



# **Vermont Psychiatric Care Hospital Workplace Violence Prevention Program**

August 2018

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## **VPCH Leadership Commitment**

VPCH leadership is fully committed to working towards creating an environment that is as safe as possible for both staff, patients, and visitors. This Policy outlines several policies and procedures that we have implemented to achieve that goal. In addition, we believe that you cannot separate employee safety from patient safety. One of the best way to keep staff safe is to provide a safe and therapeutic environment for the patients. Policies and procedures and other actions taken by VPCH to provide a safe and therapeutic environment for the patients help reduce the likelihood of them becoming aggressive. In turn, employees have a safer working environment.

OSHA's "Workplace Violence Prevention and Related Goals: The Big Picture" specifically acknowledges and supports the idea that patient safety equals worker safety:

*Strategies to improve patient safety and worker safety can go hand-in-hand—particularly those that involve nonviolent de-escalation and alternatives such as sensory therapy. The nationwide movement toward reducing the use of restraints (physical and medication) and seclusion in behavioral health—which is mandated in some states—along with the movement toward “trauma-informed care,” means that workers are relying more on approaches that result in less physical contact with patients, intervening with de-escalation strategies before an incident turns into a physical assault, preventing self-harm by patients, and ultimately equipping patients with coping strategies that can help them for life. The results can be a “win-win” for patient and worker safety.*

## What is Workplace Violence?

Workplace violence consists of physically and psychologically damaging actions that occur in the workplace or while on duty.

## Typology of Workplace Violence

The typology of workplace violence was developed by California OSHA, and it describes the relationship between the perpetrator and the target of workplace violence:

**Type 1 Criminal Intent:** Violent acts by criminals who have no other connection with the workplace but enter to commit a robbery or other crime. An example of a type 1 workplace violence incident would be a hostage taking and robbery.

**Type 2 Patient/Visitor:** Violence directed at employees by patients, visitors, or any others who hospital employees provide a service to. This is the predominant type of violence in an institutional type setting such as a hospital.

**Type 3 Co-Worker:** Violence against coworkers, supervisors, or managers by a present or former employee.

**Type 4 Personal:** Violence in the workplace by someone who doesn't work there but has a personal relationship with an employee. This refers to domestic violence situations and is usually perpetrated by an acquaintance or family member while the employee is at work.

## **VPCH Workplace Violence Prevention Program**

The Vermont Psychiatric Care Hospital has a zero tolerance for workplace violence, while at the same time acknowledging the inherent risks of working with individuals experiencing acute psychiatric symptoms. VPCH leadership is committed to working towards an environment that is as safe as possible for staff and patients. VPCH leadership is committed to continually assessing our Workplace Violence Prevention Program and making changes as necessary. This program shall be reviewed at least annually by the Safety Council.

Employees of VPCH are required to create an ethical environment and culture of civility and kindness treating patients, visitors, colleagues, co-workers, contractors, trainees, students, and others with dignity and respect. Similarly, VPCH employees must be afforded the same level of respect and dignity as others.

Individuals involuntarily hospitalized under the care and custody of the Commissioner of the Department of Mental Health at VPCH have been determined to present a serious risk of harm to self or others. While hospital leadership and employees are committed to zero tolerance of workplace violence, all recognize that there exists an inherent degree of risk in providing care and treatment for this acute population.

Employees, patients, consultants, contracted employees, vendors, and visitors to VPCH shall not make threats, use threatening language, harass, intimidate, or engage in any other acts of interpersonal aggression or physical violence in the work place.

A threat includes any verbal or physical harassment or abuse, any attempt at intimidating or instilling fear in others, menacing gestures, flashing of weapons, stalking or any other hostile, aggressive, and injurious and/or destructive action undertaken for the purpose of domination or intimidation. Weapons are prohibited on VPCH premises.

Staff are encouraged to report any and all safety concerns to VPCH Leadership. This can be done in several ways. Staff may use the various event reporting forms outlined in other sections of this Program – these can be submitted with a staff members name or anonymously. In addition, there is an Employee Suggestion Box where staff can anonymously make suggestions.

## **Pro-ACT**

Pro-ACT, or Professional Assault Crisis Training, is a national model used by thousands of facilities across the country. Pro-ACT meets or exceeds the requirements set forth by CMS and the Joint Commission – the two bodies that accredit and certify our hospital.

Successful completion of Pro-ACT training is required for all direct care staff members at VPCH.

Pro-ACT was designed to provide professionals with the opportunity to develop necessary understanding and skills to maintain the safety and dignity of the client and the staff members, while avoiding or reducing the need for direct physical intervention.

Employees who have developed a systematic approach to intervention during incidents of potential assault are less likely to injure or be injured than those who have not.

Pro-ACT training includes hands-on training in early recognition and assessment of dangerousness, de-escalation skills including crisis communication, and techniques of evasion and escape. Pro-ACT also teaches and provides hands-on training in removing themselves from being grabbed, bitten, choked and having their hair pulled.

The ultimate goal of Pro-ACT is to help clients learn alternative methods for meeting their needs and developing self-control.

VPCH provides three days of Pro-ACT training during orientation, as well as routine refresher courses.

Employees are provided with detailed descriptions of Pro-ACT principles and techniques in the Basic and Restraint Certification Participant Manuals.

## Event Reporting

Newly-hired VPCH employees will be oriented to the event reporting forms and processes during initial hospital orientation.

All hospital employees are encouraged and supported in reporting all adverse events and near-misses on event reporting forms.

Follow-up investigation is facilitated when the author of the event report self-identifies. However, any employee may choose to submit an event report anonymously.

Types of Event Report:

- Patient Event
- Employee Injury Report
- Environmental Variance Report
- Nursing Process Variance
- Medication Event Report
- Potential Adverse Drug Reaction

Each event report form includes prompts for documentation of supervisor and Quality Department follow-up.

The Quality Department organizes, analyzes, reports and maintains records on all event reports except Environmental Variance reports, which are maintained by the Facilities Operations Coordinator.

The following VPCH Policy and Procedures provide detailed descriptions and guidance for use of the VPCH event reporting process.

- Event Review Policy (Appendix A)
- Event Reporting Procedure (Appendix B)
- Employee Injury Reporting Procedure (Appendix C)
- Event Review Procedure (Appendix D)

The Event Review Policy discusses VPCH's commitment to safety and the requirement to identify, document, report and investigate events; review for opportunities to improve; identify event patterns and trends; review patterns to improved; and develop corrective action plans.

The Event Reporting Procedure lays out several steps employees must take when they

become aware of an adverse event (any unintended event, accident, malfunction or injury that occurs at the hospital including, but not limited to, patient events, employee events and environmental events) or a near miss (any process variation that did not affect the outcome, but for which a recurrence carries significant change of an adverse outcome). An employee is required to 1) take immediate action, 2) notify their immediate supervisor, 3) document in the patient's medical record and 4) report in the VPCH event reporting system. The procedure goes on to discuss what the department manager, supervisor or designee must do.

The Employee Injury Reporting Procedure lays out the steps employees must take when they witness, discover, or have direct knowledge of injury, wound, or damage to the body resulting from an event at work.

The Event Review Procedure discusses what is done with the event reports. All are reviewed and, if necessary, investigated. Continuous quality improvement requires the identification of patterns and trends through the compilation and analysis of data. The procedure also requires the development of corrective action plans "that address both human and systematic factors that contributed to the adverse event." Causal analyses are done on each serious reportable event.



## **Environment of Care Committee and Environmental Variance Reporting**

The Environment of Care (EOC) Committee, which meets weekly and is comprised of representatives from multiple services – nursing, operations, maintenance, custodial services and the hospital CEO - performs monthly environmental tours of the hospital to identify actual and potential safety concerns for patients, staff and visitors at VPCH.

Actual and potential safety concerns are often identified by employees and reported on Environmental Variance Reporting Forms. Safety concerns reported on Variance Forms are scanned during the shift received by the Nursing Supervisor on duty and distributed to a Variance email distribution list. This prompt distribution of reported safety concerns provides information necessary for the hospital Facilities Operations Coordinator and the BGS Maintenance Specialist to address and correct issues in a timely manner. Many risks identified by hospital employees on Environmental Variance Forms are later added to the agenda of the EOC Committee meeting for additional consideration and intervention.

When actual or potential safety concerns are identified, the committee undertakes a formal risk assessment, utilizing the Risk Level Classification Chart, developed by the Veterans' Administration.

Following the completion of the risk assessment, a plan of correction is written. The plan includes timelines for corrections, based on the level of assessed risk.

Outcomes of risk assessments and committee recommendations for corrections are presented to the VPCH CEO and Executive Leadership for final review and decision.

## **Patient, Employee and Visitor Safety**

Safety practices on the patient care units and in the Recovery Services area are outlined in these Procedures:

- Restricted Items and Search Procedure (Appendix E)
- Levels of Observation Procedure (Appendix F)
- Levels of Autonomy Procedure (Appendix G)
- Two Way Radios and Cell Phone Procedure (Appendix H)

Also applicable is the Emergency Involuntary Procedures Administrative Rule (Appendix I) which outlines the requirements for staff to engage in a seclusion, restraint or emergency medication situation. In addition to this rule, the Emergency Involuntary Procedures Procedure applies (Appendix J).

For taking patients offsite, the Transporting Patients Procedure (Appendix K) and the Escorting Patients Procedure apply (Appendix L).

## **Safety Practices Related to Visitors**

Safety practices related to visitors are outlined in this Procedure:

- Visitor Procedure (Appendix M)

## **Emergency Involuntary Procedures/Unit Safety Review Committee**

On a weekly basis, all emergency involuntary procedure documentation and High-Risk Progress Notes, as well as a summary of the clinical presentation of the patients involved, are reviewed, analyzed, and when necessary, followed up by members of this committee.

Trends, patterns, precipitants and contributing factors are analyzed by committee members, who collaborate to make plans, and to intervene outside the meeting as necessary to address process issues, provide educational and corrective feedback, and ameliorate drivers of adverse events.

This comprehensive process ensures that all injuries and near-miss dangerous events involving patients and employees are reviewed and problem-solved as necessary by hospital leadership and non-management employees.

Committee members include the Medical Director, CEO, Chief Nursing Executive, Director of Psychology, Nursing Supervisor, Quality Department and a Senior Mental Health Specialist.

## **When an Employee is Physically Assaulted by a Patient**

As stated in the Workplace Violence Prevention Policy, “While hospital leadership and employees are committed to zero tolerance of workplace violence, all recognize that there exists an inherent degree of risk in providing care and treatment for this acute population.”

“Staff Assault Information Packets” are available to any employee who wishes to report a physical assault by a patient to law enforcement (Appendix N). These packets are available in Staffing, where employees are also assisted to submit a First Report of Injury in response to any injury that occurs in the workplace.

Packets include informational guidelines, Workers Compensation Guide, an Employee Event Form, and a blank Vermont State Police Sworn Statement Form, and the EAP brochure.

Employees must also follow the Employee Injury Procedure to report any injuries (see Appendix C).

## **State of Vermont Employee Assistance Program**

All permanent State of Vermont employees are enrolled in the Employee Assistance Program (EAP) upon hire at no cost to the employee. The Employee Assistance Program offers help and support for you and the members of your household for a wide range of issues including: Family and Relationship Issues, Anxiety/ Depression, Stress, Substance Abuse, Eating disorders, Financial Issues and Debt Management, Care Planning, Family Planning, Daycare and Eldercare Resources and so much more.

EAP is available 24/7 at (888) 834-2830 or [www.investeap.org](http://www.investeap.org) password: vteap

## Safety Council

### Purpose:

Utilizing the principles of shared governance and the Six Core Strategies model, the VPCH Safety Council will study and evaluate care delivery systems to meet the challenges of maintaining a professional practice in a cost and resource constrained environment and will plan, coordinate, and suggest operational strategies to improve patient, staff, and visitor safety. This council will provide a mechanism for ensuring that decision-making structures are characterized by integrity, effectiveness, and compliance with appropriate regulatory guidelines. The council will advise hospital administration in matters pertaining to safety. Council members are empowered to identify barriers to clinical practice and partner with administration to find solutions.



### Initial Council Bylaws:

- To achieve an appropriate balance between decentralized and centralized decision-making;
- To foster continued organizational improvement by evaluating outcomes and making changes to our structures and processes as needed;
- To serve in an advisory capacity to hospital leadership to propose and evaluate systems designed to support clinical practice in the hospital.
- To use information from multiple stakeholder groups to drive the hospital's strategic direction;
- To provide a forum for direct dialogue with the Chief Nursing Executive (CNE) on topics related to quality of work life, staff wellness, clinical practice, patient care, clinical quality, and safety.
- To provide a network for information sharing and data collection.
- To focus all stakeholders on matters pertaining to safety.
- To work together to make decisions that affect clinical practice and patient care to improve overall safety outcomes.
- To evaluate and monitor the establishment of purposeful shared decision-making structure within all nursing patient care areas; and,

- To promote and foster a dynamic staff-leader partnership that promotes collaboration, shared decision-making and accountability for improving the quality of care, safety, and enhancing work-life.

**How Membership is Determined:**

Membership will be voluntary. Interested candidates will apply for membership by completing and submitting the attached application. The organization will seek representation from all disciplines and all shifts (for a total of 12-15 members). Once members have been selected, council members will nominate and vote to elect a council chair, vice-chair, and secretary. New membership applications will be reviewed by council members for appointment routinely.

**Shared Governance:**

In its simplest form, shared governance is shared decision-making based on the principles of partnership, equity, accountability, and ownership at the point of service. This management process model empowers all members of an organization to have a voice in decision-making, thus, encouraging diverse and creative input that will help advance our stake in the success of our organization.

Shared governance is collaboration, whether in scheduling staff, educating new staff, or implementing evidence-based practice. Effective decision making depends upon the intelligent communications of needs by and to those who are charged with making decisions and those who are accountable for results. Broad based discussion ensures that those who are affected by decisions are able to provide their unique perspectives – which leads to better decisions and effective implementation of those decisions. Dedication and good faith efforts on the part of decision-makers are critical to understanding the issues/barriers and ensuring that decisions are made in the best interest of the staff and those we serve.

**Partnership**

Links staff and leadership along all points in our hospital system; a collaborative relationship among all stakeholders required for professional empowerment. Partnership is essential to building relationships, involves all council members in decisions and processes, implies that each member has a key

From HIERARCHY	to	RELATIONAL PARTNERSHIP
• Independence		• Interdependence
• Hierarchical relationship		• Collegial relationship
• Parallel functioning		• Team functioning
• Medical plan		• Patient's plan
• Resisting change		• Leading change
• Competing		• Partnering
• Indirect communication		• Direct communication

role in fulfilling the mission and purpose of the organization, and is critical to our hospital's effectiveness

### **Equity**

The best method for integrating staff roles and relationships into structures and processes to achieve positive patient outcomes. Equity maintains a focus on services; is the foundation and measure of value; and says that no one role is more important than any other. Although equity does not equal equality in terms of scope of practices, knowledge, authority, or responsibility, it does mean that each team member is essential to providing safe and effective services.

### **Accountability**

A willingness to invest in decision-making and express ownership in those decisions. Accountability is the core of shared governance and is often used interchangeably with responsibility. It supports partnerships and is secured as all stakeholder groups produce positive outcomes.

### **Ownership**

Recognition and acceptance of the importance of everyone's work and of the fact that our hospital's success is bound to how well individual staff members perform their jobs. To enable all team members to participate, ownership designates where work is done and by whom. It requires all staff members to commit to contributing something: to own what they contribute, and to participate in devising purposes for the work.

**Appendix A:**  
**Event Review Policy**



# Vermont Psychiatric Care Hospital Policy

## Event Review

Revised: X

Date: 04/07/14

The Vermont Psychiatric Care Hospital seeks to maximize the safety of the systems that support care delivery by promoting shared accountability for the safe operation of those systems.

Systems include but are not limited to conducting the following activities:

- identifying, documenting, reporting and investigating significant adverse events on a timely basis;
- reviewing events to identify opportunities for performance improvement;
- identifying event patterns and trends through the compilation and analysis of event data;
- reviewing incident patterns to identify opportunities for performance improvement;
- developing and implementing corrective action plans that address both human and systemic factors that contributed to reportable adverse events; and
- disclosing the facts to patients or their families of adverse events that cause death or serious bodily injury.

Approved by	Signature	Date
Frank Reed, Commissioner of DMH		11/29/16

**Appendix B:**  
**Event Reporting Procedure**

# Vermont Psychiatric Care Hospital Procedure

## Event Reporting

Revised: X

Date: 04/07/14

### DEFINITIONS

“**Adverse event**” means any unintended event, accident, malfunction or injury that occurs at the hospital including, but not limited to patient events, employee events and environmental events.

“**Near miss**” means any process variation that did not affect the outcome, but for which a recurrence carries a significant chance of an adverse outcome.

“**Reportable adverse events**” are the most serious adverse events and/or unexpected occurrences involving death or serious physical or psychological injury, or risk thereof including, but not limited to: untimely or unexpected patient death, an event that results in death or serious disability, rape, elopement that results in injury, intentional unsafe acts. Reportable adverse events include the list, as amended from time to time, of serious “never” events compiled by the National Quality Forum (NQF) and available on their website at [www.qualityforum.org](http://www.qualityforum.org). Reportable adverse events are required to be reported to Patient Safety Surveillance and Improvement System (PSSIS) of the Vermont Department of Health and may be required to be reported to other authorities.

“**VPCH event reporting system**” means the system, paper or electronic, for reporting all adverse events at VPCH.

### CONSIDERATIONS/REQUIRED STEPS:

#### Responsibilities following the identification of an adverse event:

- a. **Employee responsibilities.** Any employee that identifies or otherwise becomes aware of an adverse event or near miss shall:
  - i. **ACTION.** When possible, take immediate action to correct the situation, and address any injuries or other negative outcomes that may have resulted from the event.
  - ii. **NOTIFICATION.** Notify immediate supervisor of adverse event or near miss and actions taken.
  - iii. **DOCUMENTATION IN THE MEDICAL RECORD.** If the event involved a patient(s), document in the patient(s) medical record that facts of the event: what happened, who was notified and what steps were taken to address the event. If the event involved an employee and an injury was sustained, take steps as indicated by the *Employee Injury Procedure*.
  - iv. **REPORT.** Report all adverse events or near misses in the VPCH event reporting system. Include all relevant and necessary information in the report.

