Emergency Involuntary Procedures (EIP) Work Group
January 21, 2022 ~ 10:30am – 12:00am

Attendance: DMH Staff: Jennifer Rowell, Laura Flint, Sarah Sherbrook, Stephen DeVoe, David Horton; VCPI: Alex Lehning; VAHHS: Emma Harrigan; RRMC: Lesa Cathcart; CVMC: Kimberly Cookson; BR: Alix Goldschmidt; DRVT: Merry Postemski; VA: Karen Lewicki; UVMMC: Jessica Charbonneau; Dr. Janice Lebel, Dr. Kevin Huckshorn, Malaika Puffer;

Meeting minutes are intended to capture the substantive business of the meeting and should not be construed as an explicit transcript of all meeting commentary

Welcome and Introduction: Introductions took place. Review of agenda and minutes. There will be additional funding for training/implementation of Six Core Strategies.

Updates from Members:

BR: Stories are important, not just the numbers. During the quarter, there was an individual on the adult unit, in total there were 26 CONs in that timeframe, and it counted for over almost 2400 minutes. They have not had an episode since August. We also had an adolescent that was struggling as well with a number of restraints, 1900 minutes in that quarter. We transferred that person to a different unit and in doing that, they stabilized and did really well. Able to d/c with just a couple of incidents after that.

Kevin – those are brilliant comments and the kind of information that is history and can be shared as some other facilities might see that person, putting it in a safety/treatment plan is critical.

CVMC: Unit has been super busy with staffing, etc., has been doing lots of shifts and feel like we are trying to catch up.

DA: No Participation

DAIL: No Participation

DMH: Stephen introduced himself as the new Quality Director. Dr. Weigel has left DMH and we have a new medical director Dr. Kelley Anne-Klein.

NAMI: No Participation

RRMC: Lindsay Lyle was introduced. We have been running full with a high acuity. We have been impacted by COVID with staff out. Folks are filling in where able. We are in the final stages of our construction, which has created another challenge for us as our unit is broken up right now. Trying to have staff available in every wing for patients. Trying to stay focused on 6CS. Excited there is going to be funding for training in the upcoming year as we have several new staff.

Alex - One question we may have it to think about the different audiences we would like us to engage. Are there folks who need introductory, foundational piece, or more advanced training/onboarding?

SH: No Participation

UVMMC: Our biggest struggle is we are bringing on so many new staff, it is hard to keep staff trained so that everyone has the same philosophies. We have a lot of travelers from different states, making sure they are in line with the Vermont rules. The staffing crisis is impacting things, and everyone is doing the best they can.

Another huge stressor for UVMMC is out inpatient adult unit has created a subunit for 1 specific patient who had a high level of incidents.

VPCH: Trying to manage staffing and acuity as best we can. We have a weekly safety huddle and look at the plans of care for any patient who as experience S/R the week before. Brainstorm for whatever resources needed to help reduce this. The option for training, we will want to access that as well. Recently, we highlighted the direct care staff, implemented a more frequent kudos to employees.

VA: We have a program called PMDP, which is a strongly patient centered approach towards de-escalation. We make sure everyone is trained in this. We have been having more trainings recently and it has been very positive.

Janice – I want to reflect how much I appreciate the candor and the way you are all framing your respective challenges. Want to give a shoutout to Alex as language matters. Heard in this discussing everyone is laboring under extreme pressures but still focusing on 6CS and everything else. Practicing and thinking is there and holding the hopes for colleagues and persons served.

Malaika – Is there any contextual data that is collected at the different facilities for in which the EIPs are occurring. I hope there is some form of debrief and review with each situation. The situations or environmental factors that are leading to incidents where EIPs are used – collecting data?

Sarah – I think that is a great idea for a data project. At VPCH we do review the information from the debriefing from the person and the staff involved. We use the violence checklist and recently we have started tracking the score of the checklist.

Kimberly - In my facility we do an immediate debriefing with staff as to the situation - what we could have done better and what we did well at. Then within 24 hours post incident a team member will meet with the person served to discuss their perspective of the incident and what we could have done better and bring it back to the team. We have the CON reviewed in the moment by the nursing supervisor and then it goes to the DON and Medical Director for review within 24-48 hours. We had been reviewing CONs monthly with a multidisciplinary team and recently this has been moved to bi-monthly meeting. We file SAFE reports that can be data mined I believe but would need to ask what details we could mine. All of these processes are to review and improve on care and prevention. This information is then shared with staff.

Alix – At BR we review every CON, typically the next day. Looking at not just the EIP, but what was looking at before, especially if there have already been one, are there things we are missing. We are working on a new debriefing patient tool as well.

Malaika – Is there a tangible next step for this? Can folks bring this data to the next meeting?

Emma – I am wondering if we can add it as a suggested item for the information, we ask hospitals to bring when they discuss their specific data?

Merry – I am really pleased to hear the conversation and improvements in terms of patient debriefing. What comes out of that and how can you use that in a meaningful way? Are there any teams here using peers in the patient debriefing processes?

Karen – It is an interesting idea, we use it in a lot of ways, but not how we are currently using it.

Janice – In MA we do use peers and they have a dedicated role. They are peer briefers, typically a patient liaison.

Kevin – In the organization I am working with now, 50% are peer. They are often the first responders in situations.

Kimberly - We currently offer the person served if there is someone they would like us to call during or after the event. The debriefing with the person is by staff. I would be interested in what it looks like to offer peer support in this manner.

Lindsay – Our peer specialist is on staff fulltime and when incidents occur, we ask the individual if they would like peer support.

Malaika – Lead the peer support and advocacy team at HCRS. I appreciate the conversation about the role of peer support in debriefing and a lot of potential benefit in that. I want to encourage if any organization wants to create a peer position to work with the peer workforce development initiative about what you are doing.

Alex – Questions around data collection, the larger question of peer support in a variety of formats. What I might suggest is in alignment with Kevin and Janice we could do a bit of survey work to see what practices are in existence with our members and then bring those perspectives to the March meeting. Also wanted to bring forward a question for the group: would the group want to extend an invitation to the Commissioner or Deputy to join one of the meetings?

Data Presentation:

Involuntary Link:
https://mentalhealth.vermont.gov/sites/mhnew/files/documents/AboutUs/Committees/EIP/EIPs_Administered_to_Voluntary_Patients_Report_JulSep2021.pdf

No questions or comments.

Voluntary Link: EIPs_Administered_to_Voluntary_Patients_Report_JulSep2021.pdf (vermont.gov)

No questions or comments.

Next Meeting: Friday, March 11th at 10:30

Public Comments

No questions or comments.