2014 Hospital Report Card Quality of Care Information
VERMONT PSYCHIATRIC CARE HOSPITAL: INPATIENT UNIT

Screening and Assessment

Screening for Violence Risk:

All patients at the Vermont Psychiatric Care Hospital (VPCH) shall have a daily assessment of risk. The assessment includes a risk of harm to self or others or the risk of elopement from the hospital. While there are some known risk factors that help in determining a person's risk, there are no tools available that predict any person's risk on a given day. A patient's risk level should be factored in allocating levels of autonomy. Equally important considerations in deciding the level of autonomy are mitigating factors and other appropriate clinical considerations. The suggestions of levels of autonomy below are guidelines and the patient's team must determine the appropriate level for each patient.

RISK ASSESMENT:

RISK	PATIENT'S CLINICAL PROFILE
Nominal	• Remote or no history of harm to self or others • No recent thoughts, intent or plan of self-harm, suicide or homicide • No known risk of elopement
Low	• Patient has had a history of harm to self or others, but not recently • Currently has no thoughts, intent or plan of self-harm, suicide or homicide • May have engaged in or has thoughts of self-injurious behavior but it functions to relieve stress and the actions pose a low level of risk • Low risk of elopement
Moderate	• Patient has had a history of harm to self or others recently, and has signs that indicate impulsivity • Patient shows some ability to manage behavior safely, but still at risk of harm • May have engaged in self injurious behavior that has moderate risk of harm but not suicidal or homicidal • Moderate risk of elopement
High	• History of severe harm to self or others recently • Patient continues to have thoughts, intent or active plans of self-harm, suicide or homicide • Patient remains impulsive and unable to manage behavior safely on their own • High risk of elopement • self-injurious behavior that has potential for serious long-term harm or lethality

MITIGATING FACTORS:

- Participation and adherence to the treatment plan
- A plan for discharge that supports management of risk
- Patient has a behavior plan
- Strong therapeutic relationships with team members
- Strong support system in the community
- Employment (Hospital or community before hospitalization
- No current substance intoxication or withdrawal
- Behavior is lower risk while under supervision
- Patient has insight into their illness or substance abuse problems
- Positive, future oriented (hopeful) outlook

LEVELS OF AUTONOMY BASED ON RISK ASSESMENT UNLESS MITIGATING FACTORS ARE INDENTIFIED

RISK	PATIENT CLINICAL PROFILE	SUGGESTED LEVELS OF OBSERVATION	SUGGESTED LEVELS OF AUTONOMY
Nominal	• Remote or no history of harm to self or others • No recent thoughts, intent or plan of self-harm, suicide or homicide • No known risk of elopement	15 minute checks	Restrict to secure area Supervised off secure areas
Low	• Patient has had a history of harm to self or others, but not recently • Currently has no thoughts, intent or plan of self-harm, suicide or homicide • Engages in or has thoughts of self-injurious behavior but it functions to relieve stress and the actions pose a low level of risk • Low risk of elopement	15 minute checks	Restrict to secure area Supervised off secure areas
Moderate	• Patient has had a history of harm to self or others recently, and has signs that indicate impulsivity • Patient shows some ability to manage behavior safely, but still at risk of harm • Engages in self injurious behavior but not suicidal or homicidal that has moderate risk of harm • Moderate risk of elopement	15 minute checks 1-1 Constant observation I, II or Close Supervision	Restrict to secure area Supervised off secure areas
High	• History of severe harm to self or others recently • Patient continues to have thoughts, intent or active plans of self-harm, suicide or homicide • Patient remains impulsive and unable to manage behavior safely on their own • High risk of elopement • self-injurious behavior that has potential for serious long-term harm or lethality	15 minute checks 1-1 Constant Observation I, II or CS	Restrict to Unit Restrict to secure area Consider secure transport for any appointments

Assessment of the Patient Experiencing Pain:

All patients' experience of pain is assessed at the time they are admitted to VPCH by a registered nurse and physician. Pain is assessed on a daily basis and whenever clinically indicated in the judgement of the registered nurse.

Routine Pain Assessment Process by VPCH Nursing

1. Pain is to be assessed upon admission and at least once during every shift thereafter. A 0-10 scale will generally be used (0=pain-free; 10=severest pain).
2. Pain assessment must be documented by the RN but Mental Health Specialists can participate in gathering data for this assessment. (For example, a Mental Health Specialist can communicate to the RN that a patient reports he/she has no pain.)
3. If a patient reports pain, document the level of intensity, describe the nature of the pain (headache, sore back, etc.) the intervention initiated, and the pain rating 1 hour after the intervention.
4. If the patient is sleeping (particularly on night shift) the patient is not to be awakened to assess for pain. The assumption is that, if the patient is sleeping, he/she is pain-free and "0" will be documented as the level of pain on the flowsheet.
5. For patients who are experiencing cognitive impairment and are not able to rate their pain on the 0-10 scale, see Appendix C (Key Points for Pain Assessment in the Cognitively Impaired Patient).
6. Space is provided to document up to two pain assessments per shift. If additional space is needed for an assessment on a shift, use the Nursing Flowsheet Overflow Documentation form.