Department of Mental Health

Emergency Involuntary Procedures Review Committee Annual Report: Fiscal Year 2024

Published: 9.20.2024

VERMONT

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About the Committee:

The Emergency Involuntary Procedures (EIP) Review Committee is a committee convened by the Commissioner of the Department of Mental Health to review emergency involuntary procedures occurring on inpatient psychiatric units for those in the custody of the Commissioner in the State of Vermont. The Committee's responsibilities are to:

- Review aggregate EIP data from Designated Hospitals
- Review Designated Hospital's efforts to adhere to the requirements of the Vermont EIP Administrative Rule as well as CMS and Joint Commission standards
- Discuss trends in EIP data across the system
- Provide a forum for Designated Hospitals to discuss successes and barriers to EIP reduction
- Prepare an annual report to the Department summarizing its work, providing suggestions and recommendations to reduce rates of EIPs across the State. This report is submitted on behalf of the EIP Review Committee in accordance with Vermont Regulation for Establishing Standards for Involuntary Procedures (EIP Administrative Rule, adopted July 2016)

Reference Legislation and Administrative Rule:

Act 79. An act relating to reforming Vermont's mental health system

> *Sec. 33a. RULEMAKING: On or before September 1, 2012, the commissioner of mental health shall initiate a rulemaking process that establishes standards that meet or exceed and are consistent with standards set by the Centers for Medicare and Medicaid Services and the Joint Commission for the use and reporting of the emergency*

involuntary procedures of seclusion or restraint on individuals within the custody of the commissioner and that require the personnel performing emergency involuntary procedures to receive training and certification on the use of these procedures. Standards established by rule shall be consistent with the recommendations made pursuant to Sec. 33(a)(1) and (3) of this act.

Act 21. An act relating to rulemaking on emergency involuntary procedures.

Sec. 33a. RULEMAKING (a) The Commissioner of Mental Health shall adopt rules pursuant to 3 V.S.A. chapter 25 on emergency involuntary procedures for adults and children in the custody or temporary custody of the Commissioner who are admitted to a psychiatric inpatient unit. The rules shall establish standards that meet or exceed and are consistent with standards set by the Centers for Medicare and Medicaid Services regarding the use and reporting of restraint, and emergency involuntary medication. The rules shall also require the personnel performing those emergency involuntary procedures to receive training and certification on their use.

EIP Administrative Rule (2016)

8.2.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.

8.2.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.

Membership

Name	Organization
Alix Goldschmidt Sherry Providence	Brattleboro Retreat
Kimberly Cookson Terri Lynn Graham	Central Vermont Medical Center
Caitlin Miller Tonya Davis	Designated Agency Representative
Suzanne Leavitt	Department of Disabilities, Aging, and Independent Living-Division of Licensing and Protection
Katie Ruffe Allie Nerenberg Stephen DeVoe Kelley Klein, MD	Department of Mental Health
Zachary Hughes Marla Simpson	Peer Representative
Laurie Emerson	Peer/Family Representative
Lesa Cathcart	Rutland Regional Medical Center
Darcy Bixby Jim Walsh	Springfield Hospital – Windham Center
Jessica Charbonneau Kaitlin Palombini	University of Vermont Medical Center
Jeremy Smith Jaycee Sutton	Vermont Psychiatric Care Hospital
Jonathan Hastings, MD Dorothy Fuller	White River Junction Veterans Affairs Medical Center
David Horton Jennifer Rowell Karen Barber	Staff Support, Department of Mental Health
Kevin Huckshorn Janice Lebel	Department of Mental Health Contractors

Overview

Year in Review

The Committee meets on a (no less than) quarterly basis in accordance with open meeting protocols. The following meetings were held virtually during this period:

- September 8, 2023
- December 8, 2023
- April 12, 2024 (rescheduled from March 8, 2024)
- June 14, 2024

Copies of agendas, minutes, data reports, and presentations are archived and available at:
Reports Emergency Involuntary Procedures (EIP) Committee | Department of Mental Health (vermont.gov)

In Fiscal Year (FY) 2024, the Department of Mental Health resumed facilitation of the EIP Review Committee meetings. This change was enthusiastically welcomed by Committee members. The Department of Mental health also took over support for Six Core Strategies training and resource dissemination for the State. These tools were discussed frequently throughout the meetings.

Each Designated Hospital (with the exception of the White River Junction VA) gave a short presentation to the Committee outlining current quality initiatives and improvement projects in process to reduce EIP rates and/or keep low rates from rising, as applicable. The VA is scheduled to present in the first quarter of FY 2025. Important topics and learning opportunities for all Designated Hospitals were discussed as a result of these presentations, including:

- The EIP review process by unit leadership and the tools used
- How environments with less resources to implement EIPs work to keep EIP rates low
- The use of the Six Core Strategies model for reducing seclusion and restraint on the units, as well as other emerging care models (such as A.V.A.D.E.®: Awareness-Vigilance-Avoidance-Defense-Escape)
- How leadership can support staff decision making and critical thinking around when and how to use EIPs

In FY 2024, the Committee provided opportunities for EIP Case Reviews to take place during the quarterly meetings.