**PLEASE NOTE:** The attached *Appendix - Guidelines for Event Reports* outlines the specific types of event reports and provides guidance for when each report should be completed.

- b. Department Manager, Supervisor or Designee responsibility.** Any department manager, supervisor or designee that becomes aware of an adverse event or near miss shall:
- i. ACTION.** When possible, take immediate action to ensure that action has been taken to correct the situation and address any injuries or other negative outcomes that may have resulted from the event
    1. If the event involves a suspicion that any patient has been the subject of abuse, neglect or exploitation, take steps as indicated by the *Mandatory Reporting Procedure*.
    2. If the event involves a patient elopement, take steps as indicated by the *Elopement and Late Return Procedure*.
    3. If the event involves the death of a patient, take steps as indicated in the *Patient Death Procedure*.
    4. If the event involves suspected criminal activity of a patient, take steps as indicated by the *Reporting Patient Criminal Activity to Law Enforcement Procedure*.
    5. If the event involves an untimely patient death, patient serious injury or any suspected criminal act, take steps as indicated by the *Securing the Scene Procedure*.
  - ii. NOTIFICATION.**
    1. Manager or supervisor shall notify the Director of Nursing, Associate Director of Nursing or designee of events of significant magnitude. Events requiring such notifications include:
      - a. reportable adverse events;
      - b. events that result in any injuries that require outside medical attention;
      - c. events that do or have imminent potential to compromise patient care services and/or threaten the hospital environment;
      - d. events that require police, fire or other emergency personnel response;
      - e. Events that result in a report to an outside regulatory authority (e.g. APS, DLP, CMS, JCAHO).
    2. The Director of Nursing, Associate Director of Nursing or designee shall notify Chief Executive Officer or designee
  - iii. INVESTIGATE.** When appropriate, conduct a sufficiently thorough initial investigation to identify the fundamental reasons the incident occurred, including both human errors and clinical and non-clinical systems, processes and risk areas that may have contributed to the event. Depending on the nature and severity of the incident, initial investigation

may include securing the scene (See *Securing the Scene Procedure*), preservation of evidence and interviewing witnesses.

- iv. **REPORT.** Report, assist staff in reporting or ensure that a report of the event was made in the VPCH event reporting system and that all relevant and necessary information is included in the report.
- v. **FOLLOW-UP.** Using VPCH event reporting system, follow up as appropriate on all events that have occurred in assigned area of responsibility.

- c. **Confidentiality of reports made to the VPCH event reporting system.** All information reported through the VPCH event reporting system and information related to root cause analysis is peer review protected and considered confidential and privileged pursuant to 26 VSA §1441-1443 and 18 VSA §1917.

Approved by	Signature	Date
Frank Reed, Commissioner of DMH		1/29/16

## Appendix

### Vermont Psychiatric Care Hospital

#### Guidelines for Event Reports

Effective date: 8/26/2010

Type of Event Report	Form #	When to complete
Patient Event Form	NCF-31	<p>Whenever you witness, discover, or have direct knowledge of an incident in which a patient:</p> <ul style="list-style-type: none"> <li>• was injured (by accident or deliberately)</li> <li>• experienced a “near miss/close call” without injury</li> <li>• was aggressor or victim in a patient-to-patient altercation</li> <li>• alleged abuse, neglect, and/or exploitation</li> <li>• attempted or completed suicide</li> <li>• eloped or attempted to elope</li> <li>• damaged property</li> <li>• set or attempted to set a fire</li> <li>• experienced a serious medical event or emergency</li> <li>• was involved in any other event that was potentially dangerous to self or others</li> </ul> <p><u>In addition:</u> Any event that has been reported as a Patient Event Report should also be documented in a Progress Note in the patient’s medical record.</p>
Medication Event Form	NCF-19	<p>Whenever you witness, discover, or have direct knowledge of a medication-related error or variance in any of the following categories:</p> <ul style="list-style-type: none"> <li>• prescription</li> <li>• transcription</li> <li>• administration</li> <li>• documentation</li> <li>• monitoring</li> <li>• dispensing</li> <li>• ordering</li> <li>• storage</li> <li>• medication security (includes variance in narcotic count)</li> </ul>

Type of Event Report	Form #	When to complete
Potential Adverse Drug Reaction (ADR) Reporting Form	NCF-35	<p>Whenever you witness, discover, or have direct knowledge of a patient's possible or suspected adverse reaction to one or more medications.</p> <p>An "adverse reaction" includes subjective discomfort ranging from mild to severe, as well as unwanted physical symptoms up to and including death.</p>
Employee Event Form	NCF-9	<p>Whenever an employee or staff member who witnesses, discovers, or has direct knowledge of injury, wound, or damage to the body resulting from an event at work, within 24 hours.</p> <p><u>In addition:</u> Any injury to an employee that occurs as a result of an interaction with a patient, that has been documented on an Employee Event Form, should also be documented in a Progress Note in that patient's medical record.</p>
Variance Reporting Form	NCF-7	<p>To be completed by the employee discovers or witnesses an event or environmental hazard or other condition not involving a patient or employee injury and not related to an emergency involuntary procedure.</p>

**Appendix C:**  
**Employee Injury Reporting**  
**Procedure**



# Vermont Psychiatric Care Hospital Procedure

## Employee Injury Reporting

Revised: X

Date: 04/07/14

1. Any employee who witnesses, discovers, or has direct knowledge of injury, wound, or damage to the body resulting from an event at work shall complete an Employee Event Report within 24 hours.
2. If an employee is unable to complete the report due to the extent of injury, the employee's immediate supervisor will initiate the report on the employee's behalf.
3. All fields of the Employee Event Report must be completed to provide accurate and prompt processing of employee events and to ensure that employee injury reporting meets Risk Management and Department of Labor requirements.
4. If the employee believes that the reported injury will require outside medical treatment and/or lost time from work, s/he must contact the Worker's Compensation office at 828-2899 and notify the Staffing Office of the need for medical evaluation and/or time out of work.. The employee may leave a voice mail after hours for Worker's Compensation, including information on how to contact the employee.
5. The employee shall bring the completed Employee Event Report to the Nursing Supervisor on-duty at the time of the event.
6. The Employee Event Report will be brought to the VPCH Staffing Office by the Nursing Supervisor.

Follow-up by the Employee Assistance Program (EAP) is available upon request for those employees who are eligible. The employee's nursing or departmental supervisor is responsible for making this information available to the employee. The EAP Services contact number is 1-888-834-2830 and is available 24-hours a day.

Approved by	Signature	Date
Frank Reed, Commissioner of DMH		11/29/16

**Appendix D:**  
**Event Review Procedure**

# Vermont Psychiatric Care Hospital Procedure

## Event Review

Revised: X

Date: 04/07/14

### Definitions:

**“Adverse event”** means any unintended or unexpected event, accident, malfunction injury or malfunction that occurs at the hospital.

**“Serious Reportable Events (SREs)”** are the most serious adverse events and/or unexpected occurrences involving death or serious physical or psychological injury, or risk thereof including, but not limited to: untimely or unexpected patient death, an event that results in death or serious disability, rape, elopement that results in injury, intentional unsafe acts. SREs include the list, as amended from time to time, of serious “never” events compiled by the National Quality Forum (NQF) and available on their website at [www.qualityforum.org](http://www.qualityforum.org). Serious Reportable Events are required to be reported to Patient Safety Surveillance and Improvement System (PSSIS) of the Vermont Department of Health and may be required to be reported to other authorities. Deaths associated with the use of seclusion or restraint must be reported to CMS as indicated in § IV(2)(d) below.

**“Causal analysis”** means a formal root cause analysis, similar analytic methodologies or any similarly effective but simplified processes that use a systematic approach to identify the basic or causal factors that underlie the occurrence or possible occurrence of a reportable adverse event, adverse event, or near miss.

**“Corrective action plan”** means a plan to implement strategies intended to eliminate or significantly reduce the risk of recurrence of an adverse event and to measure the effectiveness of such strategies.

**“Intentional unsafe act”** means an adverse event or near miss that results from: (A) a criminal act; (B) a purposefully unsafe act; (C) alcohol or substance abuse; or (D) patient abuse **and** that meets the criteria in this policy (see section IV. 4)).

**“Near miss”** means any process variation that did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

**“Serious bodily injury”** means bodily injury that create a substantial risk of death or that causes substantial loss or impairment of the function of any bodily member or organ or substantial impairment of health or substantial disfigurement.

**“Vermont Department of Health (VDH) Patient Safety Surveillance and Improvement System (PSSIS)”** means the program at the Vermont Department of Health that monitors hospitals’ patient safety programs.

## CONSIDERATIONS/REQUIRED STEPS:

1) **Review of all event reports.** On a regular basis, Quality Management shall:

- a) Receive and review all reports made through the event reporting system.
- b) In collaboration with Nursing Administration and other operational leaders as indicated, ensure that the appropriate level of review and investigation has been completed.
- c) Ensure that the proper external reports are filed in a timely manner. See below for instruction on external reporting of **serious reportable events** and **intentional unsafe acts**.

2) **Continuous quality improvement.** Quality Management shall:

- a) Identify patterns and trends through compilation and analysis of event report data, and on a regular basis, provide that information to clinical and administrative leaders.
- b) In collaboration with clinical and administrative leaders:
  - review patterns and trends to identify opportunities for performance improvement.
  - Develop and implement corrective actions plans that address both human and systemic factors that contributed to adverse events.
- c) Ensure that outcome(s) of performance improvement initiative(s) are reported to appropriate leadership and quality committees.

3) **Reportable Adverse Events**

- a) **Conduct causal analyses on each serious reportable event.** Quality Management shall be responsible for conducting a causal analysis on each reportable adverse event. A causal analysis shall include, at a minimum:
  - i) Interdisciplinary participation including individuals closely involved in the processes and systems under review.
  - ii) A detailed description of the reportable adverse event including date, day of week, time and location and services involved and chronology of events.
  - iii) A primary focus on systems and processes rather than individual performance.
  - iv) A systematic and comprehensive assessment of factors contributing to the reportable adverse event, as applicable to the specific event.
  - v) Consideration of literature relevant to the specific reportable adverse event.
- b) **Develop and implement a corrective action plan for each serious reportable event.**
  - i) Quality Management shall be responsible for developing and ensuring the implementation of a corrective action plan on each reportable adverse event. A corrective action plan shall include, at a minimum:
    - (1) Specific actions to correct the identified causes of the event to prevent a similar event occurring in the future.
    - (2) Identified and measurable outcome(s).

- (3) A specific implementation plan, including completion dates and provisions for education of and communication with appropriate hospital staff and a description of how the corrective action plan will be assessed and evaluated following full implementation.
- (4) A designated person(s) responsible for implementation and evaluation.

**c) Serious reportable events to VDH Patient Safety Surveillance and Improvement System.**

- i) **Initial Report.** Quality Management shall be responsible for submitting an initial report to the VDH PSSIS as soon as reasonably possible and no later than seven (7) calendar days after the discovery or recognition of a reportable adverse event.
- ii) **Casual analysis and corrective action plan.** Quality Management shall be responsible for ensuring that each causal analysis and corrective action plan related to a reportable adverse event is submitted to VDH PSSIS no later than sixty (60) calendar days from the submission of the initial report.
- iii) Reports to PSSIS shall be on approved forms and shall not include the names of individuals involved in any adverse event.

**d) Reporting deaths associated with the use of seclusion or restraint to CMS.**

- i) **Deaths requiring a report.** VPCH must report the following information to CMS:
  - (1) Each death that occurs while a patient is in seclusion or restraint.
  - (2) Each death that occurs within 24 hours after the patient has been released from seclusion or restraint.
  - (3) Each death known to the hospital that occurs within 1 week after seclusion or restraint where it is reasonable to assume that the use of seclusion or restraint contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time. Or death related to chest compression, restriction of breathing or asphyxiation.
- ii) Each death requiring a report must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.
- iii) The date and time the death was reported to CMS must be documented in the patient's medical record.

**4) Intentional Unsafe Acts**

- a) An intentional unsafe act is an act or omission by hospital staff resulting in an adverse event or near miss **only if all of the following criteria are met:**
  - i) The act or omission was directly associated with patient care or services,
  - ii) The act or omission affected or could have affected a patient or patients, regardless of whether an actual patient injury occurred, and
  - iii) The information available to the hospital supports a reasonable, good faith belief that the adverse event or near miss resulted from one or more of the following:
    - (1) The act or omission was a criminal act, including circumstances where there may have been an intent to harm; or
    - (2) The act or omission was **purposefully unsafe** as defined below

- (3) The act or omission took place while the individual involved was under the influence of alcohol or other substances; or
  - (4) The act or omission was of a type or nature that Vermont law makes reportable to a designated department or agency as abuse, neglect or exploitation.
- b) An act or omission by hospital staff resulting in an adverse event or near miss shall be considered to be purposefully unsafe if **only if meets all of the following criteria:**
- i) There was a conscious act or omission or reckless behavior,
  - ii) The adverse event or near miss did not happen as a result of understandable accident or inadvertence,
  - iii) No reasonable person with similar qualifications, training and experience would have acted the same way under similar circumstances; and
  - iv) There were no extenuating circumstances that could justify the act or omission.

**c) Reporting Intentional Unsafe Acts**

- i) VPCH shall report an intentional unsafe act to the VDH PSSIS as soon as reasonably possible, but no later than seven (7) calendar days after the information available to the hospital supports a reasonable, good faith belief that an intentional unsafe act has occurred.
- ii) The report shall be submitted on a form approved by the Department of Health or, if the intentional unsafe act has been reported in writing to another department or agency, the hospital may provide a copy of that written report. The Patient Safety Surveillance and Improvement System will review the report and may require additional information from the hospital.
- iii) Complete names of individuals involved in the intentional unsafe act shall be provided in the report to the Patient Safety Surveillance and Improvement System.
- iv) Intentional Unsafe Acts must be reported to all other appropriate agencies.

**5) Disclosures to patients of Serious Reportable Events.** In the unfortunate event of a reportable adverse event, VPCH shall disclose to patients, or, in the case of a patient death, an adult member of the immediate family, any adverse events that cause death or serious bodily injury, including those resulting from intentional unsafe acts. Adverse events shall be reported on an event form; employees shall not document the submission of an event form in the patient's medical record. Disclosures shall always be made by the appropriate professional staff and shall be done in such a way as to minimize trauma and protect the confidentiality and emotional health of all of the participants to the extent possible. At a minimum any disclosure shall comply with the following requirements:

- a) Disclosures shall be timely and done as soon as possible after the hospital becomes aware of the reportable adverse event and its consequence.
- b) Disclosures will be made to the patient or, in the case of a patient death, an adult member of the immediate family. Disclosures may also be made to a patient's health care agent or guardian if applicable and appropriate and/or to any other person as requested by the patient.
- c) Disclosures will most often be done by the treating physician with a member of the leadership team. The staff members of the affected patient's treatment team shall meet with members of the leadership team to determine which individual(s) will be responsible

for participating in the disclosures and what resources will be available to assist individual(s) responsible for disclosures.

- d) Disclosures shall be documented in the patient medical record, including a description of the disclosure, who was present and any response or requests made by the patient or the patient's family.
- e) **Quality Management shall facilitate root cause analysis as indicated:**
  - i) Performs preliminary analysis of the event
  - ii) Initiates root cause analysis for events according to the following criteria:
    - (1) Meets PSSIS definition of Serious Reportable Event.
    - (2) Meets the Joint Commission definition of a sentinel event or reviewable event.
    - (3) Is otherwise a reportable event under state or federal law.
    - (4) At the discretion of Quality Management for systems issues deemed to be a potential risk to patient safety.
    - (5) Identifies root cause team members.
    - (6) Notifies the appropriate managers, physicians and other staff involved in the event and establishes purpose, time frame and expectations for the analysis.
- f) **Conducts comprehensive analysis.**
  - i) Reviews the root cause analysis process steps with participants.
  - ii) Reviews the details of the event using appropriate performance improvement methodology.
  - iii) If variation in system performance is identified by the root cause analysis, the team:
    - (1) Determines if all practices met acceptable standards.
    - (2) Determines which systems issues contributed to the variation in performance.
    - (3) Reviews staffing in affected areas of service
    - (4) Determines appropriate attendees for a meeting, which will focus on performance improvement.
- g) **Facilitates performance improvement meeting** if variation in performance or opportunity to improve safety of systems has been identified. During this meeting the team:
  - i) Reviews system issues identified during the comprehensive analysis meeting.
  - ii) Identifies potential systems improvement(s).
  - iii) Identifies measures of success for monitoring the systems improvements.
  - iv) Designates accountable individuals for implementation of components of the performance improvement plan.
  - v) Establishes time frame and method for reporting results of plan at designated intervals.
- h) Sends draft of root cause analysis report to identified team members for review/edit.
- i) Revises root cause analysis report as necessary. Final report is sent to the appropriate leadership and/or managers as indicated.
- j) **Identifies opportunities to replicate improvement plan** in all areas which may contain similar risk and facilitates rapid cycle improvement as indicated.

- k) Sends follow-up notification to accountable individuals at determined time intervals.
  - l) Ensures outcome(s) of root cause analysis and performance improvement initiative(s) are reported to appropriate leadership and quality committees.
- 6) **Retention of records.** VPCH shall retain all documents and data (in any format) relating to the investigation of any adverse event, near miss or intentional unsafe act for a period of at least seven (7) years. Discarding or destroying such documentation or data during that period is prohibited.

Approved by Signature	Date
Frank Reed, Commissioner of DMH	April 7, 2014



**Appendix E:**  
**Restricted Items and Search**  
**Procedure**

# Vermont Psychiatric Care Hospital Procedure

## Restricted Items and Search

Revised: X

Date: 12/04/14

**Restricted Items** are items that pose a potential risk of harm to self or others and include, but are not limited to, the following:

- all medications (Over The Counter and prescribed), illegal drugs, alcohol, and toxic substances;
- matches, lighters, cigarettes and other smoking materials;
- shampoo, hair care products, aerosol products, and razors;
- hair dryers, curling irons, and other electric appliances;
- items that readily lend themselves to use as weapons (guns, metal knives, etc.);
- mirrors, bottles, and other items made out of glass;
- scissors, sewing kits, and other sharp objects;
- shoe laces, ties, string, straps, cords, belts, scarves, drawstrings, and other items that present a potential strangulation hazard;
- plastic bags;
- keys;
- hooded garments;
- perishable food when it is in a patient's room
- jewelry that could pose a strangulation or cutting hazard
- any other item that, at the discretion of staff, poses a potential risk of harm to self or others.

