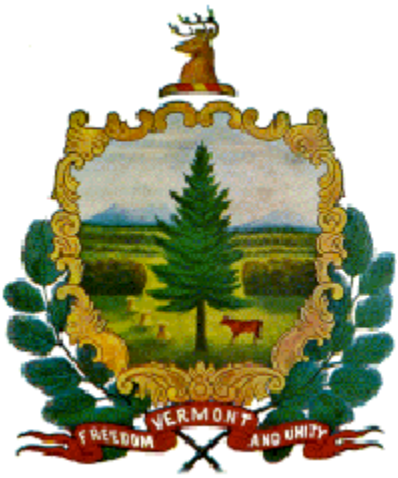

Vermont Psychiatric Care Hospital
Workplace Violence
Prevention Program

August 2023

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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, hospitalized persons, and visitors. This plan outlines several policies and procedures that we have implemented to achieve that goal. In addition, we believe that you cannot separate employee safety from the safety of hospitalized persons. The best way to keep staff safe is to provide a safe and therapeutic environment for persons hospitalized. Policies and procedures and other actions taken by VPCH to provide a safe and therapeutic environment for persons hospitalized 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 safety for persons hospitalized equates to 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 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 persons hospitalized. 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 VPCH employee-led Safety Council.

Employees of VPCH are required to create an ethical environment and culture of civility and kindness treating persons hospitalized, 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, persons hospitalized, 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 workplace.

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 are Employee Suggestion Boxes 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 and 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 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. In addition, VPCH Pro-ACT instructors assess for and address employee attitudes toward ongoing supervision, Pro-ACT course content, and teaching/testing/practice of scenario-based drills and provide further coaching with these individuals as needed.

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 action 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 Reports:

- Adverse Drug Reaction
- EHR Computer Variance
- Employee Event
- Environmental Variance
- Infection Control Incident Report
- Medication Event
- Patient Care Procedure and Process Variance
- Patient Event

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

The Quality Department organizes, analyzes, reports and maintains records on all event reports and collaborates closely with corresponding department heads.

The VPCH Event Reporting Policy provides detailed descriptions and guidance for use of all VPCH event reporting forms and processes.

The Event Reporting 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 be improved; and develop corrective action plans.

The Event Reporting Policy 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 hospitalized person'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 Event Report policy also 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 though 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.

The Employee Event Report form outlines 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. *Workplace Injury Information Packets* are also available to any employee who sustains a workplace injury.

VPCH also offers a structure for post-event debriefings which are intended as a platform to allow an opportunity for open, honest, blame-free discussion and professional reflection without fear of retribution. From a debriefing we aim to develop a shared understanding of what happened. The goals of a post event debriefing are to assure that everyone is safe, the documentation is sufficient to be helpful in later analysis, to check in with staff, to gather information, to identify potential needs for policy and procedure revisions, and to gain insight that will help us Improve our process. Debriefing also provides a valuable opportunity for newer employees to learn from more experienced employees.

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 persons hospitalized, 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. 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.

Persons Hospitalized, Employee and Visitor Safety

Safety practices on the hospitalized person's care units and in the Recovery Services area are outlined in these Procedures:

- Restricted Items Policy (Appendix A)
- Patient Observation Policy (Appendix B)
- Levels of Autonomy Policy (Appendix C)
- Two Way Radios and Cell Phones Policy (Appendix D)

Also applicable is the Emergency Involuntary Procedures Administrative Rule (Appendix E) 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 F).

For taking persons hospitalized offsite, the Escort – Unsecure and Off Campus Locations Policy (Appendix G) and the Elopement Policy apply (Appendix H).

Safety Practices Related to Visitors

Safety practices related to visitors are outlined in this Procedure:

- Visitor Policy (Appendix I)

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 hospitalized individuals 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 persons hospitalized and employees are reviewed and problem-solved as necessary by hospital leadership and non-management employees.

When an Employee is Physically Assaulted by a Person Hospitalized

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."

Workplace Injury Information Packets are available to any employee who wishes to report a physical assault by a person hospitalized to law enforcement. 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.

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 password: vteap

Safety Council

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 persons hospitalized, 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.

