	0	0	3	1
Patient self injurious behaviors											1	1
Staffing and Training												
Personnel vacancies (RN and MHS permanent positions)	17	18	17	15	16	12	12	15	16	14	12	17
New VPCH employees attending orientation	6	3	1	5	1	1	0	0	2	4	1	0
VPCH RN overtime hours	517.27	369.44	418	466	380.6	546.35	469.1	505.75	436.45	603.6	416.6	465.35
VPCH MHS overtime hours	1275.11	1059.68	1129.72	1129.4	1051.73	1227	1147.46	1298.57	1366.19	1745.87	1293.15	1150.12

Client Data Label

Score the patient based on the highest score they would achieve based on your assessment of his/her behavior throughout your shift. Absence of a behavior gives a score of 0. Presence of a behavior gives a score of 1. Maximum score (SUM) is 6. If behavior is normal for a well-known client, only an increase in behavior should score a 1. For example, if a well-known client is confused at baseline his/her score for this item would be 0. If an increase in confusion is observed than you would score a 1.

Tuesday / /			
	DAY	EVE	NIGHT
Confused			
Irritable			
Boisterous			
Verbal Threats			
Physical Threats			
Attacking Objects			
SUM			
RN Initials			

Saturday / /			
	DAY	EVE	NIGHT
Confused			
Irritable			
Boisterous			
Verbal Threats			
Physical Threats			
Attacking Objects			
SUM			
RN Initials			

Wednesday / /			
	DAY	EVE	NIGHT
Confused			
Irritable			
Boisterous			
Verbal Threats			
Physical Threats			
Attacking Objects			
SUM			
RN Initials			

Sunday / /			
	DAY	EVE	NIGHT
Confused			
Irritable			
Boisterous			
Verbal Threats			
Physical Threats			
Attacking Objects			
SUM			
RN Initials			

Thursday / /			
	DAY	EVE	NIGHT
Confused			
Irritable			
Boisterous			
Verbal Threats			
Physical Threats			
Attacking Objects			
SUM			
RN Initials			

Monday / /			
	DAY	EVE	NIGHT
Confused			
Irritable			
Boisterous			
Verbal Threats			
Physical Threats			
Attacking Objects			
SUM			
RN Initials			

Friday / /			
	DAY	EVE	NIGHT
Confused			
Irritable			
Boisterous			
Verbal Threats			
Physical Threats			
Attacking Objects			
SUM			
RN Initials			

Last updated: 2/2018

Client Data Label

Behavior Definitions:

Confused	Appears obviously confused and disoriented. May be unaware of time, place, or person.
Irritable	Easily annoyed or angered. Unable to tolerate the presence of others.
Boisterous	Behavior is overtly loud, energetic, and unruly. For example, slams doors, shouts out, etc.
Physically Threatening	Where there is a definite intent to physically threaten another person. For example, the taking of an aggressive stance; the grabbing of another person's clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.
Verbally Threatening	A verbal outburst which is more that just a raised voice; and where there is a definite intent to intimidate or directly threaten another person. For example, verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.
Attacking objects	An attack directed at an object and not an individual. For example, the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting and object; or the smashing of furniture.

Score Interpretations:

Score	Violence Risk and possible risk mitigation interventions
0	Risk is nominal.
1-2	Risk is minimal. o Proactive, preventative, trauma-informed crisis planning (include plan on Coping Partnership board and/or individual treatment plan as indicated). o Identify triggers and appropriate coping strategies, provide alternatives and choices. o Educate about communication and the appropriate way to outlet and express anger. o Encourage use of stress reduction and relaxation techniques. o Praise efforts made to manage anger and/or hostility towards others and provide feedback and positive reinforcement when appropriate and effective communication is used. o Use assertive communication to provide structure, clearly define expectations, and prevent further escalation. o Provide reality-based reorientation. o Reduce milieu stimulation/noise or offer quiet alternative. o Offer PRN medication and medication education.
3-4	Risk is moderate. o Listen. o Work to engage client in redirection and proactive crisis prevention. o Identify trigger/need/conflict and work to meet or resolve. o Maintain a consistent environment, schedules, and routines. o Offer cathartic activities to help appropriately manage anger and agitation - engage in some form of physical activity or sensory modulation to diffuse anxiety, anger, and hostility. o Offer alternatives, complementary strategies, and choices. o Promote appropriate socialization and leisure time activities. o Assertive communication and limit setting. (present a calm appearance, speak softly, speak in a non-provocative and nonjudgmental manner, speak in a neutral and concrete way put space between yourself and patient, show respect to the patient, avoid intense direct eye contact, etc.) o Offer voluntary time out on or off unit. o Consider area restrictions. o Consider adjusting level of supervision to meet need for safety and individual's sense of safety.
5-6	Risk is high: o Utilize a team approach. o Engage in crisis communication and rapid de-escalation. o Remove other patients from the immediate area. o Provide clear and concise ways to cease the behavior using a calm voice and demeanor. o Provide positive reinforcements when efforts are made to follow direction and independently manage behavior. o Offer clear, concise, and simple choices. o Set and adhere to behavioral limits – safety is the priority. o Offer medications. o Seclusion or restraint as a last resort when all other measures have failed, and the client remains an imminent risk of serious harm to self and/or others o (Debrief with client to review triggers, review alternative interventions, and modify care plan.)