Plastic dining utensils are not considered restricted items; however, access to plastic utensils shall be closely monitored when a patient has been determined to be at high risk for serious harm to self or others.

**Room Inspection:** A room inspection is a scan of a patient room for potentially unsanitary or unsafe conditions. Items may be moved and/or uncovered to facilitate the inspection. Room inspections are also a means to assist the patient with structure, by providing organization and cleanliness within their living space. Room inspections shall be conducted on a daily basis.

**Room Search:** A room search is a thorough search of a patient room for potentially dangerous and restricted items. Room searches shall be conducted weekly and whenever there is a suspicion that restricted items are on the unit or in a patient room. Room searches are also conducted as part of unit searches.

**Unit Search:** A unit search is a thorough search of all patient rooms and all common areas of the unit. Unit searches shall be conducted weekly and whenever there is a suspicion that restricted items are on the unit.

**Patient Search:** A patient search is a search of a patient and his or her clothing and belongings for the purpose of identifying and securing restricted items. Patient searches shall be conducted upon admission and whenever a patient returns from off unit activities or visits. As with other searches, the extent of a patient search shall be based on a weighing of the relative risks and

benefits of the search, including the potential for harm, the imminence of the harm, the risk of trauma to the patient, and whether less intrusive procedures exist which could verify the presence or absence of restricted items. All patient searches shall be conducted in a manner that respects the patient's dignity and privacy.

**Strip Search:** A strip search is a search in which a patient is asked to remove all of his or her clothing and expose the surface of his or her body to visual examination by a staff member. This type of search shall always be done in the presence of a physician and a Registered Nurse (RN). The gender of the staff conducting the search will be determined in collaboration with the patient, and after considering all relevant clinical factors. Strip searches shall only be conducted pursuant to a physician's order and following approval from the Chief Executive Officer and Medical Director or their designee, when there is reasonable suspicion that the patient is in possession of restricted items that pose a risk of harm to the patient or others.

**Body Cavity Search:** A body cavity search is a strip search that additionally involves the visual examination of the interior of the patient's mouth and a digital search of the rectum and vagina by a licensed physician. This type of search shall always be conducted by a physician and in the presence of a RN. The gender of the RN shall be determined in collaboration with the patient, and after considering all relevant clinical factors. Body cavity searches shall only be conducted pursuant to a search warrant or, in the event of an emergency, pursuant to a physician's written order and following approval by the Chief Executive Officer and the Medical Director or their designee. A physician shall only order a body cavity search when the physician reasonably believes that restricted items are sequestered within the patient's body and present an immediate risk of harm to the patient or others.

**Security Sweep:** Security sweep means a walk-through of the yard to visually inspect the area to identify whether any restricted items or other potential hazards are present.

**A. General Considerations**

1. Searches of patients, their belongings, or their rooms shall only be conducted by VPCH personnel trained in search procedures.
2. Unless otherwise warranted by health, safety, or security concerns, a patient must be given the option of being present when staff conduct a search of his or her belongings.
3. Staff shall open and examine the contents of any containers (e.g. food, clothing, boxes) that are brought into the units by patients and by patients' visitors, when the container is not secured by manufacturer's packaging.
4. To comply with standard precautions, staff members shall wear gloves when conducting a search.
5. When screening for potentially dangerous items brought into the units, staff shall make the initial determination as to whether an item, which is not included on the list of restricted items, could pose a danger. Whenever there is any uncertainty, questions shall be referred to the Nursing Supervisor.
6. Whenever restricted items are found in the unit or in a patient's possession, the items shall be removed, the incident shall be documented in the patient's medical record and an event report shall be completed.
7. Any personal items brought into the unit by visitors shall be subject to search. See *VPCH Visitors Policy and Procedure*.

8. In limited circumstances, based on a documented risk assessment, and after consultation with the Medical Director and Chief Executive Officer or their designee, the attending physician may write an order that deviates from this policy.

**B. Patient Searches**

**1. Patients returning from the Yard or Recovery Services (RS) space**

- a) Staff shall conduct a patient search when a patient is returning the Yard or RS space and shall:
  - i. Explain the process to the patient, and specifically ask the patient whether he or she has any restricted items in his or her possession.
  - ii. Ask the patient to empty all pockets and turn them inside out.
  - iii. Staff shall ask patient to stand with feet apart and with hands slightly raised.
  - iv. To determine whether objects are concealed, staff shall scan patient with a metal detector wand.
  - v. If there is any reason to suspect that restricted items may be hidden on the patient or in the patient's undergarments, a physician must be called to determine whether or not a higher intensity search is necessary.
- b) At staff discretion, staff may lightly run fingertips of gloved hands down sides of patient's arms, legs and torso to feel for restricted items.
- c) Staff shall not leave a patient unobserved at any time during the search process.

**2. Patients returning from appointments outside of the hospital**

- a) Staff shall conduct a patient search when a patient returns from an appointment outside of the hospital and shall:
  - i. Explain the process to the patient, and specifically ask the patient whether he or she has any restricted items in his or her possession.
  - iii. Ask the patient to empty all pockets and turn them inside out.
  - iv. Staff shall ask patient to stand with feet apart and with hands slightly raised.
  - v. To determine whether objects are concealed, staff shall scan patient with a metal detector wand.
- b) At staff discretion, staff may:
  - ask the patient to remove jacket, coat, hat, and/or shoes
  - turn removed clothing inside out, check pockets, etc.
  - check shoes
  - turn socks inside out
  - lightly run fingertips of gloved hands down sides of patient's arms, legs and torso to feel for restricted items.
- c) If there is any reason to suspect that restricted items may be hidden on the patient or in the patient's undergarments, a physician must be called to determine whether or not a higher intensity search is necessary.
- d) Staff shall not leave a patient unobserved at any time during the search process.

**3. Patients being admitted, returning from elopement or when a physician or an RN has determined that there is reason to suspect that restricted items may be hidden on the patient.**

- a) This type of search shall always be conducted by a minimum of 2 staff members; one of whom is of the same gender (RN or Mental Health Specialist) as the patient, unless decided otherwise by the Nursing Supervisor. Staff conducting a patient search when a patient is being admitted or returning from elopement shall:
- i. Explain the process to the patient, and specifically ask the patient whether he or she has any restricted items in his or her possession.
  - ii. Ask the patient to empty all pockets and turn them inside out.
  - iii. Ask the patient to remove any jacket, coat, hat, shoes and any other outer clothing. Removed clothing shall be turned inside out, shaken out, pockets checked and hemlines examined for restricted items. Shoes shall be inspected,
  - iv. Staff shall take belts and shoelaces from all patients. Patients who require substitute clothing or shoes to maintain dignity and appropriate appearance shall be provided with the necessary attire.
  - v. Staff shall ask patient to stand with feet apart and with hands slightly raised.
  - vi. To determine if objects may be concealed, staff shall scan patient with a metal detector wand. If there is any reason to suspect that contraband may be hidden on the patient or in the patient's undergarments, a physician must be called to determine whether or not a higher intensity search is necessary.
  - vii. Before a newly admitted patient is permitted to enter the unit, unit staff shall require the patient to turn in his or her personal belongings and inventory those belongings in accordance with *VPCH Patient Personal Effects Policy and Procedure*.
- b) At staff discretion, staff may :
- ask the patient to remove jacket, coat, hat, and/or shoes
  - turn removed clothing inside out, check pockets, etc.
  - check shoes
  - turn socks inside out
  - Lightly run fingertips of gloved hands down sides of patient's arms, legs and torso to feel for restricted items.
- c) Staff shall not leave a patient unobserved at any time during the search process.

**C. Strip Searches**

1. A strip search may only be conducted upon a physician's order, following authorization by the VPCH Medical Director and the VPCH Chief Executive Officer or their designees. A decision to conduct a strip search shall be based on a reasonable suspicion that the patient is in possession of restricted items that poses a risk of harm to the patient or others.
2. Before ordering a strip search, the physician shall personally attempt to interview and assess the patient, and ask the patient whether he or she will consent to the search.

The physician shall consider whether less intrusive procedures exist that could reasonably verify the presence or absence of restricted items. The physician shall document the rationale for the search.

3. Before ordering a strip search or a body cavity search, the physician shall consider and document the likelihood of trauma to the patient and the detrimental effect such a search may have on any existing or potential therapeutic alliance with the patient.
4. The search shall always be conducted by a minimum of two staff members in an area where privacy and safety can be assured. A strip search shall always be conducted by a Physician or a Registered Nurse. The gender of the staff conducting the search shall be determined in collaboration with the patient and after considering all relevant clinical factors.
5. The patient shall be asked to remove his or her clothing and put on a hospital gown. Staff shall visually examine the surface of the patient's body, lifting the hospital gown as necessary to complete the search. Staff shall also search the patient's clothing including pockets, hems, seams, and waistband.
6. Except where a specific article of clothing is found to contain restricted items, the patient's clothing shall be returned immediately after the search is completed. Staff shall document the results of the search in the patient's progress notes.
7. Patients who have undergone a strip search shall be offered counseling by an RN or physician or other qualified staff person once the search has been completed.

**D. Body Cavity Searches**

1. Before proceeding with the body cavity search, the physician shall consider the feasibility of alternative measures for confirming the presence of restricted items, such as x-rays, or other means of protecting the patient and others, such as constant one-to-one observation.
2. A body cavity search is a strip search that additionally involves the visual examination of the interior of the patient's mouth and a digital search of the rectum and vagina by a licensed physician. This type of search shall always be conducted by a physician and in the presence of a RN. The gender of the RN shall be determined in collaboration with the patient, and after considering all relevant clinical factors.
3. Body cavity searches may only be conducted pursuant to a search warrant or, in the event of an emergency, and following authorization by the VPCH Medical Director and the VPCH Chief Executive Officer or their designee, pursuant to a physician's written order. Only a licensed physician may perform the digital penetration of the vagina and rectum.
4. A physician shall not order a body cavity search except in cases where the physician reasonably believes that restricted items are sequestered within the patient's body and that they present an immediate risk of harm to the patient or others.
5. Before ordering a strip search or a body cavity search, the physician shall consider the likelihood of trauma to the patient and the detrimental effect such a search may have on any existing or potential therapeutic alliance with the patient.
6. The search shall be conducted in an area where privacy and safety can be assured.
7. Following the body cavity search, the physician shall document the results of the search in the patient's progress notes, including the rationale for the search.
8. Patients who have undergone a strip search or a body cavity search shall be offered counseling by an RN or physician or other qualified staff person once the search has been completed.

**E. Non-Cooperative Patients**

1. When a patient refuses to cooperate with a search, staff shall monitor the patient in a secure area and promptly summon a physician.
2. Patients refusing to cooperate with search procedures may be restricted to the unit.
3. When the patient refuses to consent to search procedures and the physician reasonably suspects that the patient is concealing restricted items that pose an immediate risk of harm on his or her person, and less restrictive alternatives have been considered, the physician may order the patient restrained so that the search may proceed. The physician who orders a non-cooperative patient placed in seclusion or restraint shall complete a Certificate of Need form documenting the rationale for the procedure pursuant to the *VPCH Emergency Involuntary Procedures Policy and Procedure*.

**F. Room Inspections**

1. All patient rooms shall be inspected for sanitation on a daily basis and documented on the Nursing Flow Sheet.
2. Unit staff shall conduct a scan of a patient room for potentially unsanitary conditions. Items may be moved and/or uncovered to facilitate the inspection.
3. Room inspections are also a means to assist the patient with structure, by providing organization and cleanliness within their living space.
4. Whenever restricted items are found in a patient's room or in patient's possession, the items shall be removed, secured and a patient event report shall be documented.

**G. Daily Security Sweep of the Yard**

Prior to daily use of the yard, a security sweep of the area shall be conducted. To conduct a security sweep, staff shall walk through the area, visually scan all surfaces to identify and remove any restricted items or other hazardous conditions. When restricted items are identified during a security sweep, an event report shall be completed.

**H. Room and Unit Searches**

1. On a weekly basis, an unscheduled (unannounced) unit search shall be conducted.
2. In addition, whenever there is suspicion that restricted items are concealed somewhere within the unit a unit search shall be conducted.
3. To conduct a unit search:
  - a. As each room is searched, the patients occupying that room are entitled to be present unless clinically contraindicated or unless otherwise warranted by health, safety, or security.
  - b. Two staff members must be present in order to search a patient's room.
  - c. The search shall include, but is not limited to, the following:
    - i. Behind and under furniture, above door and window frames;
    - ii. Contents of wardrobes (look in pockets, socks, sleeves, and legs of all clothing);
    - iii. Pillows and mattresses – with particular attention paid to incisions or protrusions;
    - iv. Under mattresses
  - d. Staff shall complete the Search Check List.
  - e. Staff shall also complete a thorough search of common areas of the unit including the bathrooms, laundry room, visitor's rooms, dining room, etc. Particular attention shall be paid to areas behind and under furniture, appliances and fixtures as well as door and window frames.

- f. Staff shall document that the unit search was conducted. Restricted items found in a patient's room shall be documented on a patient event form.

**I. Patients Placed on Constant Observation or Close Supervision**

1. When a physician orders that a patient be placed on constant observation or close supervision during his or her hospital stay (but not at time of admission) as a result of assaultive or self-injurious behavior, staff may, at their discretion, conduct a patient search (consisting of any or all of the Search Tasks), and a thorough room search to ensure that the patient does not possess any restricted items. When patients are placed on CO or CS for other reasons, this type of search activity may not be warranted.
2. If restricted items are found, the items shall be removed, secured and a patient event report shall be documented.

**J. Whenever Restricted Items Are Found**

1. The Nursing Supervisor shall be notified anytime restricted items are found in the unit. S/he shall ensure that any restricted items found have been properly secured or disposed of and that an event report has been completed.
2. Any alcohol that is found during a search for restricted items shall be discarded by pouring down a drain. Illegal drugs shall be turned over to law enforcement. The VPCH Chief Executive Officer or designee shall be immediately notified of any illegal restricted items found on Hospital premises and shall be responsible for any necessary notification of law enforcement authorities. *See VPCH Reporting Patient Criminal Activity to Law Enforcement Policy and Procedure.* Other restricted items shall be removed and securely stored with the patient's belongings.
3. Weapons of any kind shall be removed from the patient's possession. Staff shall contact the law enforcement to arrange for the disposal of any weapon taken from the patient. Patients shall not be permitted to possess weapons of any kind on Hospital premises. *See VPCH Weapons Policy.*
4. Any patient found with restricted items in his or her possession without authorization shall be restricted to the unit until such time as the treatment team has an opportunity to reassess the patient's level of autonomy and supervision.

**K. Patients Use of Restricted Items**

1. **Patients may never use the following items in the unit under any circumstances:**
  - Guns, or other items that are commonly considered to be weapons.
  - Mirrors, bottles, or other items made from glass.
  - Illegal drugs, alcohol, toxic substances.
  - Lighters, matches.
  - Keys.
  - Cell phones and cameras.
2. **The following items may be used by patients under staff supervision, in the unit, unless a physician has specifically ordered otherwise:**
  - Blow driers, curling irons, and other electric appliances.
  - Razors – Patients may use safety or cordless electric razors for their daily shaving needs when such use is supervised by staff. Razors shall be returned to staff when the patient has finished shaving.



- Shampoo and hair products in large bottles shall be stored by staff and made available to their owners for their use.
- Nail clippers may be used under staff supervision upon request. Nail clippers are not otherwise permitted on the patient care units.
- Scissors or sewing supplies may be used during group activities under staff supervision.
- On the unit, scissors and sewing supplies are used by individual patients under nursing staff supervision.
- Writing utensils larger than an approved unit pen.
- Materials used in psychosocial groups or individual activities under staff supervision (*See Recovery Support Guidelines for Use of Restricted Items on the Unit*).

**3. The following items may be used by patients off of the unit with a doctor's order:**

- Shoe laces, ties, cords, belts, and other items used as belts such as drawstrings may be used only with a physician's order during time spent off of the unit.
- Cell phones

**3. In exceptional circumstances a doctor may order that a patient may have access to otherwise restricted items. All such cases shall be reviewed by the Medical Director and Chief Executive Officer or their designee.**

Approved by	Signature	Date
Frank Reed, Commissioner of DMH		11/29/16

**Appendix F:**  
**Levels of Observation**  
**Procedure**

# Vermont Psychiatric Care Hospital Procedure

## Levels of Observation

Revised: X

Date: 04/02/15

### I. Observation Generally

1. All patients shall be monitored by direct visual observation by an assigned staff person at least every thirty (30) minutes. Observations may be performed within five (5) minutes before, or five (5) minutes after the thirty (30) minute time periods pre-printed on the observation forms.

Staff members must have direct observation of patients without any artificial barrier (e.g. a window, curtain, or viewing by camera) between the staff and the patients except while the patient is dressing, showering and toileting. During these times the assigned staff may monitor the patient through auditory contact.

2. A patient's physician may order a more intensive level of observation as defined herein. Physicians shall consider the trauma history of a patient and the trauma that may result from intensive observation prior to ordering a more intensive level of observation. Assigned nursing staff shall check the patient and monitor the patient as per the physician order. The physician order shall include the reason for the increased level of observation and how closely to observe the patient.
3. The Levels of Observation Policy and Procedure does not apply to observation of patients in seclusion. Patients in seclusion shall be observed as described in the *Emergency Involuntary Procedures Policy and Procedure*.

- II. **Admission: All patients shall be observed 1:1 or every fifteen (15) minutes ("15 minute checks") upon admission.** There must be a physician's order to formally discontinue 1:1 observation or 15-minute checks.

- III. **Fifteen (15) minute checks:** Under an order for 15-minute checks, when the patient is on the unit, the patient shall be observed at least every 15 minutes and a record of patient behavior will be kept by the assigned staff member. The assigned staff member must have visual contact with the patient and not simply assume he or she knows where the patient is on the unit. Observations may be performed within five (5) minutes before, or five (5) minutes after the fifteen (15) minute time periods pre-printed on the observation forms.