Appendix A

Vermont Psychiatric Care Hospital Policy and Procedure		
Restricted Items and Search Policy		
Effective: December 2018	Revised: May 2023	Due to Review: May 2025

POLICY

To maintain a safe and secure environment, the Vermont Psychiatric Care Hospital (VPCH) may search persons and items entering the facility. Item(s) that are determined to pose risk may be prohibited, restricted in certain areas of the facility, or limited to a very specific use.

DEFINITIONS

Inspection: An *inspection* is a visual scan for potentially unsanitary or unsafe conditions. Items may be moved and/or uncovered to facilitate an inspection.

Person Search: A *person search* is a thorough examination of an individual and their clothing and belongings for the purpose of identifying and securing restricted items.

Room Search: A *room search* is a thorough examination of a room or specific area for restricted items or other unsafe condition.

Unit Search: A *unit search* is a thorough examination of all unit bedrooms and all common areas of the unit.

Visitor: A hospital *visitor* is defined as any individual who cannot access the facility using their own state issued identification badge and keys. For the purpose of this policy an individual who is issued badge/key access is no longer considered a visitor.

PROCEDURE

Inspection

Personnel shall continuously inspect their working spaces and the care environment to identify actual or potentially unsanitary or unsafe conditions.

Inspections of the yard and other off unit spaces shall be conducted to identify whether any restricted items or other potential hazards are present prior to hospitalized individuals occupying the space.

Person Search

Person searches can be used for both visitors and hospitalized individuals. The process for visitor searches is distinctly different and is outlined in the *VPCH Visitor Policy*.

When conducting searches of hospitalized individuals, more invasive techniques may be used as described in the procedure below. This procedure shall only be conducted for hospitalized individuals and shall occur at the following times:

- During the admission process and before escort to the unit
- Upon return from elopement
- When returning from escorts outside of secure areas
- When mechanical restraints or seclusion is initiated
- Whenever there is reasonable suspicion that restricted items may be hidden on the individual (i.e., consider a search following an act of self- or other-directed violence, or when an ordered observation status is increased).

The invasiveness of a search for a hospitalized individual shall be determined by assessing relative risks and benefits of the search, including the potential for harm, the imminence of the harm, the risk of trauma to the individual, and whether less intrusive procedures exist which could verify the presence or absence of restricted items. Searches shall be conducted in a trauma-informed manner that respects the individual's dignity and privacy.

1. With a minimum of two (2) personnel, trained in search procedures, conduct the search in an area where privacy and safety can be assured. Personnel shall not leave a hospitalized individual unobserved at any time during the search process until it is complete.
2. Explain the search process to the individual, and specifically ask whether they have any restricted item(s) in their possession.
3. Ask the individual to remove their outer layers of clothing, to empty all pockets and turn them inside out.
4. Personnel shall ask the individual to stand with feet apart and with arms lifted away from the body.
5. To determine whether objects are concealed, staff shall scan the individual with a metal detector wand.
6. Whether listed in this policy as a restricted item or not, item(s) that are determined by the searcher to pose risk may be prohibited, restricted in certain areas of the facility, or limited to a very specific use. Whenever there is any uncertainty, questions shall be referred to the on-duty Nursing Supervisor.
7. At the discretion of the personnel conducting the search, they may:
    - Turn removed clothing inside out, check pockets, etc.
    - Inspect shoes.
    - Lightly run the back of gloved hands/fingers down the sides of the individual's arms, legs, torso, etc. to feel for the presence of restricted items that may be concealed.
8. If there is reason to suspect that restricted items may be concealed on the person and not discoverable using the above listed steps, the Nurse Supervisor and on-duty Physician shall be consulted to determine whether a more invasive search is necessary.
9. When conducting a *Person Search* where the last remaining layer of clothing removal will be requested, a Physician or a Registered Nurse shall be present. The gender of the

staff conducting the search shall be determined in collaboration with the hospitalized individual and after considering relevant clinical factors.

