Vermont Psychiatric Care Hospital Policy and Procedure		
Emergency Involuntary Procedures		
Effective: 3/9/2020	Revised: August 2023	Due to Review: August 2025

POLICY

The Vermont Psychiatric Care Hospital (VPCH) is committed to establishing and maintaining a treatment environment that is safe, clinically effective, and non-violent.

VPCH leadership will:

- Establish internal policy and procedure to ensure that VPCH complies with laws and rules set forth in Act 79, the Vermont Regulation Establishing Standards for Emergency Involuntary Procedures, Centers for Medicare and Medicaid Services (CMS) Conditions of Participation, and The Joint Commission standards.
- Protect and promote the rights of each hospitalized individual.
- Facilitate a hospital culture that supports a hospitalized individual's right to be free from restraint or seclusion.

Emergency Involuntary Procedures (EIPs) at VPCH are used as safety measures of last resort, with the sole 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.

DEFINITIONS:

Competency: Competency is a series of knowledge, abilities, skills, experiences, and behaviors, which leads to effective performance in an individual's activities. Competency is measurable and can be developed through training.

Emergency: Emergency means an imminent risk of serious bodily harm to the hospitalized individual or others.

Emergency Involuntary Medication: Emergency Involuntary Medication (EIM) means one or more medications used as a restriction to manage the individual's behavior or restrict the individual's freedom of movement. EIMs are not a standard treatment for the individual's condition and are administered against a hospitalized individual's wishes without a court order. Medications taken voluntarily (without verbal or physical coercion) in the context of an EIP are not involuntary and are therefore not subject to the EIM provisions outlined in this policy.

Emergency Involuntary Procedure: Emergency Involuntary Procedures (EIP) means restraint, seclusion, or emergency involuntary medication.

Licensed Independent Practitioner: Licensed Independent Practitioner (LIP) 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.

Manual Restraint: A hold performed by staff which immobilizes or reduces the ability of a hospitalized individual to move their arms, legs, body, or head freely, without the use of equipment.

Non-Physical Intervention Skills: 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 adjust for the individual's needs.

PRN: PRN is an abbreviation of the Latin term pro re nata, meaning "as needed" or "as circumstances require."

Restraint: Restraint means any method, physical hold or mechanical device, material or equipment, that immobilizes or reduces the ability of a hospitalized individual to move their arms, legs, body or head freely.

Seclusion: Seclusion means the involuntary confinement of a hospitalized individual alone in a room or area from which the individual is physically or otherwise prevented from leaving. If a hospitalized individual is restricted to a room alone and staff are physically intervening to prevent the hospitalized individual from leaving the room or giving the perception that an attempt to leave the room/area would result in a physical intervention, is seclusion, whether a physical barrier is in place or not.

PROCEDURE

The following types of restraint are acceptable for use at (VPCH):

- Manual restraint
- Chair Restraint
- 4-point restraint (wrists and ankles are secured to a bed).

*No restraint shall not be used when the individual is in a prone (face down) position.

Upon admission or at the earliest reasonable time, the treatment team shall work with the individual and their family, caregivers, and health care agents (if necessary release(s) of information are in place) to identify strategies that might minimize or avoid the use of EIPs. Staff shall also discuss the hospitalized individual’s preferences regarding the use of such procedures should they become necessary. Although the hospital is not obligated to follow the hospitalized individual’s preferences, individual preference shall be considered when determining the least intrusive and least restrictive EIP to use to address the imminent risk of harm. The information about the hospitalized individual’s preferences is accessible via the electronic health record to direct care staff to refer to when an individual is exhibiting signs of escalation.

Prior to or as soon as possible after admission to VPCH, the assigned social worker will verify whether the hospitalized individual has an advance directive for health care, including any amendment, suspension or revocation thereof. Staff shall:

- Ask the individual directly whether they have an advance directive
- Check the Vermont Advance Directive Registry (see VPCH Advance Directive Procedure).

On admission, hospitalized individuals are informed about their right to designate someone to be notified whenever an emergency involuntary procedure is applied to them and informed that they have a right to have an attorney notified when EIPs are used.

The Initiation and Use of EIPs

EIPs may only be used to prevent the imminent risk of serious bodily harm to the hospitalized individual, a staff member, or others, or to administer court-ordered medication. EIPs may be used only when other interventions have been attempted and been 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 individual or others. EIPs must be discontinued at the earliest possible time based on an individualized clinical assessment that determines the individual no longer is considered to pose an imminent risk of serious bodily harm.

Any staff member(s) trained in accordance with VPCH's specific training requirements (see page 6 for training detail) may initiate a manual restraint if a hospitalized individual is attempting to cause serious bodily harm to self or others and immediate action is necessary.

In accordance with VPCH's adopted crisis intervention model, EIPs shall be used in the least intrusive and least restrictive manner and shall adequately accommodate a hospitalized individual's physical and environmental needs without undue violation of their personal dignity.