- A. The Nursing Supervisor will assign specific staff to do 15-minute checks and will orient the assigned staff member to the patient and the purpose of the level of observation. It is the responsibility of the assigned staff member to report any observed changes in behavior to the Nursing Supervisor.
- B. An RN may initiate 15-minute checks while waiting for the patient to be evaluated by the MD.
- C. A Fifteen (15) Minute Check Flow Sheet must be kept and filed in the Medication/Treatment Section of the chart when completed. These may be thinned from the chart and sent to the old record in Medical Records.

**IV. Constant Observation I and II (CO I and CO II) and Close Supervision (CS). The physician's order will specify whether the observation is CO I, CO II or CS as defined below and shall include a rationale for the CO and why a less restrictive alternative is not clinically justified. The physician's order will also indicate whether the CO is 2:1 or 1:1.**

**Constant Observation I (CO I).** Under an order for CO I, the patient shall be constantly observed and generally within an arm's length plus ten (10) inches from the assigned staff at all times when the patient is awake and out of his or her room. When the patient is in his or her room, assigned staff shall observe the patient from the doorway of the patient's room.

**Constant Observation II (CO II).** Under an order for CO II, the patient is constantly observed and generally within up to eight (8) feet from the assigned staff at all times when the patient is awake and out of his or her room. When the patient is in his or her room, assigned staff shall observe the patient from the doorway of the patient's room.

**Close Supervision (CS).** Under an order for CS, the patient is constantly observed and generally within up to eight (8) feet from the assigned staff at all times except while the patient is dressing, showering and toileting. During these times the assigned staff shall stay as close as possible to the patient and remain in auditory contact.

An order may specify when CO or CS is to be in effect, and when CO or CS is not to be in effect. If the order does not specify certain time periods, then the observation is to be applied continuously.

**Intermittent CO I, CO II and CS.** A physician may write an order indicating the specific intermittent situation when the patient shall be observed continuously (e.g. while in room, while out of room). The order shall state the type of constant observation required. During interval periods when constant observation is not required by the order, the patient shall be on 15 minute checks. When intermittent 1:1 observation is ordered, a 1:1 staff must remain assigned to that patient during the intervals when constant observation is not required. During those interval periods, the assigned 1:1 staff shall complete and document the 15 minute checks on the constant observation documentation sheet.

Intermittent constant observation may also be ordered for discrete periods of time (such as during yard group or during activities in the group room). These constant observations shall be recorded on an individual constant observation sheet by the assigned 1:1 staff. At the conclusion of these discrete periods of 1:1 observation, the patient shall be on 15 minute checks and the assigned 1:1 staff shall complete and document the checks on the constant observation documentation sheet.

**Orders for Constant Observation.** Under an order for **CO I** or **CO II**, the patient is constantly observed either by one assigned staff (1:1) or two assigned staff (2:1) as follows:

1. The assigned nursing staff shall keep the patient within constant visual observation, as directed by the physician's order. CO means that if the patient is showering, using the toilet or getting dressed or undressed, they must be observed. The staff doing the CO must be able to see an unobstructed (other than by the patient's own body positioning) view of the patient's body length, not just a part of their body. If the patient has an opposite gender staff assigned to him or her, the staff member should arrange to have a same gender staff observe the patient while dressing and go into the bathroom with the patient.
2. The assigned staff may observe the patient from the doorway of the patient's room when the patient is in his or her room but must maintain constant visual observation.
3. **When the patient is asleep in his or her room:**
  - a) If the door is closed, the staff member doing observation must open the door in order to observe the patient.
  - b) The assigned staff must be able to count the patient's respirations.
  - c) A physician may order that the assigned staff must be able to see the patient's hands when the patient is in bed and/or asleep.

**Orders for Close Supervision.** Under an order for **close supervision (CS)** the patient shall be constantly observed by at least one assigned staff as follows:

The assigned staff shall keep the patient within constant visual observation at all times, **except when the patient is dressing, showering and toileting.** During these times, the assigned staff shall stay as close as possible to the patient and remain in auditory contact. At all other times, the assigned staff must be able to see an unobstructed (other than by the patient's own body positioning) view of the patient's body length, not just a part of the body.

The assigned staff may observe the patient from the doorway of the patient's room when the patient is in his or her room but must maintain constant visual observation.

**When the patient is asleep in his or her room:**

The staff member doing observation must open the door in order to observe the patient carefully.

The assigned staff must be able to count the patient's respirations.

A physician may order that the assigned staff must be able to see the patient's hands when the patient is in bed and/or asleep.

During unit emergencies: A physician's order for CS may include allowance for assigned staff to respond to unit emergencies.

- A. When a patient exhibits a change in behavior that may indicate an increased risk of harm to self or others, a RN may assess the patient's status and place him or her on CO I or CO II or CS. The RN shall notify the patient's physician of the patient's change in status. The physician shall see and assess the patient within one hour and determine whether the level of observation should be continued or otherwise modified.
- B. If the physician does not continue the order for CO or CS and the Nursing Supervisor disagrees with the physician's discontinuation order, the Nursing

Supervisor shall contact the Director of Nursing and the Medical Director to review the situation.

- C.** The Nursing Supervisor shall assign specific staff to do CO or CS, and shall orient the assigned staff to the patient and the purpose of the level of observation. It is the responsibility of the assigned staff to review the Constant Observation Assignment Sheet and report to the Nursing Supervisor on changes in the patient's condition. The Constant Observation Assignment sheet must be kept and filed in the Medication/ Treatment section of the patient's chart when completed. These may be thinned from the chart from time to time and sent to the older record in Medical Records.
- D.** The staff assignment for CO and CS shall not exceed four (4) consecutive hours per patient, at which time another staff member shall be assigned to take over. When the assignment changes, the new assigned staff shall immediately review the Constant Observation Assignment Sheet.
- E.** CO and CS can be discontinued only with a physician's order, except when a patient is released from seclusion or restraint. Patients released from seclusion or restraint who were on an order for CO I, CO II, or CS prior to the seclusion or restraint shall remain on that level of observation until discontinued by a physician. Prior to any order to discontinue CO or CS, the physician must conduct and document a risk assessment.
- F.** When a physician orders that a patient be placed on CO or CS as a result of assaultive or self injurious behavior, staff shall conduct a patient search and a thorough room search to ensure that the patient does not possess any restricted items. *See Restricted Items and Search Policy and Procedure.*
- G.** No patient may be discharged from VPCH while on an order for CO I, CO II or CS unless the attending physician has conducted and documented a risk/benefit analysis in the progress note.

Approved by	Date
Frank Reed, Commissioner of DMH	April 2, 2015

**Appendix G:**  
**Levels of Autonomy**  
**Procedure**

# Vermont Psychiatric Care Hospital Procedure

## Levels of Autonomy and Supervision

Revised: X

Date: 07/09/15

### DEFINITIONS:

“Secure Areas” refers to the unit, recovery services area including the secure yard areas.

“Unit” refers to an inpatient unit.

### The “Levels of Autonomy and Supervision” are defined as follows:

- Level 1**      **Restricted to the Unit:** A patient may not leave the unit except to attend legal proceedings or medical appointments. *See Transport Policy and Procedure.*
- Level 2**      **Restricted to Secure Areas:** A patient may be escorted to the staffed yard or any secure area, as well as attending legal proceedings or medical appointments. A patient may participate in groups and activities in staffed secure areas.
- Level 3**      **Supervised Off-Secure Area:** A patient may leave the hospital accompanied by authorized personnel.

### CONSIDERATIONS/REQUIRED STEPS:

#### I. LEVELS OF AUTONOMY AND SUPERVISION DETERMINATIONS

- A. At the time of admission, all patients shall be assigned to Level 1 (Restricted to the Unit), unless a physician assesses the patient in consultation with the Nursing Supervisor and writes an order designating that the patient be assigned to Level 2 (Restricted to Secure Areas).
- B. Following admission, the attending physician, after consultation with the patient and members of the patient’s treatment team, will be responsible for setting the patient’s level of autonomy and supervision and for reviewing and documenting the level on a daily basis. Level of autonomy and supervision determinations shall be accompanied by a physician’s order and based upon a documented individualized risk of harm assessment.
- C. Following any order for an emergency involuntary procedure, any late return from an off-unit activity or, return from elopement status, a patient will immediately be assigned to Level 1 (Restricted to the Unit), until the attending physician in consultation with the patient and members of the patient’s treatment team order the patient to a higher level of autonomy and supervision.



## **II. STAFF LEVELS OF SUPERVISION IN THE YARD**

1. When escorting patients off the secure areas, staff shall ensure that the patient to staff ratio is as follows:
  - i. For 1 patient = 1 staff, only with physician order.
  - ii. For 1 to 5 patients = 2 staff;
  - iii. For 6 to 8 patients = 3 staff.

See also *VPCH Escorting Patients Policy and Procedure*.

## **III. MAIL**

Every patient is entitled to “communicate by sealed mail or otherwise with persons, including official agencies, inside or outside the hospital.” A patient’s right to communication and visitation shall not be restricted unless the Vermont Psychiatric Care Hospital (VPCH) Chief Executive Officer “determines that it is necessary for the medical welfare or needs of the patient or the hospital to impose restrictions.”

Notwithstanding any restrictions imposed pursuant to 18 V.S.A. § 7705 on a patient’s right of communication, every patient is entitled to communicate by sealed mail with the “board, the Commissioner, his [or her] attorney, his [or her] clergyman and the district judge, if any, who ordered his [or her] hospitalization.”

The VPCH Chief Executive Officer has delegated the authority to impose restrictions on communication and visitation to medical staff, as clinically warranted and in a manner consistent with the purposes of this policy.

### **A. Sending Mail.**

Patients without funds may mail up to seven letters per week at hospital expense.

Every piece of outgoing mail must be properly return-addressed and sealed. Letters without a return address will be returned to the unit for correction. Letters with illegible addresses or without valid mailing addresses will not be considered bona fide mail and shall be returned to the patient.

If correspondence is found in an area other than a patient's room and is not in an envelope, it shall be returned to the patient.

Writing implements shall be available to patients, with the level of individual supervision necessary at staff discretion based upon safe use.

If a patient’s use of the mail becomes excessive or problematic, the patient’s treatment team shall discuss the issue with the patient and set appropriate limits.

If an individual contacts the Hospital to request that he or she not receive correspondence from a particular patient, staff shall document and evaluate that request in the patient's chart.

If the patient's behavior warrants limiting his or her use of the mail, the rationale for imposing such limits shall be documented in the patient's clinical records. Limitations on mail use must be reviewed for continuing necessity by the treatment team on a weekly basis. Where the patient or interested third parties request such a review, the treatment team shall initiate it the next business day.

#### **B. Receiving Mail.**

Staff shall examine and may open all incoming mail in front of the patient to whom it is addressed in order to screen it for dangerous items or valuables that should be stored. Staff shall not read the patient's correspondence or otherwise unnecessarily invade the patient's privacy.

### **IV. TELEPHONE USE**

A patient telephone is available on the unit. Local calls from this telephone are free. Staff will assist patients in making long distance calls.

Patients are permitted to use the telephones between the hours of 0700 and 2200 hours. Because the patient telephone is shared, calls from this phone may be limited to ten minutes to allow other patients time on the phone.

Patients may refuse to receive phone calls.

If the patient's behavior warrants limiting his or her use of the telephone, the rationale for imposing such limits shall be documented in the patient's clinical records. Limitations on telephone usage must be reviewed for continuing necessity by the treatment team on a weekly basis. Where the patient or interested third parties request such a review, the treatment team shall initiate it the next business day. Phone use may be limited or supervised if a patient makes abusive, obscene, threatening, legally prohibited, or what can be considered harassing.

A patient whose phone access has been restricted will always be allowed to contact their attorneys, Disability Rights Vermont, the Patient Representative, clergy, health care agent, guardian, or family members who wish to receive calls.

### **V. PATIENT ACCESS TO VISITORS**

The Vermont Psychiatric Care Hospital encourages patients to receive visitors. Except where the patient's treatment team finds visits by a specific individual to be clinically contraindicated, or where an individual visitor fails to abide by the rules set forth in the *VPCH Visitors Policy and Procedure*, patients shall be permitted to receive visits from anyone with whom they wish to meet.

There are two kinds of visits at VPCH:

1. **Supervised** – a visit that takes place on the unit, under the visual observation of a staff member.
2. **Unsupervised** – a visit occurring on the unit, without staff in close attendance.

When necessary, visits may be limited to 30 minutes.

Each patient's treatment team shall determine, in consultation with the patient, whether safety considerations or clinical need warrant supervised visits. The treatment team must document the rationale for this determination in the patient's clinical record. The treatment team shall review any restrictions on a patient's right to receive visitors. A patient or visitor may request the treatment team reconsider its determination at any time.

As outlined in the *VPCH Visitors Policy and Procedure*, representatives of Disability Rights Vermont and the Patient Representative have a right to reasonable unaccompanied access to all VPCH patients. A lawyer who represents the patient has a right to meet privately with that patient in any area of the inpatient unit. All other visitors on the unit are restricted to the visiting areas. Except for visits by representatives of Disability Rights Vermont, the Patient Representative, and a lawyer who represents a specific patient, visitors who may have reason to access the main patient care unit (e.g., advocates, licensing inspectors, non-VPCH clinicians, external maintenance contractors) will be escorted by a unit nurse or designee.

## **VI. YARD ACCESS**

1. All patients may access the yard except for those patients who have been restricted to the unit by their Treatment Team, pursuant to the procedures outlined in this policy.
2. The yard will be open to patients for at least thirty minutes per day unless weather conditions create an unreasonable risk to health or safety.
3. Patients must be dressed appropriately for weather conditions and, when necessary, shall be assisted in getting access to necessary clothing.
4. The yard will remain open unless the hospital's ability to maintain safety and security of patients and staff both on the unit and in the yard is adversely affected.
5. The patient-to-staff ratio will never be greater than five patients to every staff member in the yard, always with a minimum of two staff present.
6. Staff in the yard will carry a two-way radio at all times.
7. A patient who refuses to return to the unit will be restricted to the unit until reevaluated for risk by his or her Treatment Team.

### **Related Policies and Procedures:**

*Escorting Patients Policy and Procedure*

*Patient Transport Policy and Procedure*

*Volunteer Policy*

*Visitors Policy and Procedure*  
*Restricted Items and Search Policy and Procedure*

<b>Approved by</b>	<b>Date</b>
<b>Frank Reed, Commissioner of DMH</b>	<b>July 9, 2015</b>

**Appendix H:**  
**Two Way Radios and Cell  
Phone Procedure**

# Vermont Psychiatric Care Hospital Procedure

## Two-Way Radios and Cell Phones

Revised: X

Date: 07/31/18

Two-way radios and cell phones are provided for staff communication at the Vermont Psychiatric Care Hospital (VPCH).

VPCH uses three different models of 2-way radios.

- **PKT 23-** These radios are the smallest, most portable option and are intended to be utilized by direct care staff for activities, groups and yard time. This radio will only operate on one channel and cannot be placed in a stand-by “silent” mode.
- **TK3360** – These radios are the medium sized handhelds which have the orange button on the side located above the “push to talk” (PTT) button. The orange button can be held for three continuous seconds to activate the 3-click paging system (see 3-Click Paging System below) These radios are intended to be used by the Charge RN on each unit, so they are able to use the orange button to initiate an emergency notification to all radios in the hospital. These radios can be placed in “stand-by” mode by utilizing the Channel 2.
- **TK3302U-** These radios are the largest radio model used at VPCH and are equivalent to the TK3360 minus the orange button feature.

The Facility Operations Coordinator is responsible for the overall management of VPCH-provided two-way radios and cell phones. The cell phones and radios shall be inspected annually, and the results shall be documented in the Emergency Management Inventory.

### Two-Way Radios

Two-way radios shall be stored in a docking station.

#### Proper Use of a Two-Way Radio:

1. Ensure the radio is functioning properly
  - a. Conduct a radio check with a co-worker by pressing the “push to talk” (PTT) button on the side or front of the radio
  - b. Only use the radio if it successfully transmits and receives a transmission via the radio check with a co-worker
  - c. Two-way radios shall be tested for functionality each time they are used.
2. To send a transmission, press firmly on the PTT button and wait a moment before speaking
  - a. Hold the radio 6-10 inches away from your mouth and speak clearly
  - b. After you finish speaking, hold the PTT button for a few seconds, then release
3. Prior to responding to a transmission, give a brief pause and then repeat step two above.

**Medical and psychiatric emergencies shall immediately be announced over the two-way radio prior to using the 3-click paging system.** State the location and type of emergency using step two of “Proper Use of a Two-Way Radio.” State the location and type of emergency twice to ensure that your transmission is understood.

### 3-Click Paging System

VPCH radios have a 3-click paging system that can be initiated from any radio at any location in the hospital. When the 3-click system is activated it will “wake-up” the TK3360’s and the TK3302U’s that are on the standby channel. Those radios will then begin to receive all radio transmissions until placed back into standby mode. This system immediately delivers an emergency notification to multiple areas throughout VPCH.

**To activate the 3-click paging system** press the PTT button 3 times in a row with a slight pause in between each press. It may be helpful say to yourself, “**one and two and three**” as you press the button when you say each number. The paging system must receive 3 PTT clicks within a 5 second period to activate a successful alert tone.

If the system receives more than 3 PTT attempts in a 5 second period, it will activate a tone of increasing pitch for 3-4 seconds that informs the user that the 3-click entry was unsuccessful and other radios were not “awakened from stand-by mode.” If the system does not activate the alert tone the user should make another attempt. When successful, page tones will sound on all radios.

The Emergency line 828-6777 can be used in conjunction with the 3-click paging system as needed to notify Admissions staff any time there is an emergency at VPCH.

### Cell Phones

Cell phones shall be issued to the following staff members when on duty:

- a) Nursing Supervisors
- b) Charge Nurses
- c) Staff members escorting patients into the community

Before providing a phone to a staff member escorting a patient into the community, a member of the Admissions staff shall test each cell phone for battery charge and functionality and document the results on a white board in Admissions.


Each Nursing Supervisor and Charge Nurse shall ensure that their cell phone is charged and functioning while on duty.