10. Using an individualized and trauma-informed approach, the individual may be asked to remove their clothing and don searched clothing.
11. Searches at VPCH will not be more invasive than visualization of the skin as described in the process above. The Chief Executive Officer (CEO), Chief Nursing Executive (CNE), and Executive Medical Officer (EMO), or their designees, shall collaborate on a plan as needed to determine next steps (i.e., transfer for imaging, etc.) if a more invasive search is deemed necessary and/or if the individual is not cooperative with the searchers' requests.
12. The personal belongings of hospitalized individuals shall be searched and inventoried in accordance with the *VPCH Patient Personal Effects Policy and Procedure*. Unless otherwise warranted by health, safety, or security concerns, individuals must be given the option of observing a search of their belongings.
13. Whenever restricted item(s) are identified, the item(s) shall be removed, the incident shall be documented in the individual's medical record and an event report shall be completed.

Room and Unit Searches

An unscheduled and unannounced search of each unit/room shall be conducted weekly. Individual room searches are conducted as part of broader unit searches. In addition to this weekly search, a unit and/or room search may occur whenever there is reasonable suspicion that restricted items may be concealed.

1. Unless clinically contraindicated or unless otherwise warranted by health, safety, or security, hospitalized individuals have a right to be present for a search of their room and their belongings.
2. A minimum of two personnel, trained in search procedures, shall be present in order to search an individual's room.
3. The search shall include, but is not limited to, the following:
    a. Behind and under furniture, above door and window frames
    b. Contents of storage spaces
    c. Clothing items (look in pockets, socks, sleeves, and legs of all clothing)
    d. Pillows and mattresses - with attention paid to incisions or protrusions
    e. Under mattresses
4. Personnel 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.
5. Personnel shall document that the unit search was conducted using the corresponding *Unit Search* form and provide documentation to the Nurse Supervisor.

Whenever Restricted Items are Found

1. Whenever restricted items are found, the items shall be removed, secured, and inventoried in accordance with the VPCH *Patient Personal Effects Policy* as applicable.

2. Applicable clinical documentation and a corresponding event report should be completed as soon as possible, but no later than the end of the shift on which the restricted item(s) was discovered.
3. The on-duty Nursing Supervisor shall be notified when restricted items are found and is responsible for ensuring that any restricted items have been properly secured or disposed of and that the appropriate documentation and event reporting have been completed.

Weapons and Drugs

The VPCH CEO, CNE, or their designee, shall be immediately notified of any illegal restricted items found on hospital premises and shall coordinate any necessary notification of law enforcement authorities. Questions about whether any item requires a call to the State Police shall also be referred to the CEO, CNE, or their designee.

- Alcohol that is found during a search shall be discarded by pouring down a drain.
- Marijuana or marijuana products found during a search shall be discarded by VPCH pharmacy personnel.
- Illegal drugs shall be turned over to the Vermont State Police. Other restricted items shall be removed and securely stored with the patient's belongings.
- Weapons of any kind shall be turned over to the Vermont State Police.

References (if applicable):

- VPCH Visitor Policy
- VPCH Patient Personal Effects Policy

Approved by	**Signature**	**Date**
Emily Hawes Commissioner Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	5/9/2023

Appendix A: Restricted Items List

Items that pose a potential risk of harm and are therefore generally prohibited across the facility include, but are not limited to, the following:

- Weapons or items that readily lend themselves to use as weapons (guns, metal knives, Zip ties, etc.)
- Medications not provided by VPCH (over the counter and prescribed), illegal drugs, alcohol, and toxic substances
- Matches, lighters, cigarettes, and other smoking materials

In addition to the above list, items that pose a potential risk of harm and are therefore generally prohibited within the designated care areas of the facility include, but are not limited to, the following:

- Gum or other items of similar texture
- Hair products (e.g., high alcohol content, pumps, large size/weight, etc.), aerosol products, and razors
- Hair dryers, curling irons, and other electric devices
- Scissors, sewing kits, and other sharp objects
- Mirrors, bottles, and other items made from glass
- Cellphones/cameras/smartwatches or other photographing/recording devices
- Shoelaces, zip ties, neck ties, string, straps, cords, belts, scarves, drawstrings, and other items that present a potential strangulation hazard
- Plastic bags
- Non-essential keys
- Strings or cords
- Perishable food
- Certain jewelry that could pose a strangulation or other injury risk hazard
- Certain jewelry, metal/wire within clothing items
- 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

If a hospitalized individual needs to utilize or access a restricted item, it would be done so under supervision unless otherwise specified by a physician order or in an individual's treatment plan.