A registered nurse (RN) may determine the discontinuation of a manual restraint or the progression of a manual restraint to a mechanical restraint or to seclusion. The RN shall notify the LIP as soon as possible and not more than one (1) hour following the initiation to conduct the required face-to-face evaluation and to place the required orders.

Orders for Emergency Involuntary Procedures

When an EIP is used, the hospitalized individual shall be seen face-to-face by an LIP immediately. If an immediate face-to-face evaluation is not possible, it must occur as soon as reasonably possible and no later than within 1st hour after the initiation of the intervention.

After the initiation of an EIP and the face-to-face assessment, orders shall be written by the LIP who is responsible for the care of the hospitalized individual at that time and is authorized in accordance with this policy to order seclusion, restraint, and/or emergency involuntary medication. Orders for the use of seclusion or restraint can only be written by an LIP.

The order for restraint or seclusion must be obtained either during the emergency application of the restraint or seclusion or as soon as reasonably possible after the restraint or seclusion has

been applied. Each EIP utilized shall have a corresponding order (i.e. an order for the manual and for the mechanical if both methods are utilized).

Orders for the use of EIPs shall not be written as a standing order or on an as-needed (PRN) basis. Similarly, a protocol cannot serve as a substitute for obtaining a LIP's order for each episode of emergency involuntary procedure use.

No single order for restraint or seclusion shall exceed two (2) hours. At the end of two (2) hours, if the continued use of restraint or seclusion is deemed necessary based on an individualized assessment, another face-to-face assessment by a LIP and a new order is required.

If after performing a face-to-face assessment of the hospitalized individual, EIM is found to be necessary, the LIP may order the involuntary administration of one or more medications on a one-time, emergency basis.

- EIM shall only be ordered to address the emergency situation.
- Orders for EIM shall be for a single administration and shall NOT be written as PRN or standing order(s).
- There shall be NO protocol that requires a hospitalized individual to ingest oral PRN medication as a condition of release from seclusion or restraint.
- When necessary to administer involuntary medication by injection in emergency situations, an immediate acting medication that is consistent with current American Psychiatric Association practice guidelines shall be used. Use of a depot or long-acting medication as an EIM is prohibited.

Emergency Involuntary Procedures in Combination

EIPs may only be used in combination when a single emergency involuntary procedure has been determined in the clinical judgment of the LIP to be ineffective to protect the hospitalized individual, a staff member, or others from the imminent risk of serious bodily harm. Combination use at VPCH is limited to the following:

- Restraint and Emergency Involuntary Medication
- Seclusion and Emergency Involuntary Medication

A comprehensive assessment of the hospitalized individual must determine that the risks associated with the use of a combination of EIPs are outweighed by the risk of not using a combination of EIPs. Other interventions must be considered and determined by the LIP to be ineffective to protect the hospitalized individual or others from the imminent risk of serious bodily harm.

Use of an EIP to Administer Court-Ordered Medication

The use of manual restraint for the sole purpose of administering a court-ordered involuntary medication is not considered the use of a combination of EIPs. If a manual restraint is utilized for the administration of court-ordered medication, the ordered medication is NOT considered Emergency Medication and therefore those specific provisions of this policy are not applicable. All other provisions of this policy apply in full.

Observation, Assessment, and Documentation

The use of EIPs must be documented in the hospitalized individual's medical record in accordance with the standards set out in the CMS Conditions of Participation, Vermont Law, and the Joint Commission. VPCH has created documentation templates which shall be utilized to document EIP events to help ensure compliance with these standards (see Appendix A: Required EIP and EIM Documentation Guide).

The hospitalized individual undergoing an EIP shall be constantly observed by an assigned staff member who has successfully completed competency-based training on the monitoring of persons in seclusion and mechanical restraint. Observations of the hospitalized individual shall be documented at least once every 15 minutes.

At least hourly, an RN shall assess the individual's physical and psychological condition to determine whether the EIP can safely be discontinued and document their assessment. If EIM(s) are administered, the assigned RN must assess the individual every 15 minutes in the hour following EIM administration and document this assessment. Hospitalized individuals undergoing an EIP shall also be encouraged to take liquids, and shall be allowed reasonable opportunity for toileting, and shall be provided appropriate food, lighting, ventilation, and clothing or covering.

Staff shall provide hospitalized individual reasonable opportunities to debrief regarding every incident. Employees shall also be offered the opportunity to participate in event debriefing.

The use of EIPs must be followed by a written modification to the hospitalized individual's plan of care. This process shall be led by Psychology, or their designee, and shall occur at the next scheduled multidisciplinary treatment team rounds.

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:

- The necessity for the action taken to control the emergency.
- The expected or desired result of the action-on the hospitalized individual's actions or condition.
- Whether alternatives were considered or used, and why they were ineffective to prevent the imminent risk of serious bodily harm.
- The risks of adverse side effects.
- When used in combination, the basis for the determination by the LIP that the use of a single emergency involuntary procedure would not have been effective to prevent the imminent risk of serious bodily harm.

<u>Notice Requirements</u>

All documents corresponding to the use of EIPs shall be sent to the Department of Mental Health Quality Department by the VPCH Quality Department monthly.