Designated Hospital Continuous Improvement Summaries

The following information are brief summaries from each Designated Hospital about efforts to reduce EIPs at their respective facility.

- Brattleboro Retreat
  - The Brattleboro Retreat continues to work to reduce the use of restraint, seclusion, and emergency, at the hospital by:
    - Continuing to review all safety events, including any use of restraint, seclusion, or emergency involuntary medication on a daily basis
    - Reviewing weekly, monthly, and quarterly data at our weekly Quality and Patient Safety Committee Meeting
    - Increasing programming/structured groups and activities 7 days a week
    - Hiring a psychologist as part of the clinical education team and focused on increased training for behavioral health technicians (BHTs) to help them to better understand the clinical presentation of patients and to better understand what is happening and how they might help them to de-escalate
    - Continuing to include Trauma Informed Care and Six Core Strategies in all new hire orientation and have interwoven Six Core Strategies into ongoing trainings such as CPI and code drills
    - Using a blended CPI model with a strong focus on de-escalation.
    - Running weekly Code Drills in September of 2023.
      - These occur at least one a week with a focus on both patient and staff safety, milieu management, prevention, de-escalations, and time outs or “Stop Moments.”
    - Maintaining the Early Responders are staff, BHTs and RNs, with strong de-escalation skills who can provide staff with additional support and guidance with the hope of de-escalating the situations and reducing the use of EIPs.
      - Early responders are called in as early as possible to address unit unrest or first signs that someone is struggling or when identified interventions do not appear to be working called in prior to an event that might be upsetting or triggering to a patient.
    - Developing a new staff debriefing tool with additional data, especially about early responder or codes that do not result in the use of an EIP
    - Ensuring that Unit Managers/ Nursing Supervisors follow up around any EIPs and review all documentation around the use of any EIP on a daily basis
    - Continuing to have the Nursing Supervisor review and debrief all EIPs with the administrator on call after hours

- Initiating the use of a new patient debriefing form to debrief with patients 2-24 hours after the use of any EIPs and update the patient's Therapeutic Inventory Survey as part of this process.

- Central Vermont Medical Center
  - Since January 1st of this year CVMC has had to place a patient census cap of 8 on our unit related to staffing psychiatrists (3 total have left their positions). This has created a staffing per census need and greater awareness of those we serve and any concerns around the need for any additional supports or services/increase in needs and our capacity to support those additional needs. We are actively continuing our recruitment efforts to hire new providers and are utilizing part-time and LOCUMs to manage our current census. We are looking forward to having new providers so we can open our unit back up to full census in the next six months. We are also looking forward to a unit rebuild to help facilitate opening up some single room availability for ease of admissions and patient satisfaction, that we are hoping will be happing in middle to late next year, once approvals are granted. CVMC has continued to support staff's participation in A.V.A.D.E. training and has spent additional time and efforts in facilitating scenario based code situations monthly to each of the different care areas (emergency department, medical-surgical units, intensive care unit, and inpatient psychiatry unit); to teach and debrief what goes well and what are the areas of improvement we can work on as a team across the different hospital care settings. When we experience real-life code situations which require a response up to and including certificate of need (CON) applications we have a formal debrief in the moment with the team and, once the patient returns to baseline, debrief with the patient. Our focus of all interactions with those we serve is to help meet the needs in the moment and deescalate the situation. We also have a review committee that review the CONs and provide feedback to the teams as needed, which might include recommendations around educational needs etc.
- Rutland Regional Medical Center
  - The end of the pandemic provided an opportunity for Rutland Regional Medical Center to regroup and once again re-engage in the work that we had been doing with the Six Core Strategies for Reducing Seclusion and Restraint prior to COVID. We have embraced this work for many years, and it is the foundation for the work that we do every single day. We have provided education and training to our current staff on patient centered trauma informed care and have included this education in our onboarding of new staff. It is embedded in our culture. By operationalizing each one of the Six Core Strategies, we have seen a continuous reduction in seclusion and restraint. We believe in this work and though we haven't been able to completely eliminate seclusion and restraint, it continues to be a goal that we strive for. The successes that we have had are successes that we can learn from and build on, and we are committed to doing that going

forward. The Six Core Strategies for Reducing Seclusion and Restraint are a continuous performance improvement project for RRMC.