Vermont Psychiatric Care Hospital Policy and Procedure	
Patient Observation	
Revised: X	Effective Date: 7/1/2019

Policy:

Vermont Psychiatric Care Hospital (VPCH) provides the necessary frequency of patient observation to maintain patient and employee safety while balancing patient autonomy and dignity.

Purpose:

To establish a standard for assigning frequency and performance of patient observation based on the patient's individual safety needs.

Procedure:

Thirty (30) Minute Checks:

- Every patient will have an order for observation frequency and shall be monitored via direct visual observation by an assigned staff person at a minimum of once per thirty (30) minute time interval pre-printed on the Precaution Monitoring Forms.
- Staff members must have direct visual observation of patients, at a distance that allows visualization of respiration, without any artificial barrier (e.g. a window, curtain, or viewing by camera) between the staff and the patient.
- The *Patient Observation Policy and Procedure* does not apply to monitoring requirements for patients in restraint/seclusion. Patients in restraint/seclusion shall be observed as described in the *Emergency Involuntary Procedures Policy and Procedure.*

Fifteen (15) minute checks:

- An RN may initiate more frequent observation and shall obtain a physician order as soon as possible. There must be a physician's order to discontinue or reduce observation frequency.
- A physician may order more frequent observation as defined herein. Physicians shall consider the trauma history of a patient and the trauma that may result from observation frequency prior to ordering more frequent observation. If the frequency of observation is increased, the physician order shall include the reason for the increased level of observation.
- Assigned staff shall directly observe the patient as per the physician order.
- Under an order for 15-minute checks, the patient shall be monitored by direct visual observation by an assigned staff person at least once per fifteen (15) minute time interval pre-printed on the precaution monitoring form.
- It is the responsibility of the Charge Nurse to assign staff members to do 15-minute checks and orient assigned staff to the patient condition as well as the purpose of the observation frequency.
- It is the responsibility of the assigned staff member to report any observed changes in patient behavior to the lead Mental Health Specialist and/or a nurse.

- Completed precaution monitoring forms shall be placed in to-be-filed manila folders and are scanned in to the Electronic Health Record by Medical Records.

Constant Observation:

- It is the responsibility of the ordering physician to specify the rationale for Constant Observation (CO), why a less restrictive alternative is not clinically justified, and whether the CO is 2:1 or 1:1 staff to patient ratio. The order shall indicate the rationale as follows:
  - CO – V (violence other-directed)
  - CO – S (suicide risk, self-directed violence)
  - CO – F (fall risk)
  - CO – E (elopement risk)
- A physician order may specify when Constant Observation (CO) is to be in effect, and when CO is not to be in effect (e.g. while in RS, while out of room). If the order does not indicate specific periods for observation, then CO is to be continuous. During periods when CO is not required by the order, an alternative observation of a frequency no less than every 30 minutes shall be ordered.
- It is the responsibility of the Charge Nurse to assign and provide report to staff assigned to CO.
- A staff assignment for CO shall not exceed four (4) consecutive hours. At least every 4 hours another staff member shall be assigned to resume responsibility for CO.
- Under an order for CO, the patient shall not be out of sight or left unattended at any time.
- The assigned staff member(s) will remain in sufficient proximity to the patient to be constantly aware of the patient's clinical status, to be able to intervene immediately if necessary, and to count the patient's respirations.
- When CO is initiated, staff shall conduct and document a patient search and a room search to identify and remove any unsafe/restricted items. *See Restricted Items and Search Policy and Procedure.*
- Staff assigned to conduct CO shall record patient actions on a *Constant Observation Form.*
- Completed *Constant Observation Forms* shall be placed in to-be-filed manila folders and are scanned in to the Electronic Health Record by Medical Records.

The obligation of patient observation is a critical staff function and effective monitoring is of the utmost importance to patient, employee, and visitor safety. It is expected that staff will:

- Remain awake, attentive, and fully alert while on duty
- Refrain from any other activity which may decrease attention away from patient observation
- Report any staff member who is observed not upholding the ordered level of observation

Due to the seriousness of this assignment, failure to uphold the frequency of observation ordered or failure to report an employee who did not uphold an order, may be considered neglect of patient care and may result in progressive discipline up to and including dismissal.