The court-appointed guardian of the hospitalized individual shall be notified of every emergency involuntary procedure(s) within twenty-four (24) hours. Notification may occur in accordance with a guardian's documented preferences.

With the hospitalized individual's documented consent, any person identified by the individual, 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.

It is the responsibility of the ordering LIP to notify the attending physician who is responsible for the management and care of the hospitalized individual as soon as reasonably possible if the attending physician did not order the emergency involuntary procedure. Notification may occur via telephone.

Staff Training

Hospitalized individuals have the right to safe implementation of EIPs by trained staff. Staff members who participate in EIPs 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 hospitalized individual in restraint or seclusion before independently performing any of the actions specified in this policy. Training will occur 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.

VPCH requires staff who may be involved with EIPs to have education, training, and demonstrated knowledge based on the specific needs of the population served including:

- The use of nonphysical intervention skills.
- Choosing an intervention based on an individualized assessment of the hospitalized individual's medical or behavioral status or condition.
- The safe application and use of all types of restraint or seclusion used at VPCH including training in how to recognize and respond to signs of physical and psychological distress.
- Clinical identification of specific behavioral changes that indicate that EIPs are no longer necessary.
- Monitoring the physical and psychological well-being of the hospitalized individual who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by this policy associated with the one (1) hour face-to-face evaluation.
- To recognize the importance of a hospitalized individual's history of sexual, physical, and/or emotional abuse and/or incest.
- The use of cardiopulmonary resuscitation, including required periodic recertification.
- Trauma-informed training to staff who may be involved with EIPs.

Individuals providing staff training must be qualified as evidenced by education, training, and experience in interventions used to address hospitalized individuals' behaviors. VPCH will document in the staff personnel records that the training and demonstration of competency were successfully completed.

Oversight and Performance Improvement

VPCH leadership is responsible for facilitating a culture that supports a hospitalized individual's right to be free from restraint or seclusion. Leadership shall ensure that systems and processes are developed, implemented, and evaluated that support hospitalized individuals' rights and that eliminate the inappropriate use of EIPs. VPCH shall review and assess its use of EIPs to ensure that:

- Hospitalized individuals are cared for as individuals.
- Each hospitalized individual's condition, needs, strengths, weaknesses, and preferences are considered.
- EIPs are used only to address the imminent risk of serious bodily injury to the individual, staff, and others.
- Involuntary emergency procedures are discontinued at the earliest possible time, regardless of the length of the order.
- When EIPs are used, de-escalation interventions were ineffective, or were considered and determined to be ineffective to protect the individual, a staff member, or others from harm.

As soon as possible but not later than two (2) working days following an order for an involuntary emergency procedure, the hospital's Medical Director, or their designee, shall review the event.

In accordance with VPCH policy, injury, death, and/or other adverse outcomes to EIP events shall be reported to the various required internal and external stakeholders.

References:

- Act 79
- Vermont Regulation Establishing Standards for Emergency Involuntary Procedures
- Centers for Medicare and Medicaid Services Conditions of Participations Manual

Approved by	Signature	Date
Emily Hawes Commissioner Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	8/1/2023

APPENDIX A: Required EIP and EIM Documentation Guide

The use of EIPs and EIMs must be documented in the hospitalized individual's medical record in accordance with State of Vermont law, the CMS Conditions of Participation, and the Joint Commission. VPCH has created documentation templates which shall be utilized to help ensure compliance. Each applicable prompt in the template is to be addressed by the responsible party.

Emergency Involuntary Procedure Documentation

Required Documentation	Responsible Party
EIP Orders (there shall be an order corresponding to each type of EIP utilized)	LIP
Physician's Certificate of Need and Treatment Plan Addendum Restraint/Seclusion (the ordering LIP may document a manual restraint to a mechanical restraint/seclusion event on one document)	LIP
Certificate of Need and Treatment Plan Addendum for Restraint/Seclusion (one CON should correlate to each 2-hour EIP interval)	Registered Nurse
High Risk Progress Note	Registered Nurse
Emergency Seclusion/Restraint Record (one per hour)	Registered Nurse in collaboration with the assigned staff observer(s).
Patient Debriefing Following Emergency Involuntary Procedure	Registered Nurse discontinuing the EIP
Treatment Plan Update	Psychologist
Staff Debriefing (NOT part of the Medical Record)	On-Duty Nurse Supervisor or their designee

Emergency Involuntary Medication Documentation

Required Documentation	Responsible Party
EIM Orders	LIP
Physician's Certificate of Need and Treatment Plan Addendum Emergency Involuntary Medication (the ordering LIP may document all ordered EIMs on one document)	LIP
Certificate of Need for Emergency Involuntary Medications	Registered Nurse
High Risk Progress Note (if the EIM was not used in combination with a restraint or seclusion)	Registered Nurse
Patient Debriefing Following Emergency Involuntary Procedure	Registered Nurse
Treatment Plan Update	Psychologist
Staff Debriefing (NOT part of the Medical Record)	On-Duty Nurse Supervisor, or their designee