### Addressing Concerns or Problems

Problems or concerns regarding two-way radios and cell phones shall be documented on an Environmental Variance Report Form and reported immediately to the Nursing Supervisor on duty. If available, notify the Facilities Operations Coordinator as well.

### Repair and Routine Maintenance

Two-way radios and cell phones shall be maintained consistent with the manufacturer’s recommendations and replaced as necessary.

Approved by	Signature	Date
Melissa Bailey, Commissioner of DMH		7/31/18

**Appendix I:**  
**Emergency Involuntary**  
**Procedures Administrative**  
**Rule**



REGULATION  
ESTABLISHING STANDARDS  
FOR  
EMERGENCY INVOLUNTARY PROCEDURES

Agency of Human Services  
Department of Mental Health

Effective 90 days from date of adoption

These materials will be made available in alternative formats upon request.

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## **Section 1. General Provisions**

### **1.1 Introduction**

- a. The Vermont Department of Mental Health is committed to establishing and maintaining treatment environments on psychiatric units in designated and state-operated hospitals that are safe, clinically effective, and non-violent. Hospital staff providing treatment for involuntary patients must be trained in non-physical, non-coercive skills and attitudes that emphasize the prevention of emergencies.
- b. The designated hospitals shall continually explore ways to prevent, reduce, and strive to eliminate restraint, seclusion, and emergency involuntary medications through education, training, and effective performance improvement initiatives.
- c. The Department of Mental Health shall ensure that emergency involuntary procedures on psychiatric units are used only in emergency situations in accordance with generally accepted professional standards of care and the standards established by this rule. The Department of Mental Health also shall ensure that emergency involuntary procedures are used as safety measures of last resort. The standards for the use of emergency involuntary procedures are being implemented with the intention of preventing or minimizing violence in a manner consistent with the principles of recovery and cognizant of the impact of trauma in the lives of many hospitalized individuals. The standards are designed to protect and promote each patient's rights while at the same time protecting patients and others from harm.
- d. The Department of Mental Health has established these standards to meet or exceed and be consistent with standards set by the Centers for Medicare and Medicaid Services and the Joint Commission, as well as rights and protections that reflect evidence-based best practices aimed at reducing the use of emergency involuntary procedures of seclusion, restraint or emergency involuntary medication on individuals in the custody or temporary custody of the Commissioner of the Department of Mental Health. In addition, the standards require the personnel performing emergency involuntary procedures to receive training and demonstrate competency in the use of these procedures.
- e. These rules apply to adults and children in the custody or temporary custody of the Commissioner of Mental Health who are admitted to a psychiatric inpatient unit.

### **1.2 Statutory Authority**

These rules are adopted pursuant to the 2012 Acts and Resolves No. 79, Sec. 33a, as amended by 2015 Acts and Resolves No. 21.

### 1.3 Exception and Severability

If any provision of these regulations, or the application of any provision of these regulations, is determined to be invalid, the determination of invalidity will not affect any other provision of these regulations or the application of any other provision of these regulations.

## Section 2. Definitions

### 2.1 General Definitions

For the purposes of these regulations, words and phrases shall be given their normal meanings unless otherwise specifically defined.

### 2.2 Specific Definitions

- a. **Advanced Practice Registered Nurse** means a licensed registered nurse authorized to practice in Vermont who, because of specialized education and experience, is authorized to perform acts of medical diagnosis and to prescribe medical, therapeutic or corrective measures under administrative rules adopted by the Vermont Board of Nursing.
- b. **Depot Medication** means a chemical form of certain anti-psychotic medication that is injected intra-muscularly and allows the active medication to be released over an extended time frame.
- c. **Designated Hospital** means a hospital or other facility designated by the Commissioner of the Department of Mental Health as adequate to provide appropriate care for patients with mental illness.
- d. **Emergency** means an imminent risk of serious bodily harm to the patient or others.
- e. **Emergency Involuntary Medication** means one or more medications administered against a patient's wishes without a court order. See also restraint, below.
- f. **Emergency Involuntary Procedures (EIP)** means restraint, seclusion or emergency involuntary medication.
- g. **Emergency Involuntary Procedures Review Committee** means a committee appointed by the Commissioner of the Department of Mental Health to review emergency involuntary procedures involving individuals in the custody of the Commissioner of the Department of Mental Health in Vermont.

- h. **Licensed Independent Practitioner** means a physician, an advance practice registered nurse licensed by the Vermont Board of Nursing or a physician assistant licensed by the Vermont Board of Medical Practice.
- i. **Non-Physical Intervention Skills** mean strategies and techniques of communication or interaction that do not involve physical contact, such as active listening, conversation and recognition of an individual's personal, physical space, and that include a willingness to make adjustments for the individual's needs.
- j. **Physician Assistant** means an individual qualified by education and training and licensed by the Vermont Board of medical practice to whom a physician can delegate medical care. A physician assistant may prescribe, dispense, and administer drugs and medical devices to the extent delegated by a supervising physician.
- k. **PRN Order** means a standing order, an abbreviation of the Latin term *pro re nata*, meaning "as needed" or "as circumstances require."
- l. **Restraint** means any manual method, physical hold or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely, or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's condition.
- m. **Seclusion** means the involuntary confinement of a patient alone in a room or area from which the patient is physically or otherwise prevented from leaving.
- n. **Specially Trained Registered Nurse** means a registered nurse (RN) who has been trained to conduct an assessment of a patient for whom one or more emergency involuntary procedures have been ordered in accordance with the requirements specified in Section VI.

### **Section 3. Emergency Involuntary Procedures**

#### **3.1 General Policy**

- a. All patients have the right to be free from physical or mental abuse, including corporal punishment. All patients have the right to be free from restraint, seclusion, or involuntary medication imposed as a means of coercion, discipline, convenience or retaliation by staff or used as part of a behavioral intervention, and the right to have their care be trauma-informed.
- b. Upon admission or at the earliest reasonable time, with the patient's permission, staff shall work with the patient and his or her family, caregivers, and health care agents (if any) to

identify strategies that might minimize or avoid the use of emergency involuntary procedures.

1. Staff shall obtain written permission from the patient to contact the patient's family. The permission sheet shall state that a patient may refuse to give staff permission to speak with family members.
  2. Staff shall also discuss the patient's preferences regarding the use of such procedures should they become necessary. Although the hospital is not obligated to follow the patient's preferences, patient preference shall be considered when determining the least intrusive and least restrictive emergency involuntary procedure to use to address the imminent risk of harm. The information about the patient's preferences shall be made accessible to direct care staff to refer to when a patient is exhibiting signs of escalation.
  3. Staff shall inquire about the existence of an advanced directive with the patient or his or her guardian and also shall check the Advanced Directive Registry. If an advanced directive exists, a copy shall be placed in the patient's medical record and staff shall be made aware of it and shall refer to it with regard to emergency involuntary procedures, if applicable.
- c. Emergency involuntary procedures may only be used to prevent the imminent risk of serious bodily harm to the patient, a staff member or others and must be discontinued at the earliest possible time based on an individualized patient assessment and re-evaluation. Whenever feasible, a patient shall be offered an opportunity to cooperate before and during an emergency involuntary procedure.
  - d. The decision to use emergency involuntary procedures is not driven by diagnosis, but by an individual patient assessment.
  - e. Emergency involuntary procedures may be used only when other interventions have been attempted and been unsuccessful or when they have been considered and determined to be ineffective, or when a patient is attempting to cause serious bodily harm to him or herself or to others and immediate action is necessary.
  - f. The use of seclusion or restraint may be initiated by a trained registered nurse or a licensed independent practitioner who has personally observed the emergency. An individual who is not licensed to prescribe medication may not initiate emergency involuntary medication. Staff members trained in accordance with section 6.2 (below) may initiate a manual restraint if a patient is attempting to cause serious bodily harm to self or others and immediate action is necessary.
  - g. The use of emergency involuntary procedures shall be documented. The documentation shall include a description of specific behaviors justifying the use of the procedures.

- h. Patients shall be specifically informed that they have a right to have an attorney, other designee, or specified individual notified when emergency involuntary procedures are used.
- i. Every effort shall be made not to use uniformed security guards when implementing emergency involuntary procedures. When security guards are used, documentation shall substantiate the need for such response after initial response by staff is assessed as not being sufficient to prevent the imminent risk of serious bodily harm to patients and staff.
- j. There shall be no protocol, written or unwritten, that requires a patient to ingest oral PRN medications as a condition to release from seclusion or restraint.
- k. Hospitals shall not use law enforcement officers to implement emergency involuntary procedures. Firearms, electronic control devices, pepper spray, mace, batons and other similar law enforcement implements shall not be used to implement emergency involuntary procedures. The only permissible use of such devices is for the purpose of law enforcement.

### **3.2 Use of Emergency Involuntary Procedures**

The use of emergency involuntary procedures must be:

- a. In accordance with a written modification to the patient's plan of care; and
- b. Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with this rule.

### **3.3 Orders for Emergency Involuntary Procedures**

- a. The use of emergency involuntary procedures must be in accordance with the order of a licensed independent practitioner as defined in this rule who is responsible for the care of the patient and authorized to order seclusion, restraint, or emergency involuntary medication by hospital policy.
- b. If, on the basis of personal observation, any trained staff member believes an emergency exists, a licensed independent practitioner or specially trained registered nurse shall be consulted immediately.
- c. A protocol cannot serve as a substitute for obtaining a physician's or other licensed independent practitioner's order for each episode of emergency involuntary procedure use.



- d. Orders for the use of emergency involuntary procedures must never be written as a standing order or on an as-needed (PRN) basis.

### **3.4 Timeframes for Emergency Involuntary Procedures**

- a. The order for restraint or seclusion must be obtained either during the emergency application of the restraint or seclusion or immediately after the restraint or seclusion has been applied.
- b. The attending physician who is responsible for the management and care of the patient must be notified as soon as possible if the attending physician did not order the emergency involuntary procedure. The notification may occur via telephone.
- c. When an order for emergency involuntary procedure has been obtained pursuant to subsection (a) above, the patient must be seen face-to-face within 1 hour after the initiation of the intervention by a licensed independent practitioner or a specially trained registered nurse. The specially trained registered nurse must consult the licensed independent practitioner who is responsible for the care of the patient as soon as possible after completing the face-to-face assessment. The assessment must evaluate:
  - 1. The patient's immediate situation;
  - 2. The patient's reaction to the intervention;
  - 3. The patient's medical and behavioral condition; and
  - 4. The need to continue or terminate the emergency involuntary procedure.
- d. If the continued use of restraint or seclusion is deemed necessary based on an individualized patient assessment, another order is required. No order for restraint or seclusion shall exceed 2 hours for adults and for children and adolescents older than 9 years of age or 1 hour for children under 9 years of age.
- e. The licensed independent practitioner who is responsible for the care of the patient must see and assess the patient before writing a new order for the use of restraint or seclusion if the patient has been in seclusion or restraint for 12 hours.

### **3.5 Observation and Assessment**

- a. The condition of the patient who is restrained or secluded must be observed by staff who is trained and competent to perform this task at an interval determined by the licensed independent practitioner but no less often than every fifteen (15) minutes.

- b. The patient shall be monitored by a licensed independent practitioner or by a specially trained registered nurse to determine the continued need for the emergency involuntary procedure.
- c. Hospital policies are expected to guide staff in determining appropriate intervals for assessment and monitoring based on the individual needs of the patient, the patient's condition, and the type of restraint or seclusion used, but no less often than every fifteen (15) minutes. Any such policy shall be reviewed as part of the hospital designation process.
- d. Depending on the patient's needs and situational factors the use of restraint or seclusion may require either periodic or continual monitoring and assessment.
- e. Hospitals shall debrief staff following every incident involving the use of emergency involuntary procedures. Hospitals also shall give patients reasonable opportunities to debrief within 24 hours of the resolution of every such incident. The debriefing shall include, at a minimum, the elements required by the Department of Mental Health.

### **3.6 Documentation of Emergency Involuntary Procedures**

- a. The use of all emergency involuntary procedures, including any determination made in accordance with 3.7 below, must be documented in the patient's medical record in accordance with the standards set out in the CMS Conditions of Participation, which are incorporated herein by reference.
- b. The Commissioner of the Department of Mental Health shall specify the elements each hospital must document for each emergency involuntary procedure order for patients in the custody of the Commissioner for the purposes of departmental oversight and review.
- c. Hospitals shall submit the documentation on at least a monthly basis to the Commissioner.
- d. The test of adequacy of documentation is whether an independent qualified mental health professional could readily verify from such documentation the factual basis for and the medical necessity of the prescribed action, as well as its involuntary administration. The elements of adequacy shall enable the reviewer to determine whether relevant standards, policies and regulations were complied with, including:
  - 1. The necessity for the action taken to control the emergency;
  - 2. The expected or desired result of the action on the patient's behavior or condition;
  - 3. Whether alternatives were considered or used, and why they were ineffective to prevent the imminent risk of serious bodily harm;
  - 4. The risks of adverse side effects; and

5. When used in combination, the basis for the determination by the licensed independent practitioner that the use of a single emergency involuntary procedure would not have been effective to prevent the imminent risk of serious bodily harm.

### **3.7 Use of Emergency Involuntary Procedures in Combination**

Emergency involuntary procedures may be used in combination only when, in the clinical judgment of the licensed independent practitioner, a single emergency involuntary procedure has been determined to be ineffective to protect the patient, a staff member, or others from the imminent risk of serious bodily harm.

- a. An assessment of the patient must determine that the risks associated with the use of a combination of emergency involuntary procedures are outweighed by the risk of not using a combination of emergency involuntary procedures.
- b. Other interventions do not always need to be tried, but they must be considered by the practitioner to be ineffective to protect the patient or others from the imminent risk of serious bodily harm.
- c. The use of restraint only for the purpose of administering a court-ordered involuntary medication is not considered the use of a combination of emergency involuntary procedures.

## **Section 4. Additional Requirements for Emergency Involuntary Procedures**

### **4.1 Emergency Involuntary Medication**

- a. Emergency involuntary medication shall only be ordered by a psychiatrist, an advanced practice registered nurse licensed by the Vermont Board of Nursing in psychiatric nursing, or a certified physician assistant licensed by the State Board of Medical Practice and supervised by a psychiatrist.
- b. Personal observation of an individual prior to ordering emergency involuntary medication:
  1. Shall be conducted by a certified physician assistant licensed by the State Board of Medical Practice and supervised by a psychiatrist if the physician assistant is issuing the order.
  2. May be conducted by a psychiatrist or an advanced practice registered nurse licensed by the Vermont Board of Nursing in psychiatric nursing if the psychiatrist or advanced practice registered nurse is issuing the order. If a psychiatrist or advanced practice registered nurse does not personally observe the individual prior to ordering

emergency involuntary medication, the individual shall be observed by a registered nurse trained to observe individuals for this purpose or by a physician assistant.

- c. Emergency involuntary medication shall be used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the patient's distress.
- d. When necessary to administer involuntary medication by injection in emergency situations, a non-depot medication that is consistent with current American Psychiatric Association practice guidelines shall be used.
- e. When the use of emergency involuntary medication has been ordered, the patient shall be offered oral medication prior to the implementation of the order.
- f. If possible and where clinically appropriate the hospital shall give the patient a choice of injection sites and shall follow that preference if medically safe.
- g. A patient who has received emergency involuntary medication shall be monitored for adverse effects at least every 15 minutes for as long as clinically indicated following the administration of emergency involuntary medication. Each observation shall be documented.

#### **4.2 Seclusion**

- a. The placement of a patient in seclusion and the duration of its use shall be kept to a minimum, consistent with the safe and effective care of patients. The use of seclusion shall adequately accommodate a patient's physical and environmental needs without undue violation of his or her personal dignity.
- b. Seclusion is not just confining a patient to an area, but involuntarily confining the patient alone in a room or area where the patient is physically prevented from leaving. If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether the door is actually locked or not.
- c. Only a licensed independent practitioner may order seclusion of a patient.
- d. Within one hour of the initiation of the procedure, individuals placed in seclusion shall be assessed by a licensed independent practitioner or specially trained registered nurse. If assessed by a specially trained registered nurse, that individual must consult the licensed independent practitioner who is responsible for the care of the patient as soon as possible after completing the assessment. This assessment must occur face-to-face and shall include, but not be limited to, an assessment of:

1. The individual's physical and psychological status;
  2. The individual's behavior;
  3. The appropriateness of the intervention measures;
  4. Any complications resulting from the intervention; and
  5. Whether the individual is aware of what is required to be released from seclusion.
- e. A patient in seclusion shall be observed continuously by a staff member who has successfully completed competency-based training on the monitoring of persons in seclusion and the observation shall be documented no less often than every fifteen (15) minutes.
  - f. At least hourly, a specially trained registered nurse must assess the continued need for the emergency seclusion intervention and document assessment and ongoing need for the intervention.
  - g. The seclusion shall be ended at the earliest possible time that the patient no longer is considered an imminent risk of serious bodily harm.

#### **4.3 Restraint**

- a. The involuntary placement of a patient in restraints shall occur only in emergency circumstances and in the least intrusive and least restrictive manner.
- b. Restraints are to be applied in the least intrusive and least restrictive manner, providing for padding and protection of all parts of the body where pressure areas might occur by friction from mechanical restraints.
- c. Patients in restraints shall be encouraged to take liquids, shall be allowed reasonable opportunity for toileting, and shall be provided appropriate food, lighting, ventilation and clothing or covering.
- d. Mechanical restraints shall not be used when the patient is in a prone position.
- e. Only a licensed independent practitioner may order the restraint of a patient.
- f. A licensed independent practitioner or specially trained registered nurse shall assess the patient within one hour of the application of the restraints. If assessed by a specially trained registered nurse, that individual must consult the licensed independent practitioner who is responsible for the care of the patient as soon as possible after completing the

assessment. This assessment must occur face-to-face and shall include, but not be limited to, an assessment of:

1. The individual's physical and psychological status;
  2. The individual's behavior;
  3. The appropriateness of the intervention measures;
  4. Any complications resulting from the intervention; and
  5. Whether the individual is aware of what is required to be released from restraint.
- g. A patient in restraints shall be observed continuously by a staff member who has successfully completed competency based training on the monitoring of persons in restraint. The observation shall be documented no less often than every fifteen (15) minutes.
- h. The restraint shall be ended at the earliest possible time that the patient no longer is considered an imminent risk of serious bodily harm.