Approved by:	**Signature**	**Date:**
Sarah Squirrell, Commissioner of DMH		6/18/18

Vermont Psychiatric Care Hospital Policy and Procedure	
Levels of Autonomy	
Revised: X	Date: 2/22/2021

POLICY

The Vermont Psychiatric Care Hospital (VPCH) has a legal and ethical responsibility to protect the rights and safety of persons who are hospitalized. These rights include, but are not limited to, treatment in a safe environment, access to clinical programing, receiving visitors, communication by sealed mail and by telephone, and access to fresh air and natural light to the extent that health or safety considerations do not make it necessary to place limitations on the aforementioned.

PROCEDURE

Attending Physicians, in collaboration with hospitalized persons and multidisciplinary treatment teams, shall be responsible for entering patient orders establishing levels of autonomy. VPCH has established a basic framework to help guide clinical decision-making in this regard but a written physician order may specify an exception to, or individualization of, any autonomy level. Unless otherwise specified by written physician order, levels of autonomy are defined as follows:

Levels of Autonomy:

- **Unit Only:** A hospitalized person will remain on their unit unless otherwise specified in a written physician order.
- **Unit and Yard:** A hospitalized person may be escorted to the staffed yards.
- **Recovery Services Access 1 (RS1):** A hospitalized person may be escorted to the staffed yard or any secure area and may also participate in groups and activities with the designation RS1. Group and activity level designations are listed on a weekly schedule. The schedule is also posted on the unit and in the nurse's stations. RS1 is further described in Appendix A.
- **Recovery Services Access 2 (RS2):** This designation is identical to RS1, except that the hospitalized person may participate in groups and activities with the designation RS2 as well as those designated RS1. RS2 is also further described in the Appendix A.

Please note that VPCH has established this basic framework to help guide clinical decision-making in this regard but a written physician order may specify an exception to or individualization of any autonomy level.

Process

As a care and safety standard at the time of admission, an order shall be entered for the Unit Only level of autonomy. The ordered level of autonomy shall be evaluated and modified as clinically indicated throughout the course of hospitalization. A written physician order shall be required to **increase** level of autonomy.

Consistent with the ordered level of autonomy, the assigned Nurse or Nurse designee will conduct a safety assessment of individuals **before** any off-unit escort. If the Nurse determines that it is safe

and appropriate, they should initial the Precaution Monitoring form in the time slot that corresponds with their assessment.

It is within the scope and discretion of a Registered Nurse to implement a **decrease** in the ordered level of autonomy at any time to address changes in assessed care or safety needs. This nursing intervention can remain until such time that the larger multidisciplinary team can collectively review and adjust plans of care. A written physician order should be sought as soon as reasonably possible to reflect an altered autonomy level.

Approved by	**Signature**	**Date**
Sarah Squirrell, Commissioner of DMH		2/24/21

APPENDIX A

Recovery Services 1 Access:

RS1 groups are open groups. Participants may come and go from these groups but are asked to do so without causing significant disruption or distraction to other participants.

While these are open groups, and discussions or topics require less processing and focus, persons hospitalized who attend will be asked to maintain safe and respectful behavior. Those who are consistently disruptive may not be permitted to attend RS activities. Persons hospitalized who do attend an RS1 group and who become disruptive in any way will be asked to leave. This determination is made by the group facilitators and includes, but is not limited to: yelling, arguing, threatening, etc., as well as impeding the participation of other hospitalized persons. Anyone who refuses a staff member's request to return to the unit due to disruptive behavior may lose the privilege to attend future groups, based on treatment team discussion as well as nurse and group facilitator discretion.

Anyone who consistently demonstrates the ability to remain respectful, safe, focused, and engaged during groups may be reassessed by the treatment team to have RS2 group access.

Recovery Services 2 Access:

RS2 groups are "processing" groups. Participants are requested to arrive to group on time, as these groups will close five minutes after opening. Participants are expected to remain on topic, engage, listen, and contribute in a manner that is respectful to all present.