- University of Vermont Medical Center
    - To assist in reducing seclusion and restraint, UVMMC does many reviews and assessments of EIP events, in addition to prevention measures. Each of our staff members receives Pro-ACT and Management of Aggressive Behavior (M.O.A.B.) training, in addition to seclusion and restraint training. If we have a patient who has required emergency event, there is a debrief huddle after each event. During that huddle we also discuss planning to prevent future events and at times create behavior plans when appropriate. The staff fill out a packet about the emergency event and complete their required documentation in EPIC, our electronic health record system. This packet is reviewed by unit leadership, and the documentation audited for accuracy. This can lead to in person training on the event, or on the documentation. Then we meet with security and regulatory internally once every 2 weeks to review all emergency event situations to see if there are patterns or trends we can address as a unit. Then biweekly and monthly the manager reviews events and submits data to the state when applicable. We also will bring case by case situations when appropriate to our collaborative leadership model team that consists of nursing leadership, social work leadership, physician assistants, quality data analyst, and medical director. We also meet with the medical director and chief resident once a month to review any situations, for example: if a code event happened relating to a policy, we will review that and discuss additional training to residents. We also have yearly education days on emergency events to discuss reduction and avoidance of a code event turning into an emergency event, and if it does how to navigate to reduce the event and ensure folks are competent with an in-person practice.
- Vermont Psychiatric Care Hospital
    - At Vermont Psychiatric Care Hospital, we have implemented several processes and activities aimed at reducing seclusion and restraint. We have adopted a facility-side, person-centered philosophy of care that underscores all that we do. All VPCH personnel are trained during the initial onboarding period and routinely thereafter in Professional Assault Crisis Training and our clinical teams routinely practice the application of essential skills such as de-escalation, evasion, and the application of safe and humane restraint. Our quality department reviews every emergency involuntary procedure (EIP) to ensure regulatory compliance. Additionally, they hold weekly meetings with leadership to discuss findings. Clinical leaders review current treatment interventions and explore alternative activities to prevent future incidents which may include case-specific conferences, just-in-time education, individualized behavior modification plans, etc. Following an EIP, our psychologists lead multidisciplinary update treatment plan reviews with targeted interventions designed to address the underlying issues and ideally reduce or prevent similar

occurrences. Treatment plans are collaboratively developed through multidisciplinary conversations and are documented during morning rounds. These reviews take into consideration the events themselves, information gleaned from patient debriefings, staff debriefings, after action reports, and input from the various participants of the multidisciplinary meetings. Furthermore, in response to complex symptomology, our psychology department provides staff guidelines tailored to individuals who experience frequent EIPs. These guidelines offer personalized interventions and activities. In some cases, we schedule case conferences for individuals with high-frequency EIPs, inviting all hospital staff to participate. Educating and training a constant influx of new staff with various levels of experience, the hospital's responsibility to administer court ordered medication and peer to peer aggression and violence can pose challenges to restraint reduction/elimination.

- White River Junction VA Medical Center
    - Our goal is to continue to meet Vermont EIP standards and to be ready and able to care for all of our patients, through the most difficult challenges.
    - We want to especially work on maintaining staff training and readiness for dealing with EIPs, given that our facility historically has had very few EIPs. We want to make sure staff, at all levels, is familiar and comfortable with the EIP process, even if it remains a rare occurrence for us.
    - From nursing services perspective, the biggest challenges are an aging workforce, staffing shortages and turnover, and lapses between events, and while that is a good thing, it also means nursing has less experience in EIPs.
- Windham Center at Springfield Hospital
    - The Windham Center emphasizes the use of skills, verbal de-escalation and an individualized approach to minimize the risk of using restraint or seclusion with patients. We operate with some unique logistical differences which sets us apart from other hospitals, such as being a stand-alone facility, no support or back-up after hours and not having medical support on site. These variables require us to review referrals more carefully as the safety and optimal treatment of our patients and staff is our main priority. When patients are admitted to the Windham Center, they quickly discover that we focus heavily on skill-building, resources for recovery and therapeutic learning opportunities. These include Cognitive Behavioral Therapy (CBT) & Dialectical Behavioral Therapy (DBT) skills, recreational and leisure skills, and a variety of other categories to support optimal health and self-care. Our staff work diligently to apply these skills to actual scenarios when a patient may decompensate, which helps our patients see their efficacy for after discharge. Identifying individualized opportunities to de-escalate a patient is crucial. For example, bringing the patient out in the courtyard with staff, even if it's outside of the allotted time frame. Allowing the patient to make a phone call with the support of

staff may also be a simple de-escalation strategy. We have not had any instances of EIP use over the last year but credit this success to our skilled staff and supportive, therapeutic environment.

Recommendations and FY 2025 Plan

1. Consider embedding benchmarked EIP data to ensure that data is being measured against a baseline.
2. Utilize patient debriefing after EIPs as a tool to gather consumer feedback.
3. Continue discussions about how hospitals can best capture EIPs that were avoided and how to translate that to the Committee as a learning opportunity.
4. Implementation and sustainability of evidence-based practices to reduce administration of seclusion, restraint, and emergency involuntary medication.

Attachments

- EIP Data Reports can be found here: https://mentalhealth.vermont.gov/about-us/boards-and-committees/emergency-involuntary-procedures-eip-review-committee/reports