## **Section 5. Notice Requirements**

### **5.1 Medical Record**

The hospital medical record shall include documentation about the use of emergency involuntary procedures. The record shall include all of the elements specified by the Department of Mental Health. Reports of the use of emergency involuntary procedures shall be sent to the Department of Mental Health on a monthly basis.

### **5.2 Guardian or Agent**

The court-appointed guardian of the patient and any health care agent of the patient under an advance directive that is in effect shall be notified of every emergency involuntary procedure(s) as soon as practicable but not later than twenty-four (24) hours from each application.

### **5.3 Other Notice**

The hospital shall inform patients about their right to have someone notified whenever an emergency involuntary procedure is applied to them. With the patient's consent, any person identified by the patient, including a health care agent, shall be notified of the use of emergency involuntary procedure(s) as soon as practicable but not later than twenty-four (24) hours from each application.

## **Section 6. Staff Training**

### **6.1 General**

The patient has the right to safe implementation of emergency involuntary procedures by trained staff.

### **6.2 Specific Training Requirements**

- a. Any staff members who participate in emergency involuntary procedures must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment (if applicable) and providing care for a patient in restraint or seclusion before performing any of the actions specified in this paragraph, as part of orientation and subsequently on a periodic basis consistent with hospital policy based upon the chosen seclusion and restraint methodology. Only staff members trained in seclusion and restraint procedures shall perform them.
- b. The hospital shall require staff who may implement emergency involuntary procedures to have education, training (both initial and on-going), and demonstrated knowledge based on the specific needs of the patient population in at least the following:
  1. The use of nonphysical intervention skills;
  2. Choosing an intervention based on an individualized assessment of the patient's medical or behavioral status or condition;
  3. The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress;
  4. Clinical identification of specific behavioral changes that indicate that emergency involuntary procedures are no longer necessary;
  5. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation;
  6. Individuals providing staff training must be qualified as evidenced by education, training, and experience in interventions used to address patients' behaviors; and
  7. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

8. The recognition of a patient's history in the provision of trauma-informed care and in a culturally sensitive manner, including, but not limited to, a history of sexual or physical assault or incest.
- c. Training for an RN or PA to conduct the 1-hour face-to-face evaluation shall include all of the training requirements in this section as well as an evaluation of the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the seclusion or restraint.
- d. The hospital shall provide trauma-informed training to staff who may implement emergency involuntary procedures.

### **6.3 Staff Competency**

The Department shall review the competency and training records of each hospital as part of the hospital designation process.

## **Section 7. Oversight and Performance Improvement**

### **7.1 Hospital Leadership Responsibilities**

Hospital leadership is responsible for creating a culture that supports a patient's right to be free from restraint or seclusion.

- a. Leadership must ensure that systems and processes are developed, implemented, and evaluated that support patients' rights and that eliminate the inappropriate use of emergency involuntary procedures.
- b. Each hospital shall report on the use of emergency involuntary procedures using measurement specifications identified by the Department of Mental Health using a format approved by the Department.
- c. Each hospital shall identify an internal performance improvement process for regularly meeting and reviewing its training, the adequacy of the documentation, and practice trends pertaining to emergency involuntary procedures with its local quality advisory body. Such meetings should occur at regular intervals. Information generated shall be used to inform the Emergency Involuntary Procedures Review Committee quarterly meetings.
- d. As part of its quality assurance performance improvement program, each designated hospital shall review and assess its use of emergency involuntary procedures to ensure that:
  1. Patients are cared for as individuals;



2. Each patient's condition, needs, strengths, weaknesses and preferences are considered;
3. Emergency involuntary procedures are used only to address the imminent risk of serious bodily injury to the patient, staff, and others;
4. Involuntary emergency procedures are discontinued at the earliest possible time, regardless of the length of the order;
5. When emergency involuntary procedures are used, de-escalation interventions were ineffective to protect the patient, a staff member, or others from harm; and

## **7.2 Medical Director Review**

a. As soon as practicable but no later than 2 working days following an order for an involuntary emergency procedure, the designated hospital unit's Medical Director, or his or her designee, shall review the incident.

b. The Medical Director of the Department of Mental Health, or his or her designee, shall review all orders of emergency involuntary procedures at least once every thirty (30) days.

## **7.3 Death Reporting**

- a. Hospitals must report deaths associated with the use of emergency involuntary procedures to the Commissioner of the Department of Mental Health by telephone no later than the close of business the next business day following knowledge of the patient's death.
- b. Staff must document in the patient's medical record the date and time the death was reported.
- c. The hospital must report the following information:
  1. Each death that occurs while a patient is in restraint or seclusion;
  2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion; and
  3. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.

## **Section 8. Emergency Involuntary Procedures Review Committee**

### **8.1 Membership**

- a. The Commissioner of the Department of Mental Health shall designate individuals to be the members of an Emergency Involuntary Procedures Review Committee (Review Committee).
- b. The Review Committee shall include representatives from the clinical staff of each of the designated hospitals, a representative from the clinical staff of a designated agency that provides services to individuals who have been hospitalized, staff from the Department of Mental Health, a representative from the Department of Disabilities, Aging and Independent Living's Division of Licensing and Protection, a peer and a person with lived mental health experience (who may be a peer or a family member). The clinical staff on the Review Committee shall be knowledgeable about the use of seclusion and restraint.

### **8.2 Function and Responsibilities**

- a. The purpose of the Review Committee is to ensure external review and oversight of emergency involuntary procedures.
- b. The Review Committee shall review aggregate data that has been prepared based on information received from the clinical leadership teams of the designated hospitals and the state-operated facility regarding all relevant orders of emergency involuntary procedures (involuntary medication, seclusion and restraint). The aggregate data shall be prepared by the Department of Mental Health in quarterly reports.
- c. The Review Committee shall meet quarterly to review the aggregate data submitted by the designated hospitals and the state-operated facilities.
- d. The Review Committee shall prepare an annual report summarizing its advisory work, providing suggestions and recommendations regarding adherence to these standards, including trends in the frequency in the use of emergency involuntary procedures, findings relative to compliance with the requirements for the use of such procedures, the need for staff training, and other related matters.
- e. A copy of the report shall be provided to the Commissioner of the Department of Mental Health. Copies of the report also shall be provided to the designated hospitals and members of the Review Committee.
- f. If a patient wishes to seek a review of the use of an emergency involuntary procedure, he or she may request the opportunity to appear before the Review Committee with regard to specific issues for consideration. Patients seeking review by the Review Committee may be accompanied by a person or persons of their own choosing. The patient review by the

Review Committee shall be treated as “peer review” and therefore as confidential and not subject to discovery.

1. The Committee shall review compliance with the procedures required by this rule, whether the rights, dignity and interests of the patient have been considered and protected, and the appropriateness of clinical decisions including the prescribed medication and its dosage, and the use and duration of seclusion and restraint.
2. The Review Committee shall review adherence to the requirements of the standards and the appropriateness of the decisions to use emergency involuntary procedures. The Review Committee shall make suggestions and recommendations to the Quality Management Director, the Medical Director and the Commissioner of the Department of Mental Health.
3. The Review Committee shall have access to all relevant records or other information needed to perform its reviews.
4. The Review Committee may request the attendance of any person it deems helpful to the review process, including hospital staff, patients, their attorneys, outside qualified mental health professionals or other chosen support persons, to its quarterly meetings.
5. Representatives of a facility with a specific case under review may participate in the discussion but shall take no other role in the Review Committee’s conclusions or recommendations.

1. The individual's physical and psychological status;
  2. The individual's behavior;
  3. The appropriateness of the intervention measures;
  4. Any complications resulting from the intervention; and
  5. Whether the individual is aware of what is required to be released from seclusion.
- e. A patient in seclusion shall be observed continuously by a staff member who has successfully completed competency-based training on the monitoring of persons in seclusion and the observation shall be documented no less often than every fifteen (15) minutes.
  - f. At least hourly, a specially trained registered nurse must assess the continued need for the emergency seclusion intervention and document assessment and ongoing need for the intervention.
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- c. Patients in restraints shall be encouraged to take liquids, shall be allowed reasonable opportunity for toileting, and shall be provided appropriate food, lighting, ventilation and clothing or covering.
- d. Mechanical restraints shall not be used when the patient is in a prone position.
- e. Only a licensed independent practitioner may order the restraint of a patient.
- f. A licensed independent practitioner or specially trained registered nurse shall assess the patient within one hour of the application of the restraints. If assessed by a specially trained registered nurse, that individual must consult the licensed independent practitioner who is responsible for the care of the patient as soon as possible after completing the

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- g. A patient in restraints shall be observed continuously by a staff member who has successfully completed competency based training on the monitoring of persons in restraint. The observation shall be documented no less often than every fifteen (15) minutes.
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  7. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

8. The recognition of a patient's history in the provision of trauma-informed care and in a culturally sensitive manner, including, but not limited to, a history of sexual or physical assault or incest.
- c. Training for an RN or PA to conduct the 1-hour face-to-face evaluation shall include all of the training requirements in this section as well as an evaluation of the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the seclusion or restraint.
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  1. Patients are cared for as individuals;

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3. Emergency involuntary procedures are used only to address the imminent risk of serious bodily injury to the patient, staff, and others;
4. Involuntary emergency procedures are discontinued at the earliest possible time, regardless of the length of the order;
5. When emergency involuntary procedures are used, de-escalation interventions were ineffective to protect the patient, a staff member, or others from harm; and

## **7.2 Medical Director Review**

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- c. The Review Committee shall meet quarterly to review the aggregate data submitted by the designated hospitals and the state-operated facilities.
- d. The Review Committee shall prepare an annual report summarizing its advisory work, providing suggestions and recommendations regarding adherence to these standards, including trends in the frequency in the use of emergency involuntary procedures, findings relative to compliance with the requirements for the use of such procedures, the need for staff training, and other related matters.
- e. A copy of the report shall be provided to the Commissioner of the Department of Mental Health. Copies of the report also shall be provided to the designated hospitals and members of the Review Committee.
- f. If a patient wishes to seek a review of the use of an emergency involuntary procedure, he or she may request the opportunity to appear before the Review Committee with regard to specific issues for consideration. Patients seeking review by the Review Committee may be accompanied by a person or persons of their own choosing. The patient review by the

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1. The Committee shall review compliance with the procedures required by this rule, whether the rights, dignity and interests of the patient have been considered and protected, and the appropriateness of clinical decisions including the prescribed medication and its dosage, and the use and duration of seclusion and restraint.
2. The Review Committee shall review adherence to the requirements of the standards and the appropriateness of the decisions to use emergency involuntary procedures. The Review Committee shall make suggestions and recommendations to the Quality Management Director, the Medical Director and the Commissioner of the Department of Mental Health.
3. The Review Committee shall have access to all relevant records or other information needed to perform its reviews.
4. The Review Committee may request the attendance of any person it deems helpful to the review process, including hospital staff, patients, their attorneys, outside qualified mental health professionals or other chosen support persons, to its quarterly meetings.
5. Representatives of a facility with a specific case under review may participate in the discussion but shall take no other role in the Review Committee’s conclusions or recommendations.

**Appendix J:**  
**Emergency Involuntary**  
**Procedures Procedure**

# Vermont Psychiatric Care Hospital Procedure

## Emergency Involuntary Procedures

Revised: X

Date: 01/08/15

### Definitions

- a. **Advanced Practice Registered Nurse** means a licensed registered nurse authorized to practice in Vermont who, because of specialized education and experience, is authorized to perform acts of medical diagnosis and to prescribe medical, therapeutic or corrective measures under administrative rules adopted by the Vermont Board of Nursing.
- b. **Depot Medication** means a chemical form of certain anti-psychotic medication that is injected intra-muscularly and allows the active medication to be released over an extended time frame.
- c. **Designated Hospital** means a hospital or other facility designated by the Commissioner of the Department Mental Health as adequate to provide appropriate care for patients with mental illness.
- d. **Emergency** means an imminent risk of serious bodily harm to the patient or others.
- e. **Emergency Involuntary Medication (EIM)** means one or more medications administered against a patient's wishes without a court order.
- f. **Emergency Involuntary Procedures (EIP)** means restraint, seclusion or emergency involuntary medication.
- g. **Emergency Involuntary Procedures Advisory Panel** means a panel appointed by the Commissioner of the Department of Mental Health to review emergency involuntary procedures involving individuals in the custody of the Commissioner of the Department of Mental Health in Vermont.
- h. **Licensed Independent Practitioner** means a physician, an advanced practice registered nurse licensed by the Vermont Board of Nursing as a nurse practitioner in psychiatric/mental health nursing or a Physician Assistant licensed by the Vermont Board of Medical Practice.
- i. **Manual restraint:** A manual hold that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.
- j. **Non-Physical Intervention Skills** means strategies and techniques of communication or interaction that do not involve physical contact, such as active listening, conversation and recognition of an individual's personal, physical space, and that include a willingness to make adjustments for the individual's needs.

- k. **Physician Assistant** means an individual qualified by education and training and licensed by the Vermont Board of medical practice to whom a physician can delegate medical care. A physician assistant may prescribe, dispense, and administer drugs and medical devices to the extent delegated by a supervising physician.
- l. **PRN Order** means a standing order, an abbreviation of the Latin term *pro re nata*, meaning “as needed” or “as circumstances require.”
- m. **Restraint** means any manual method, physical hold or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely, or a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment for the patient’s condition.
- n. **Seclusion** means the involuntary confinement of a patient alone in a room or area from which the patient is physically or otherwise prevented from leaving.

### **Emergency Involuntary Procedures**

- a. The following types of restraint are acceptable for use at the Vermont Psychiatric Care Hospital (VPCH):
  - Manual restraint
  - 4-point restraint (patient’s wrists and ankles are secured to a bed).
  - 5-point restraint (as above, with the addition of a chest strap, also secured to the bed).
  - Belt and wristlets (patient’s wrists are secured to a waist belt and the patient is allowed to ambulate freely). NOTE: Belt and wristlets may not be used without prior approval by the Medical Director or designee and the Executive Director or designee.
- b. Upon admission or at the earliest reasonable time, with the patient’s permission, staff shall work with the patient and his or her family, caregivers, and health care agents (if any) to identify strategies that might minimize or avoid the use of emergency involuntary procedures. They shall also discuss the patient’s preferences regarding the use of such procedures should they become necessary. Although the hospital is not obligated to follow the patient’s preferences, patient preference shall be considered when determining the least intrusive and least restrictive emergency involuntary procedure to use to address the imminent risk of harm. The information about the patient’s preferences shall be made accessible to direct care staff to refer to when a patient is exhibiting signs of escalation.
- c. Prior to or as soon as possible after admission to VPCH, admission staff will verify whether the patient has an advance directive for health care, including any amendment, suspension or revocation thereof. Staff shall:
  - ask the patient directly whether he or she has an advance directive;
  - check the hospital’s internal electronic database; and
  - check the Vermont Advance Directive Registry (*see VPCH Advance Directive Procedure*).

- d. The hospital shall inform patients about their right to have someone notified whenever an emergency involuntary procedure is applied to them.
- e. Emergency involuntary procedures may only be used to prevent the imminent risk of serious bodily harm to the patient, a staff member or others and must be discontinued at the earliest possible time based on an individualized patient assessment and re-evaluation.
- f. The decision to use emergency involuntary procedures is not driven by diagnosis, but by the dangerousness of the situation and a comprehensive individual patient assessment.
- g. Emergency involuntary procedures may be used only when other interventions have been attempted and been unsuccessful or when they have been considered and determined to be ineffective, or when the imminent risk of serious bodily harm is of such magnitude as to warrant immediate action to protect the safety of the patient or others.
- h. The use of seclusion or restraint may be initiated and terminated by a registered nurse who has been specifically trained to initiate such procedures, or at the direction of a licensed independent practitioner.
- i. A licensed independent practitioner may order one or more medications to be administered involuntarily on a one-time, emergency basis, after performing a face-to-face assessment.
- j. The use of emergency involuntary procedures shall be documented. The documentation shall include a description of specific behaviors justifying the use of the procedures.
- k. Patients shall be specifically informed that they have a right to have an attorney notified when emergency involuntary procedures are used.
- k. There shall be no protocol, written or unwritten, that requires a patient to ingest oral PRN medication as a condition to release from seclusion or restraint.

### **Use of Emergency Involuntary Procedures**

- a. If, on the basis of personal observation, any staff member believes an emergency exists, a licensed independent practitioner or registered nurse shall be consulted immediately.
- b. The use of emergency involuntary procedures must be:
  - 1. In accordance with a written modification to the patient's plan of care; and
  - 2. Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with this rule.

## **Orders for Emergency Involuntary Procedures**

- a. The use of emergency involuntary procedures must be in accordance with the order of a licensed independent practitioner who is responsible for the care of the patient and authorized to order seclusion, restraint, or emergency involuntary medication by hospital policy.
- b. A protocol cannot serve as a substitute for obtaining a licensed independent practitioner's order for each episode of emergency involuntary procedure use.
- c. Orders for the use of emergency involuntary procedures must never be written as a standing order or on an as-needed (PRN) basis.

## **Timeframes for Emergency Involuntary Procedures**

- a. The order for restraint or seclusion must be obtained either during the emergency application of the restraint or seclusion, or as soon as possible and not more than one (1) hour after the restraint or seclusion has been initiated.
- b. The attending physician who is responsible for the management and care of the patient must be notified as soon as possible if the attending physician did not order the emergency involuntary procedure. The notification may occur via telephone.
- c. When an emergency involuntary procedure is used, the patient shall be seen face-to-face within 1 hour after the initiation of the intervention by a licensed independent practitioner. The one hour assessment must evaluate:
  1. The patient's immediate situation;
  2. The patient's reaction to the intervention;
  3. The patient's medical and behavioral condition; and
  4. The need to continue or terminate the emergency involuntary procedure.
- d. At the end of 2 hours, if the continued use of restraint or seclusion is deemed necessary based on an individualized patient assessment, another face-to-face assessment by a licensed independent practitioner and a new order is required. No order for restraint or seclusion shall exceed 2 hours.

## **Observation and Assessment**

- a. The patient shall be constantly observed by a staff member who has successfully completed competency based training on the monitoring of persons in seclusion and mechanical restraint. Observations of the patient shall be documented every 15 minutes.
- b. At least hourly, a registered nurse (RN) shall assess the continued need for the emergency seclusion intervention and document assessment and ongoing need for the intervention.

