

This meeting was not recorded.

6/14/2024

FINAL

Emergency Involuntary Procedures Review Committee Minutes

Designated Hospitals: Alix Goldschmidt (Brattleboro Retreat) Kimberly Cowan (Brattleboro Retreat) Terri Lynn Graham (Central Vermont Medical Center) Kimberly Cookson (Central Vermont Medical Center) Lesa Cathcart (Rutland Regional Medical Center) Darcy Bixby (Springfield Hospital-Windham Center) Jeremy Smith (Vermont Psychiatric Care Hospital) Jessica Charbonneau (University of Vermont Medical Center) Kaitlin Palombini (University of Vermont Medical Center) Kristin Husher (Veterans Affairs Medical Center) Jim Walsh (Springfield Hospital-Windham Center)

Designated Agencies: None present

Peer/Family Representatives: Laurie Emerson (NAMI-VT; Peer/Family Representative) Zachary Hughes (Peer/Family Representative) Rhonda Prenskey (Disability Rights Vermont) Michael Sabourin (Vermont Psychiatric Survivors) Amy Richardson (Disability Rights Vermont)

DMH: Katie Ruffe Allie Nerenberg Kelley Klein, MD Karen Barber Eva Dayon Steve DeVoe Dave Horton Megan Shedaker

State of Vermont: Suzanne Leavitt (DAIL)

Six Core Strategies Consultants: Janice LeBel Kevin Huckshorn

Public: None.

Agenda

Agenda Item	Facilitator/Timekeeper: Steve DeVoe; Minutes: Katie Ruffe
Introductions and Updates	The meeting began with introductions of new members. Katie Ruffe, Interim Quality Nurse Management Specialist, was introduced to the group and a brief background of her previous experience was given. Jim Walsh, Director of Nursing at Windham Center at Springfield Hospital, was also introduced to the group. Amy Richardson from DRVT was introduced as well. Katie Ruffe began with an update regarding EIP Reports across hospitals and efforts to create more parity in the reports. There is a wide variation in the amount of information different hospitals are submitting in their EIP reports, making it difficult for DMH to validate compliance with all requirements of the Vermont EIP rule. Over the next quarter, information will be sent to all hospitals detailing the required elements of EIP reports, as well as hospital-specific EIP report feedback. The new fiscal year’s hospital presentation schedule will also be sent out for input and feedback from hospitals. Steve reminded members of the upcoming 2024 Annual Report to come from the EIP committee, and requested that each hospital submit a paragraph summarizing their goals for 2024, the challenges faced, and how well goals for EIP reduction were able to be met. Steve also reminded members of the accessibility to Six Core Strategies resources, training, and support.

This meeting was not recorded.

<p>Review of April 2024 Meeting Minutes</p>	<p>The vote to approve was passed unanimously. (Kimberly Cookson motioned to approve, Lisa Cathcart seconded the motion.) No discussion or edits to meeting minutes. Will be posted on DMH website.</p>
<p>EIP Hospital Presentations – UVMHC and WC</p>	<p>Jessica Charbonneau began with her presentation for UVM-MC. Jessica presented on their hospital’s process for auditing, correcting, and communicating about EIP data. There is interdisciplinary rounding daily. Staff have multiple ways to contact providers throughout the day if they have questions about emergency and voluntary procedures. If there is a code that leads to an involuntary procedure, nursing leadership is present from 6:00 AM to 9:00 PM four days a week. Any EIP that occurs during these hours will have leadership presence on the floor. Leadership will lead thoughtful discussions with staff around EIP circumstances and work to guide thinking around rationale in the moment. The staff debrief is conducted using a packet to guide discussion. All staff involved in an EIP must take part in the debrief. Nursing leadership also provides hands on assistance with EIP documentation for nursing staff and, when required, physician staff. For times when nursing leadership is not available, there is a detailed reference binder to aid in documentation. All EIP documentation is reviewed by leadership. Any documentation patterns that are noticed will be reviewed during a collaborative leadership meeting with the department’s quality partner, leader of social work, and medical director. If specific staff are exhibiting gaps in knowledge around the documentation process, individual follow up will take place. There will be a discussion around the policy and why the policy is the way that it is and how it serves to increase the quality of patient care. This increases Staff’s buy in. The department also has a unit-based practice council that discusses ways to increase teamwork and understanding of other disciplines so that clear and consistent messages can be given to patients to avoid confusion and increase quality of care. Putting in so much time up front to reduce EIPs and increase accuracy of documentation takes a lot of work, but it takes much less work then trying to correct errors after the fact and is better for patients. Janice LeBel Had positive comments about the presentation and praised the use of peer communication and peer feedback. Some hospitals requested sharing of Jessica’s tools.</p> <p>Jim Walsh was next to present for the Windham Center. He started by giving a historical background on the Windham center and how it came to be a 10-bed, stand-alone psychiatric unit with only three staff on night shift. They have an average capacity of eight patients at a time and usually only see 8 to 10 involuntary patients a year. During the pandemic, it was designated as a COVID unit for involuntary psychiatric patients in Vermont. Structural changes were made to the unit to accommodate this population of individuals. If required, the unit had to accommodate those on a level 1 status if need be. Staff have always been trained in CPI and there EIP policies and processes are reviewed annually, but the unit only sees about 10 EIPs a year. The unit is not set up with the space, resources, or staff to regularly manage emergency involuntary procedures. For these reasons, their approach must be very preventative in nature. Heavy emphasis is placed on training staff in de-escalation and meeting the needs of patients well in advance of any emergency involuntary procedure being needed. There is nursing leadership presence seven days a week and there is very strong interdisciplinary</p>

This meeting was not recorded.

	<p>communication. Every staff member is expected to personally meet the needs of patients, including dietary staff who regularly interact with the patients. There is also a strong emphasis placed on transparent communication with patients about their care and what the team is seeing. Buy-in and goal setting with the patient is very important. Patient set goals with nursing staff at the start of every day, and they have an opportunity to do a 15-minute end of day check in with nursing staff to review how well they met their goals. When needed, the unit can be partitioned off into different sections to allow for a lower stimulation environment. Janice LeBel commented that they were very excited to hear that all staff have personal rapport with patients and is impressed with how dynamic their resources are for de-escalation.</p>
Update on Quarterly EIP Data Reporting	<p>Steve shared that DMH has internally been reviewing processes around how EIP data is received, entered, and analyzed. Because so much time is required of the quality team to follow up with hospitals about their data, it has been determined that more lag time is needed between data submission and those data being presented to the committee to ensure accurate and clean data is used during meetings. Moving forward, there will be a six-month lag time between when quarterly EIP data is received and when it is presented to the EIP committee.</p>
Public Comment	<p>no public comments were received during this meeting.</p>
Adjourn	<p>Motion to adjourn by Jessica Charbonneau. Meeting adjourned at 11:30 AM.</p>