Those designated as having RS1 access are not permitted to attend RS2 groups; however, anyone who is designated as having RS2 access is allowed to attend all groups (with the exception of any restrictions made by the treatment team). As with RS1 access, persons hospitalized who attend RS2 groups are expected to maintain safe and respectful behavior both on the unit prior to the group as well as during group. Anyone who does not demonstrate these expectations may either be not permitted to attend group at that time or may be asked by staff to leave group and return to the unit.

Because RS2 groups require the ability to process sometimes emotionally sensitive topics/conversations while maintaining respect and open dialogue, anyone with RS2 access who consistently demonstrates the inability to remain respectful, safe, and sufficiently engaged will be reassessed by the treatment team and may be switched back to RS1 access.

Appendix D

Vermont Psychiatric Care Hospital Policy and Procedure		
Two-Way Radios and Cell Phones		
Effective: July 2018	Revised: January 2023	Due to Review: January 2025

POLICY

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

PROCEDURE

Two-Way Radios

1. Unit personnel are responsible for ensuring they obtain a radio at the start of shift. Generally, unit personnel shall have a radio on their person at all times while on-duty.
2. Ensure the radio is functioning properly.
    a. Conduct a radio check with a coworker 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.
    c. Two-way radios shall be tested for functionality each time they are used.
3. 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 moments, then release.
4. Prior to responding to a transmission, give a brief pause, then repeat step 3 above.
5. Two-way radios shall be stored in a docking/charging station when not in use. It is preferable to have charging radios powered off.
6. At the end of each shift, the assigned unit-lead is responsible for two-way radio accountability for their assigned unit.

Medical and psychiatric emergency circumstances shall immediately be announced over the two-way radio. State the location and type of emergency using steps outlined above. State the location and type of emergency twice to ensure that your transmission is understood. It is preferable to utilize wayfinding titles when identifying a caller's location versus a letter identifier:

- Snowflake (A Unit)
- Maple Leaf (B Unit)
- Monarch (C Unit)
- Red Clover (D Unit)

Announcements over two-way radio should include only the information needed to garner the needed response. The Health Insurance Privacy and Portability Act (HIPPA) guidelines apply to information communicated via two-way radio communication.

The emergency line 828-6777 shall be called in conjunction with two-way radio communication as needed to notify Admissions personnel any time there is an emergency at VPCH.

Cellphones

State-issued cellphones shall be distributed to the following personnel when on duty:

- Covering Nurse Supervisors
- Charge Nurses
- Personnel escorting individuals to unsecure locations and/or off hospital campus.

Before providing a cellphone to escorting personnel, a member of the Admissions staff shall test the cellphone for battery charge and functionality.

Each Nursing Supervisor and charge nurse shall ensure that their cellphone is charged and functioning while on duty.

Addressing Concerns or Problems

Problems or concerns regarding two-way radios and cellphone functionality shall be documented on an Environmental Variance Form and reported immediately to the on-duty Nurse Supervisor. If available, notify the Facility Operations Administrator as well.

Repair and Routine Maintenance

Two-way radios and cellphones shall be maintained consistent with the manufacturers recommendations and replaced as necessary. The Facility Operations Administrator is responsible for the overall management of VPCH-provided two-way radios and cellphones, reviewing Environmental Variance Forms, and tests their functioning.

Approved by	**Signature**	**Date**
Emily Hawes Commissioner Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	1/24/2023

Appendix E

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.

Appendix F

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 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 threatening to and/or 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

Vermont Psychiatric Care Hospital Policy and Procedure		
Escort – Unsecure and Off-Campus Locations		
Effective: July 2014	Revised: October 2022	Due for Review: October 2024

POLICY

The Vermont Psychiatric Care Hospital (VPCH) has a duty to protect the rights and safety of persons who are hospitalized. These rights include but are not limited to access to the least restrictive modes of escort to off-campus providers or services to the extent that health or safety considerations do not make it necessary to place limitations on the aforementioned. This policy also applies to VPCH personnel providing escort to discharge locations.

DEFINITIONS

Escort: For the purposes of this policy, *escort* shall refer to the accompaniment and direct supervision of hospitalized persons when accessing locations that are unsecure and/or off the hospital campus**.**

Secure: For the purposes of this policy, *secure* shall refer to off unit areas of the hospital in which an individual's mobility is limited by the badge/key access and/or exit points.