Last updated: 2/2018

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version – Since Last Contact

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Since Last Contact**	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?***		
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
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Vermont Psychiatric Care Hospital Policy and Procedure	
Suicide Risk Assessment and Prevention	
New: X	Date: 12/19/2018 – Effective 01/31/2019

Policy
The Vermont Psychiatric Care Hospital (VPCH) recognizes that patients admitted to this hospital may present with a risk of suicide.

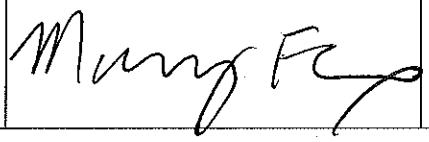
VPCH shall utilize a frequent and dynamic process for the assessment and management of risk of suicide that balances the individual's need for autonomy with the need to protect individuals from self-destructive behavior. Assessment of the risk of suicide shall be initiated for all patients upon admission and continued throughout their hospitalization. VPCH shall seek to continually improve its suicide risk assessment and interventions to prevent self-destructive behavior.

Procedure
The Columbia Suicide Severity Rating Scale (C-SSRS) is an evidence-based tool used at VPCH to assess the presence and severity of suicidal thoughts. This measure also captures information on suicide attempts and actions taken in preparation for suicide attempts. The C-SSRS aims to improve risk identification and prediction, to standardize how staff at VPCH measure and articulate risk, to enable the use of intervention strategies aimed at mitigation risk as early as possible, and to ultimately prevent suicidal actions.

Assessment and Prevention
Upon admission, the admitting psychiatrist shall conduct a suicide risk assessment and document the assessment and the level of risk on the Physician Admission Assessment. The risk of suicide shall be assessed on an ongoing basis by the treating psychiatrist basis and documented in the Comprehensive Physician Progress Notes.

Additionally, all patients at VPCH shall be assessed using the C-SSRS Screener—Since Last Contact version (APPENDIX A) once per shift when awake. Results of the C-SSRS shall be communicated to direct care staff and other members of patients' treatment teams. Information obtained from the C-SSRS may inform decision making about the creation and implementation of interventions to prevent suicidal and self-destructive behaviors. Interventions generated as a result of C-SSRS and other clinical data shall be integrated into patients' treatment plans. Patients shall again be assessed for risk of suicide by their treating psychiatrist prior to discharge.

Staff Training
All VPCH staff expected to use the C-SSRS shall receive education and training in the administration, scoring, and interpretation of the C-SSRS. Nurses shall demonstrate competency prior to using this instrument.

Approved by	Signature	Date
Mourning Fox, Interim Commissioner of DMH		**12/19/2018*** **(*Effective 01/01/2019)**

Vermont Psychiatric Care Hospital Policy and Procedure	
Violence Risk Assessment and Prevention	
New: X	Date: 12/19/2018

Policy
The Vermont Psychiatric Care Hospital (VPCH) recognizes that patients admitted to this hospital may pose a risk of harm to others.

VPCH shall utilize a frequent and dynamic process for the assessment and management of risk of harm to others that balances the individual's need for autonomy and the need to protect others from violence. Assessment of the risk of other-directed violence shall be initiated for all patients upon admission and continued throughout their hospitalization. VPCH shall seek to continually improve its violence risk assessment and interventions to prevent violence.

Procedure
The Broset Violence Checklist (BVC; APPENDIX A) is an evidence-based tool used at VPCH to predict the likelihood of an acute episode(s) of other-directed violence among psychiatric inpatients within the following 24-hours. The BVC aims to improve risk identification and prediction, to standardize how clinical staff at VPCH quantify and articulate risk, to stimulate early risk-mitigation interventions, and to ultimately prevent and reduce the frequency and severity of other-directed violence.

Assessment and Prevention
Upon admission, the admitting psychiatrist shall conduct a violence risk assessment and document the assessment and the level of risk on the Physician Admission Assessment. The risk of violence shall be assessed on an ongoing basis by the treating psychiatrist and documented in the Comprehensive Physician Progress Notes.

Additionally, all patients at VPCH shall be assessed using the BVC once per shift. Scores on the BVC shall be communicated to all direct care staff and other members of patients' treatment teams. Information obtained from the BVC may inform decision making about the creation and implementation of interventions to eliminate and reduce the occurrence of violence. Interventions generated as a result of BVC data shall be integrated into patients' treatment plans. Patients shall again be assessed for risk of violence by their treating psychiatrist prior to being discharged.

Staff Training
Nurses shall receive education and training in the administration, scoring, and interpretation of the BVC. Nurses shall demonstrate competency prior to using this instrument.

Approved by	**Signature**	**Date**
Mourning Fox, Interim Commissioner of DMH	Mourning Fox	**12/19/2018**