- c. Treatment staff shall engage in debriefing of every incident involving the use of emergency involuntary procedures. Treatment team members also shall give patients reasonable opportunities to debrief regarding every incident. The debriefing shall include, at a minimum, the elements required by the Department of Mental Health.

### **Documentation of Emergency Involuntary Procedures**

- a. The use of all emergency involuntary procedures must be documented in the patient's medical record in accordance with the standards set out in the CMS Conditions of Participation.
- b. The test of adequacy of documentation is whether an independent qualified mental health professional could readily verify from such documentation the factual basis for and the medical necessity of the prescribed action, as well as its involuntary administration. The elements of adequacy shall enable the reviewer to determine whether relevant standards, policies and regulations were complied with, including:
  1. The necessity for the action taken to control the emergency;
  2. The expected or desired result of the action on the patient's behavior or condition;
  3. Whether alternatives were considered or used, and why they were ineffective to prevent the imminent risk of serious bodily harm.
  4. The risks of adverse side effects.
  5. When used in combination, the basis for the determination by the licensed independent practitioner that the use of a single emergency involuntary procedure would not have been effective to prevent the imminent risk of serious bodily harm.

### **Use of Emergency Involuntary Procedures in Combination**

Emergency involuntary procedures may only be used in combination when a single emergency involuntary procedure has been determined in the clinical judgment of the licensed independent practitioner to be ineffective to protect the patient, a staff member, or others from the imminent risk of serious bodily harm.

- a. A comprehensive assessment of the patient must determine that the risks associated with the use of a combination of emergency involuntary procedures are outweighed by the risk of not using a combination of emergency involuntary procedures.
- b. Other interventions do not always need to be tried, but they must be considered and determined by the licensed independent practitioner to be ineffective to protect the patient or others from the imminent risk of serious bodily harm.
- c. The use of manual restraint only for the purpose of administering a court-ordered involuntary medication is not considered the use of a combination of emergency involuntary procedures.



## **Additional Requirements for Emergency Involuntary Procedures**

### **Emergency Involuntary Medication**

- a. If after personal assessment of the patient, an emergency involuntary medication is found to be necessary, the licensed independent practitioner may order the involuntary administration of one or more medications. Orders for emergency involuntary medication shall be for a single administration and shall not be written as a PRN, telephone or standing order.
- b. Emergency involuntary medication shall be used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the patient's distress.
- c. When necessary to administer involuntary medication by injection in emergency situations, a non-depot medication that is consistent with current American Psychiatric Association practice guidelines shall be used.

### **Seclusion**

- a. The placement of a patient in seclusion and the duration of its use shall be kept to a minimum, consistent with the safe and effective care of patients. The use of seclusion shall adequately accommodate a patient's physical and environmental needs without undue violation of his or her personal dignity.
- b. Seclusion is not just confining a patient to an area, but involuntarily confining the patient alone in a room or area where the patient is physically prevented from leaving. If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, this is considered to be seclusion, whether the door is actually locked or not.
- c. The registered nurse shall notify the licensed independent practitioner as soon as possible and not more than one (1) hour following the initiation of seclusion.
- d. The order for seclusion of a patient may be written only by a licensed independent practitioner.
- e. Within one hour of the initiation of seclusion, the individual in seclusion shall be assessed by a licensed independent practitioner. This assessment must occur face to face and shall include, but not be limited to, an assessment of:
  1. The individual's physical and psychological status;
  2. The individual's behavior;
  3. The appropriateness of the intervention measures; and
  4. Any complications resulting from the intervention.
  5. Whether the individual is aware of what is required to be released from seclusion.

- f. The patient shall be constantly observed by a staff member who has successfully completed competency based training on the monitoring of persons in seclusion and mechanical restraint. Observations of the patient shall be documented every 15 minutes.
- g. At least hourly, a registered nurse (RN) must assess the continued need for the emergency seclusion intervention and document assessment and ongoing need for the intervention.

## **Restraint**

- a. The involuntary placement of a patient in mechanical restraints shall occur only in emergency circumstances and in the least intrusive and least restrictive manner.
- b. Restraints are to be applied in the least intrusive and least restrictive manner, providing for padding and protection of all parts of the body where pressure areas might occur by friction from mechanical restraints.
- c. Patients in restraints shall be encouraged to take liquids, shall be allowed reasonable opportunity for toileting, and shall be provided appropriate food, lighting, ventilation and clothing or covering.
- d. Mechanical restraints shall not be used when the patient is in a prone position.
- e. The registered nurse shall notify a licensed independent practitioner as soon as possible following the initiation of restraint.
- f. The order for the restraint of a patient may be written only by a licensed independent practitioner.
- g. A licensed independent practitioner shall assess the patient within one hour of the application of the restraints. This assessment must occur face to face and shall include, but not be limited to, an assessment of:
  - 1. The individual's physical and psychological status;
  - 2. The individual's behavior;
  - 3. The appropriateness of the intervention measures; and
  - 4. Any complications resulting from the intervention.
  - 5 Whether the individual is aware of what is required to be released from restraint.
- h. The patient shall be constantly observed by a staff member who has successfully completed competency based training on the monitoring of persons in seclusion and mechanical restraint. Observations of the patient shall be documented every 15 minutes.
- i. The restraint shall be ended at the earliest possible time that the patient no longer is considered an imminent risk of serious bodily harm.

## **Notice Requirements**

The hospital medical record shall include documentation about the use of emergency involuntary procedures. The record shall include all of the elements specified by the Department of Mental Health. Reports of the use of emergency involuntary procedures shall be sent to the Department of Mental Health as required on a monthly basis.

The court-appointed guardian of the patient shall be notified of every emergency involuntary procedure(s) within twenty-four (24) hours.

With the patient's consent, any person identified by the patient, including a health care agent, shall be notified of the use of emergency involuntary procedure(s) as soon as practicable but not later than twenty-four (24) hours from each procedure.

## **Staff Training**

### General

The patient has the right to safe implementation of emergency involuntary procedures by trained staff.

### Specific Training Requirements

- a. Staff members who participate in emergency involuntary procedures must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment if applicable, and providing care for a patient in restraint or seclusion before performing any of the actions specified in this paragraph, as part of orientation and subsequently on a periodic basis consistent with hospital policy. Staff members shall perform only those tasks in which they have been determined to be competent.
- b. The hospital shall require staff who may be involved with emergency involuntary procedures to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:
  1. The use of nonphysical intervention skills;
  2. Choosing an intervention based on an individualized assessment of the patient's medical or behavioral status or condition;
  3. The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress;
  4. Clinical identification of specific behavioral changes that indicate that emergency involuntary procedures are no longer necessary;
  5. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation;

6. The use of first aid techniques (except in the case of licensed registered nurses) and certification in the use of cardiopulmonary resuscitation, including required periodic recertification;
  7. Individuals providing staff training must be qualified as evidenced by education, training, and experience in interventions used to address patients' behaviors; and
  8. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.
- c. The hospital shall provide trauma-informed training to staff who may be involved with emergency involuntary procedures. Staff are trained to recognize the importance of a patient's history of sexual, physical or emotional abuse and/or incest.
  - d. Training for an RN to conduct the 1-hour face-to-face evaluation shall include all of the training requirements in this section as well as content to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the emergency involuntary procedure.

## **Oversight and Performance Improvement**

### Hospital Leadership Responsibilities

Hospital leadership is responsible for creating a culture that supports a patient's right to be free from restraint or seclusion.

- a. Leadership must ensure that systems and processes are developed, implemented, and evaluated that support patients' rights and that eliminate the inappropriate use of emergency involuntary procedures.
- b. As part of its quality assurance performance improvement program, each designated hospital shall review and assess its use of emergency involuntary procedures to ensure that:
  1. Patients are cared for as individuals;
  2. Each patient's condition, needs, strengths, weaknesses and preferences are considered;
  3. Emergency involuntary procedures are used only to address the imminent risk of serious bodily injury to the patient, staff, and others;
  4. Involuntary emergency procedures are discontinued at the earliest possible time, regardless of the length of the order; and
  5. When emergency involuntary procedures are used, de-escalation interventions were insufficiently effective, or were considered and determined to be insufficiently effective to protect the patient, a staff member, or others from harm.

These finding shall be reported to the Commissioner and Medical Director of the Department of Mental Health as required.

Medical Director Review

As soon as practicable but not later than 2 working days following an order for an involuntary emergency procedure, the hospital's Medical Director, or his or her designee, shall review the incident.

Reporting Patient Death to the Department of Mental Health

- a. VPCH must report any death associated with the use of emergency involuntary procedures to the Commissioner of the Department of Mental Health or his/her designee by telephone no later than the close of that business day, or on the next business day following knowledge of the patient's death.
- b. Staff must document in the patient's medical record the date and time the death was reported. *(See also the VPCH Patient Death Procedure)*
- c. The hospital must report the following information:
  - 1. Each death that occurs while a patient is in restraint or seclusion;
  - 2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion; and
  - 3. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.

Reporting Patient Death to CMS

VPCH must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death.

- a. Each death that occurs while a patient is in restraint or seclusion.
- b. Each death that occurs within 24 hours after the patient has been removed from restraint of seclusion.
- c. Each death known to the hospital that occurs within 1 week after restraint or seclusion, where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.
- d. The staff must document in the patient's medical record the date and time the death was reported to CMS.

Approved by	Signature	Date
Frank Reed, Commissioner of DMH		11/29/14

**Appendix K:**  
**Transporting Patients**  
**Procedure**

# Vermont Psychiatric Care Hospital Procedure

## Transporting Patients

Revised: X

Date: 7/7/16

### **I. Transport to Appointments or Transfers to Other Hospitals**

When a patient requires transport, the attending or on-call physician shall determine whether the patient shall be transported by hospital staff or law enforcement personnel.

When the physician decides an individual is in need of transport by law enforcement personnel, the reasons for such determination shall be documented in writing.

### **II. Transport to Off-site Legal Proceedings**

Transportation to and from criminal court shall be authorized and scheduled by employees of the court, rather than by a VPCH physician and a VPCH Admissions Specialist.

### **III. Guidelines for Transport by VPCH Staff**

- A. In general, a minimum of one non-driving staff person must be assigned to supervise each patient being transported unless otherwise ordered by a physician (*see items H., I and J. in this Procedure*). When two staff transport, staff shall ensure that the patient does not sit in the front seat or behind the driver. Staff shall comply with the *Escorting Patients Policy and Procedure* when they are transporting patients. A staff person assigned to an individual patient must keep the patient generally within arm's length at all times during the transport.
- B. In the event that the patient needs to use the restroom, the staff shall take reasonable steps to maintain the safety of the patient and others in the environment of the restroom. When the patient is in the restroom, staff member shall at a minimum maintain voice contact with the patient.
- C. Staff shall use VPCH Fleet Vehicles to transport patients; those vehicles shall be scheduled with the VPCH Staffing Office. Personal vehicles may not be used for patient transport.
- D. Each time a staff member signs out a State vehicle for the purpose of driving a patient the staff member shall show a current valid driver's license to a Staffing Coordinator, who shall document having viewed the staff member's current driver's license
- E. Whenever possible, staff shall obtain a bag lunch for the patient prior to departure. If bag lunches are not available, or if the trip may take longer than expected, staff may use a drive-through to obtain a meal for themselves and the patient. Other than stops required to obtain drive-through meals, stops may only be made to refuel the vehicle or to use a restroom



- F. Smoking is prohibited in VPCH vehicles and at any time during the transport.
- G. When a VPCH patient is being transported to another hospital via ambulance, the Nursing Supervisor shall collaborate with ambulance staff to determine whether VPCH staff shall ride with the patient in the ambulance, follow the ambulance in a VPCH vehicle, or both.
- H. An individual staff member may transport a patient in a VPCH vehicle without a second accompanying staff person only when this has been specified in a physician order. As stated in D. above, each time a staff member signs out a State vehicle for the purpose of driving a patient, the staff member shall show a current valid driver's license to a Staffing Coordinator, who shall document having viewed the staff member's current driver's license
- I. When part of the discharge planning process, staff from a Designated Agency or other community program may transport a VPCH patient if this has been ordered by a VPCH physician. Staff of the community agency or program are expected to abide by their organization's transportation policy.
- J. Each VPCH employee providing patient transport shall review, in the Staffing Office, and document knowledge and willingness to comply with the following policies and procedures before transporting: *VPCH Transporting Patients Policy and Procedure*, *VPCH Escorting Patients Policy and Procedure*, and the *VPCH Elopement/Late Return Policy and Procedure*. The most recent copies of each document shall be maintained.
- K. All staff members transporting patients off hospital grounds shall carry a cell phone that shall be turned on at all times. Fully charged cell phones shall be obtained from the Admissions Office.
- L. If a patient elopes during transport, the VPCH staff member shall follow the *VPCH Elopement/Late Return Policy and Procedure*. The staff member shall immediately call 911 to report the patient elopement and provide patient information as outlined in the Elopement Procedure. The staff member shall then contact the VPCH Admissions Office to notify the hospital of the patient elopement.
- M. The driver is responsible for leaving the vehicle clean and with a full tank of gas.
- N. Following transport, the driver shall complete the vehicle log.

Approved by	Signature	Date
Frank Reed, Commissioner of DMH		11/29/16



**Appendix L:**  
**Escorting Patients Procedure**

# Vermont Psychiatric Care Hospital Procedure

## Escorting Patients

Revised: X

Date: 04/07/14

### Individual and Group Escort

- A.** Staff members are assigned to escort patients either in supervised groups or individually.
- B.** Staff may not use any mechanical restraints for the routine escort of patients.
- C.** Consistent with the assigned level of autonomy, the Nursing Supervisor will approve an individual patient or a group of patients that are identified to leave the unit with the assigned staff member(s). The Nursing Supervisor will ensure that the staff-to-patient ratio is no less than two staff members for every group of up to five patients. Exceptions will be per written order of the attending physician.
- D.** The Nursing Supervisor or designee shall evaluate, using available clinical information, staff report, or direct observation the mental status of each patient, before the patient leaves the unit. The purpose of this evaluation is to ensure that the patient's mental status is consistent with the patient's current treatment plan and physician's order related to level of autonomy.
- E.** The Nursing Supervisor and an on-call physician may exercise clinical discretion and judgment to further reduce level of autonomy if either discipline determines that clinical presentation supports a reduction in a patient's level of autonomy. The Nursing Supervisor or on-call physician must document any reduction in level of autonomy in the medical record and bring the change in level of autonomy to the attention of the patient's treatment team. The attending physician in consultation with the treatment team has authority to determine whether a change in level of autonomy is appropriate. Refer to the *Levels of Autonomy and Supervision Policy and Procedure* for guidance
- F.** Staff escorting an individual patient off the unit will remain generally within arm's length of the patient at all times while the patient is off the unit. Staff escorting a group of patients off the unit will keep all patients in the group within eye sight and patients shall generally be within 25 feet of a staff person.
- G.** In the event that a patient needs to use a bathroom, one of the staff members shall maintain voice contact with the patient while the patient is in the bathroom. When escorting in a group, the other staff member will continue to observe the rest of the group.
- H.** A staff member will immediately contact the switchboard if a patient leaves the group and does not respond to encouragement to return to the group. A staff member will follow the patient who has left the group only if there is another staff member present who can stay with the group. Refer to *Late Return/Elopement Policy and Procedure* for patient elopement.

Approved by	Date
Frank Reed, Commissioner of DMH	April 7, 2014

**Appendix M:**  
**Visitor Procedure**

# Vermont Psychiatric Care Hospital Procedure

## Visitor Procedure

Revised: X

Date: May 24, 2018 –  
effective July 1, 2018

**Note:** Staff shall contact the nursing supervisor with any questions regarding visitors and/or compliance with this policy. It is the goal of VPCH to assist visitors in the most supportive way possible while promoting safety and security and adhering to our policies and procedures.

1. All visitors to the hospital (except for authorized BGS staff and delivery service personnel) shall enter through the front door of the hospital.
2. The visitor shall inform Reception who s/he is there to visit and show a form of government issued ID. Should the visitor not have an ID, the Nursing Supervisor shall be consulted to personally review the situation and decide as to whether the visitor shall be admitted.

a. Visitor of a Patient:

- i. Reception shall notify the charge nurse that the patient has a visitor. The charge nurse shall alert the patient to the visitor and ask the patient if s/he would like to see the visitor.
  1. If the patient says no, the charge nurse will inform Reception, who will then relay that information to the visitor and ask them to return later.
  2. If the patient says yes, the charge nurse will inform Reception, and the rest of this procedure shall be followed.

b. Visitors Under 18 Years Old

- i. Visitors under 18 years old (“minors”) must be pre-approved by the Patient’s Treatment Team.
- ii. An approved minor must be accompanied and supervised by an adult at all times. VPCH staff shall not be responsible for supervising minors.
- iii. Visits by minors must occur off unit.

c. Professional Visitors:


- i. Professional visitors should attempt to schedule their visits in advance, if possible, with the patient’s treatment team or DMH Legal. If the visit is not scheduled in advance, the Nurse Supervisor shall be consulted to determine whether the patient is willing and/or able to have a visitor.

- ii. Hospital employees or contracted physicians who expect a visitor for a patient shall inform Reception (or Admissions if they are covering for Reception) in advance of the visit.
  - iii. If the hospital employee or contracted physician is not present when their visitor arrives, Reception shall call the employee or contractor to alert them of their visitor's arrival.
- 3. Reception shall sign the visitor into the Visitor Log and provide a temporary badge to the visitor. The visitor shall wear the badge in a visible location throughout the entire visit. The visitor must sign the *Visitor Acknowledgement Regarding Patient Rights to Privacy and Confidentiality* form before entering the lobby.
  - a. An assigned staff member or contracted physician shall meet the visitor in the outer entrance area. All visitors must lock up their personal belongings (cell phone, keys, wallet/purse, etc.) in a locker and shall be provided with a locker key unless the Nurse Supervisor determines there is a clinical or legal need to bring certain items into patient care areas.
- 4. All visitors shall be wanded before exiting the outer entrance area by assigned staff.
  - a. If an individual does not consent to a search, assigned staff shall call a nursing supervisor. The person shall be denied access to the hospital until either the person consents to a search or the CEO or designee personally reviews the situation and makes a determination.
  - b. If the wand goes off, assigned staff shall ask consent to manually search the area in question.
    - i. If consent is given, staff shall manually search the area. If they do not find any prohibited items, the person may be allowed to enter the hospital. If they do find a prohibited item, it must be locked in a locker while the visitor is at VPCH.
      - 1. If a staff member finds a weapon in the person's possession, the staff member shall leave the potential visitor in outer entrance area, return to Reception and call the nursing supervisor.
    - ii. If consent is not given, assigned staff shall call a nursing supervisor. The person shall be denied access to the hospital until such time as either the person consents to a search or the CEO or designee personally reviews the situation and makes a determination.
  - c. Once in the Reception Area, assigned staff shall open and examine the contents of all containers, bags, boxes or other containers that a visitor intends to be brought to the patient or on a unit. Please see a list of restricted items in Restricted Items and Search Procedure. If there are any questions, contact the nursing supervisor.



- d. Assigned staff shall advise visitors that any food brought in for the patient must be consumed at the time of the visit and that left-overs must be taken home (unless approved by the Charge Nurse to be saved; *see* Food Guidelines).
  - e. Drinks must be in plastic sealed containers (no aluminum or glass) and no caffeine drinks will be permitted by VPCH staff before 0500 or after 1300.
  - f. Assigned staff shall bring the approved items to the unit and give them to the Charge Nurse or designee for a second review and inventory. The Charge Nurse or designee shall complete the second review process in a timely manner and shall make every effort to complete the review before the visitor leaves the unit.
  - g. If the visitor asks to visit the unit or the patient before assigned staff can complete the container examination, the assigned staff may leave the containers at Reception while s/he escorts the visitor to the unit vestibule. When the assigned staff is no longer needed at the unit, and the visitor has been escorted by nursing staff onto the unit, the assigned staff shall return to the Reception area to continue the container review and determine which, if any, items are suitable to bring to the unit.
5. Assigned staff or hospital employee or contractor shall escort the visitor to the unit vestibule where unit staff will meet the visitor and escort them to the visitors' room or other appropriate location, as determined by the Charge Nurse.
  6. When the visit ends, the Charge Nurse shall assign a staff member or contact the contracted physician (if not present during the visit) to escort the visitor back to the Reception area. Assigned staff shall remind visitors to retrieve any belongings in the lockers. The Reception staff will open the sally port and exterior doors so the visitor can exit the locked areas of the hospital. If the visitor left possessions in a locker, the visitor shall retrieve their possessions and then pass the locker key to the Reception staff before departing the building.
  7. The employee or contractor is responsible at all times for their visitor and required to always escort them within areas of the hospital as necessary.
  8. At all times during the visit, employees and contracted physicians shall maintain the confidentiality of all VPCH patients consistent with all VPCH policy and procedures.
  9. VPCH reserves the right to limit or adjust visiting times as several factors can affect the length of a visit (*i.e.* availability of visiting space, staff considerations, other patient needs on the unit, etc.)
  10. In addition to the above procedures, hospital employees and contracted physicians must follow the attached Appendix A – Guidelines for Employees Hosting Visitors to, or through, a Patient Care Area.

11. Delivery and Other Service Personnel Who Enter the Hospital through the Loading Dock or Storeroom Entrances
  - a. Delivery and other service personnel who enter the hospital through the loading dock or storeroom area shall be accompanied by a hospital employee at all times while in the building. The visitor does not have to be wanded.
  
12. At all times during the visit, hospital employees shall maintain the confidentiality of all VPCH patients consistent with all VPCH policy and procedures.
  
13. In the event of an emergency, visitors shall follow the directions of VPCH personnel.

<b>Approved by DMH Commissioner</b>	<b>Approval Date:</b>
	5/24/18* (*policy effective July 1, 2018)

**Appendix N:**  
**Staff Assault Information**  
**Packet**



# **Vermont Psychiatric Care Hospital**

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## **PATIENT ON STAFF ASSAULT**

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### CONTENTS:

- **Information for Staff Assaulted by patients**
- **Workers' Compensation Guide for Injured Workers**
- **Employee Event Form (NCF-09)**
- **Vermont State Police Sworn Statement**

Return Instruction sheet to Medical Records

Rev. 04-13-17

## Vermont Psychiatric Care Hospital

### Information for Staff Assaulted by Patients

VPCH strives to create the safest environment possible for staff and patients and we want you to know how much we value your safety. This document is intended to provide you with resources and other basic information.

As a state employee, you have been automatically enrolled in the Employee Assistance Program (EAP) free of charge. This is a program that offers free help and support to employees and their families. You can call EAP 24/7. Their number is 888-834-2830.

We encourage you to seek medical care if you feel necessary.

You will need to complete an Employee Event Report within 24 hours. This form is attached. You should bring this completed form to the Staffing Office so a Staffing Specialist can enter the information into the online Workers' Comp/OSHA First Report of Injury form. You will receive copies of the First Report of Harm and the Employee Event Report forms.

If you believe you require outside medical treatment and/or lost time from work, you must contact the Workers' Compensation Office at 828-2899 (leave a message if not during normal working hours with contact information) and notify the Staffing Office of the need for a medical evaluation and/or time off from work.

Should you wish to do so, you have the right to report the patient's behavior to law enforcement. The following information is provided to assist you in this process.

1. Assault against an on-duty health care worker is a crime under Vermont law. 13 V.S.A. § 1028. In imposing a sentence, "the court shall take into consideration whether the defendant was a patient at the time of the offense and had a psychiatric illness, the symptoms of which were exacerbated by the surrounding circumstances, irrespective of whether the illness constituted an affirmative defense to the charge." 13 V.S.A. § 1028(c).

2. You may file a complaint with the Vermont State Police (VSP), Middlesex Barracks, by calling: 802-229-9191.
3. VSP may ask you to complete a Sworn Statement form (a copy is attached). Consistent with VSP instructions, you may fax completed forms to VSP at 802-229-2648 or a VSP officer may pick up the form at VPCH.



## Workers' Compensation Guide for Injured Workers

*For questions and concerns regarding your specific workers' compensation claim, please contact the PMA Customer Service Center, 888.476.2669, or your PMA Claims Representative.*

### Getting Started with Workers' Compensation

#### **What should I do if I am injured on the job?**

- Immediately report the accident to your supervisor
- Your employer will report your accident to PMA, who administers your employer's workers' compensation program
- Once your accident has been reported to PMA, you'll receive an acknowledgement letter. You may be asked to fill out forms related to your injury. Please provide as much information as possible and promptly return the forms to PMA. Among the forms you may receive is a "Medical Authorization" form. This form enables PMA to obtain your medical records from your treating physician, so we can make a prompt determination as to your eligibility for benefits
- You may also be contacted by a PMA representative regarding your injury/illness
- If you have any questions, contact the PMA Customer Service Center at 888.476.2669

#### **What should I know about PMA?**

- PMA has been selected by your employer to administer their workers' compensation program
- We provide insurance and risk management services to employers throughout the United States. Founded in 1915 and headquartered in Blue Bell, PA, PMA is part of the Old Republic Insurance Group, the largest business segment within Old Republic International, one of the nation's 50 largest publicly held insurance organizations
- We will work with you to help you return to your pre-injury condition and to gainful employment
- Throughout the workers' compensation process, we will communicate with you to ensure that you receive proper medical care, and to make certain your claim is handled appropriately and promptly
- We maintain a complete staff of insurance and risk management professionals to help administer your claim

#### **What is workers' compensation?**

Workers' compensation provides medical care and reimbursement for a portion of lost wages to workers who are injured on the job, or have a work-related illness. Each state has its own specific law regarding workers' compensation. See [State Resources](#) in the Injured Worker Center to learn more about specific benefits provided in your state.

#### **How will I know if I am entitled to receive workers' compensation benefits?**

A claims representative will review the relevant documentation and medical reports and investigate your claim. If it is determined that your injury/illness is compensable under your state's workers' compensation laws, you are entitled to receive benefits.

## **The Workers' Compensation Process**

### **What is covered by workers' compensation?**

Workers' compensation is a system regulated by each state and benefits vary according to state. Some benefits that may be included as part of workers' compensation are:

1. All necessary and reasonable medical expenses related to your injury/illness, such as:
  - Doctor visits
  - X-rays
  - Diagnostic tests
  - Prescriptions
  - Surgical procedures
  - Hospital stays

2. Reimbursement for lost wages:

Workers' compensation generally provides payment for a portion of your lost wages if your injury/illness prevents you from working or you return to work in a modified capacity with a wage loss. You may be entitled to other additional benefits as provided by the workers' compensation law in your state. See State Resources in the PMA Injured Worker Center to learn more about specific benefits in your state.

### **What can I expect if my workers' compensation claim is accepted?**

The workers' compensation process focuses on optimum medical recovery for injured workers and return to work as soon as medically appropriate. PMA works in collaboration with you, your employer, and your medical providers to help you achieve these goals.

When you receive medical treatment, it is important for you to notify your medical provider that you are receiving treatment for a work-related injury/illness *to avoid medical bills being sent to you.*

To help facilitate your recovery and return to work, keep your employer and PMA advised of doctor appointments and your return to work status. If your doctor releases you to return to work, let your employer and your claims representative know right away.

If you are a Medicare beneficiary, or are receiving Social Security Disability benefits, advise your PMA Claims Representative of this important information as soon as possible, so that benefits can be properly coordinated.

## **Communication with PMA**

### **I have completed forms and other mail for PMA. Where should I send them?**

Send all PMA claim correspondence to: PMA Customer Service Center, P.O. Box 5231, Janesville, WI 53547-5231, fax: 800.432.9762.

### **Who at PMA should I contact if I have a change of address?**

Contact the PMA Customer Service Center, 888.476.2669 to report your change of address.

### **How do I find out if my workers' compensation check has been sent?**

Contact the PMA Customer Service Center, 888.476.2669, and a representative will be able to assist you.

**I can't remember who my claims representative is. What should I do?**

Contact the PMA Customer Service Center, 888.476.2669, and a representative will be able to assist you.

**Medical Bill Questions**

**If I receive bills from medical providers for treatment related to my work injury, what should I do?**

If your claim has been accepted for workers' compensation benefits, send the bills to PMA at the following address or fax number:

PMA Customer Service Center  
P.O. Box 5231  
Janesville, WI 53547-5231

Fax: 1-800.432.9762

**About PMA Companies**

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*PMA Companies ([www.pmacompanies.com](http://www.pmacompanies.com)) provides risk management solutions and services in the U.S., specializing in workers' compensation for larger accounts. Headquartered in Blue Bell, PA, PMA Companies is part of the Old Republic General Insurance Group ([www.oldrepublicinsurancegroup.com](http://www.oldrepublicinsurancegroup.com)), the largest business segment within Old Republic International (NYSE: ORI), one of the nation's 50 largest publicly held insurance organizations.*

*PMA Companies includes the PMA Insurance Group, specializing in workers' compensation and providing other commercial property & casualty insurance products; PMA Management Corp. and PMA Management Corp. of New England, providing results-driven TPA and risk services for workers' compensation, commercial auto, general liability, and commercial property.*



### EMPLOYEE EVENT FORM

ALL FIELDS MUST BE COMPLETED TO PROVIDE ACCURATE AND PROMPT PROCESSING OF EMPLOYEE EVENTS AND ENSURE EMPLOYEE INJURY REPORTING MEETS RISK MANAGEMENT AND DEPARTMENT OF LABOR REQUIREMENTS.

**TO BE COMPLETED BY THE EMPLOYEE OR STAFF MEMBER WHO WITNESSES, DISCOVERS, OR HAS DIRECT KNOWLEDGE OF INJURY, WOUND, OR DAMAGE TO THE BODY RESULTING FROM AN EVENT AT WORK, WITHIN 24 HOURS.**

1. Event report date: \_\_\_\_\_ Time (military): \_\_\_\_  Injury  Near Miss/Close Call

2. Event date: \_\_\_\_\_ Event time (military): \_\_\_\_\_

3. Location of event: Unit  A  B  C  D  Other (Specify): \_\_\_\_\_

4. Type of event:  
 Workplace Injury  Blood and/or Body Fluid Exposure  Fall/Trip/Slip  
 Infectious Disease Exposure  Other: \_\_\_\_\_

5. Person reporting event: \_\_\_\_\_  
Print Name Title Date/Time

6. Employee information: \_\_\_\_\_  
Print Name Employee ID# Date of Birth

Work Phone Title Department  
Home Phone Home Address

7. Date & time (military) employee began work on day of event/injury: \_\_\_\_\_

8. If patient involved, identify patient MRN(s): \_\_\_\_\_

9. Did injury occur during the following interactions with a patient?  
 During an Emergency Involuntary Procedure  
 While attempting to redirect/change patient's behavior  
 From deliberate action by a patient (punch, push, kick, bite, etc.)  
 While assisting patient (while preventing patient fall, while assisting patient movement – lifting, etc.)

10. If injury occurred in an interaction with a patient, what was the patient's observation status at the time of the event?  
 15 minute checks  30 minute checks  COI  COII  CS

11. Description of event/injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Immediate follow-up actions/treatment following event/injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Witnesses: \_\_\_\_\_  
Name & Title Name & Title

Vermont Psychiatric Care Hospital  
**EMPLOYEE EVENT FORM**

ALL FIELDS MUST BE COMPLETED TO PROVIDE ACCURATE AND PROMPT PROCESSING OF EMPLOYEE EVENTS AND ENSURE EMPLOYEE INJURY REPORTING MEETS RISK MANAGEMENT AND DEPARTMENT OF LABOR REQUIREMENTS.

12. **Degree of Harm:**
- NONE – Event reached the employee, may have required monitoring/intervention, but did not cause any harm.
  - MINOR (First Aid) – Event increased the need for treatment/intervention and caused temporary employee harm.
  - MODERATE – Event that contributed to or resulted in temporary harm to the employee and required initial or prolonged hospitalization.
  - SEVERE – Event that contributed to or resulted in permanent harm to the employee and required initial or prolonged hospitalization, and/or interventions necessary to sustain life.
  - DEATH – Event contributed to or resulted in employee’s death (unexpected death).
  - NOT KNOWN – Not enough information available to assign a degree of harm for this event.

15. **Will this reported injury require outside medical treatment and/or lost time from work?**  Yes  No  
Please note: If #16 is checked yes, you must complete the on-line VT State Employee Workers’ Compensation Incident Reporting Form. Staffing Officers are available to assist you with this process.

16. **Do you need follow-up because of body fluid exposure?**  Yes  No

The following constitute a significant exposure incident:\*

- Percutaneous (*penetrating skin*) exposure by a needle stick or other sharp instrument
- Contamination of a fresh cut (*less than 2 hours old*)
- Mucous membrane exposure via splash in mouth or eye
- Human bites that penetrate the skin
- Cutaneous (*skin*) exposure when the skin is non-intact

\* VPCH Infection Control Manual 2014

\_\_\_\_\_  
Printed name of employee completing report

\_\_\_\_\_  
Signature of employee completing report

**AFTER COMPLETING PREVIOUS SECTIONS, GIVE FORM TO THE NURSING SUPERVISOR ON DUTY.**

**NURSING SUPERVISOR ON DUTY REVIEW AND ACTIONS TAKEN:** \_\_\_\_\_

**SUPERVISOR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**NURSE MANAGER OR 1<sup>ST</sup> SHIFT SUPERVISOR COVERING REVIEW AND CLOSE:**

**ADDITIONAL ACTIONS TAKEN:** \_\_\_\_\_

**NM OR DESIGNEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

- If you were injured, the Staffing Officer assists you to complete the on-line Workers’ Compensation Incident Reporting Form and prints a copy of the Form for you
- Nursing Supervisor on duty follows up as necessary and documents
- Supervisor leaves report in Staffing Office by the end of the shift
- Staffing Officer makes copies of the Employee Event Report for Nurse Manager and Quality
- Nurse Manager or 1<sup>st</sup> shift Supervisor covering reviews the form, follows up as necessary and closes the event
- Staffing maintains a file of original copies of Employee Event Reports

*This communication is confidential and privileged as required by 26 VSA Section 1443 and may not be disclosed outside of a peer review committee proceeding.*



VERMONT STATE POLICE  
SWORN STATEMENT

STATE OF VERMONT

\_\_\_\_\_ COUNTY S.S.

\_\_\_\_\_ Case Number

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_

Work: (\_\_\_\_) \_\_\_\_\_

I, \_\_\_\_\_ (DOB: \_\_\_\_\_) hereby swear under the penalty of perjury (Title 13 VSA section 2904, penalty not more than 15 years in prison, not more than \$1,000 fine) that I have personal knowledge of the following facts and that this statement is true and accurate to the best of my knowledge and belief. No threats or promises have been made to me to provide this statement.

Subscribed and sworn to before me on this \_\_\_\_\_

\_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Signature & Date

State of Vermont  
Employee and Family Assistance Program



What is Invest EAP?

Short-term confidential counseling,  
information, and resources

Am I covered?

Yes! Services are free for all  
permanent employees of the State of  
Vermont and their family members.

If it's on your mind, it's worth a call!

 Family/ Relationships	 Childcare and Eldercare
 Workplace Conflict	 Depression/ Anxiety
 Financial/Legal Problems	 Grief and Loss
 Alcohol and Drug Use	 Stress/Work-Life Balance



- Short-term counseling
- Resource and referrals
- Confidential & free
- Employees and all household members

Call Toll-Free: **1-888-834-2830**

[www.investeap.org](http://www.investeap.org)

Organization Password: vteap



What happens when you call EAP?

A call to Invest EAP puts you in immediate touch with Master's or Doctoral level counselors, 24 hours a day. Our counselor will listen to you and explore your questions and concerns, which will allow us to provide specific and tailored information and referrals to meet your needs.

We're local! You will be referred to your choice of two local counselors convenient to your home or work.

*We welcome you or any household member to call us 24 hours a day, 7 days a week, 365 days a year at:*

**1-888-834-2830**

*Customer service:*

*Should you encounter any difficulty, please call 1-888-392-0050 to speak with an Account Manager.*

**1-888-834-2830**

Our online resource center is full of helpful information! Visit us at [www.investeap.org](http://www.investeap.org) to access self-assessments, videos, articles... and much more!