PROCEDURE

The Commissioner of the Department of Mental Health delegates authority to authorize modes of transportation and escort to VPCH providers. VPCH has established the following standard modes of transportation and escort to help guide clinical decision making in this regard. A written provider's order may further specify transportation and escort requirements.

1. State of Vermont vehicle transport with a minimum of two trained VPCH escort personnel (least restrictive mode of transportation).
2. Emergency Medical Personnel/Ambulance with the number of trained escort personnel as deemed necessary by the ordering provider and/or request for law enforcement personnel escort.
3. Law Enforcement transport and escort (note that when law enforcement personnel provide transportation/escort, custody of the hospitalized person is transferred from VPCH personnel to law enforcement personnel) (most restrictive mode of transportation).

The on-duty Nurse Supervisor shall inform and coordinate with the Admissions team any time a hospitalized person is being provided escort outside of secure hospital areas and/or off the hospital campus.

A provider shall complete and document a face-to-face assessment, collaborate with members of the individual's treatment team, and enter a written order indicating the determined mode of transport and escort in the medical record prior to departure. If the ordering provider determines transportation/escort by law enforcement personnel is needed, the rationale for such determination shall be documented in the medical record.

Prior to a transfer of authority between hospital staff and law enforcement, hospital procedures guiding emergency involuntary procedures apply. Following the transfer from hospital staff, law

enforcement personnel have the authority to make professional decisions regarding the use of restraints. Date and time transfers of authority occur should be documented in the medical record.

Transportation to and from criminal court shall be authorized, scheduled, and facilitated by employees of the court, and this may happen in collaboration with a VPCH Admissions Specialist.

Medical Director approval, or approval from their designee, is required for off-site transportation requests unrelated to emergent medical needs OR required legal proceedings. The Medical Director, or their designee, shall also be notified of any emergent transfers that occur.

Approved by	**Signature**	**Date**
Emily Hawes Commissioner Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	10/18/2022

APPENDIX A

Emergency Medical Transfer Guidance:

- Any personnel assessing an emergent medical condition can and should seek assistance from emergency personnel by calling 911.
- EMT/ambulance transportation should be the standard mode of transportation for urgent and emergent medical services. Law enforcement personnel can be requested as health and safety considerations warrant but shall NOT delay emergent transfer. If a Provider determines emergent medical transportation should not be utilized, the reasons for such determination shall be documented in the medical record.
- The on-duty supervisor shall assign VPCH escort personnel to accompany the hospitalized person. Consultation shall occur with Emergency Medical Personnel regarding whether VPCH escort personnel should accompany the hospitalized individual in the ambulance OR if VPCH escort personnel should meet them at the receiving facility.
- The on-duty VPCH provider shall complete a provider-to-provider handoff with the Emergency Department attending about the transfer. This handoff can be delegated to the medical consultant however the VPCH provider retains accountability for initial handoff as well as ongoing communication with the Emergency Department.
- VPCH has established packets of emergency paperwork that may be utilized for emergent or urgent medical transfers. Paperwork applicable to the circumstance should be sent with the hospitalized person or to the receiving facility.
- The receiving facility assumes ALL care and observation responsibilities. Assigned VPCH escort personnel shall collaborate with providers at the receiving facility to maintain observation of the hospitalized person until determination of ongoing care and treatment needs is made.
- If the hospitalized person is referred back to VPCH, the complete medical record should be reviewed by the on-duty VPCH provider and the on-duty Nursing Supervisor. The VPCH accepting provider shall also pursue a provider-to-provider handoff from the discharging facility physician. The individual needs to be medically cleared and accepted to return to VPCH by a VPCH Provider BEFORE escort back to VPCH occurs. The accepting Provider shall work with the on-duty Nurse Supervisor to communicate with assigned escort personnel and coordinate return transportation.
- If the person hospitalized is admitted to a facility other than VPCH, the hospitalized person shall be discharged from VPCH by following standard discharge procedure. VPCH escort personnel can return to VPCH and the admitting facility can work directly with the DMH Administrator on active status to facilitate any law enforcement or additional supports they may deem necessary.

APPENDIX B

Standard Safety Guidance for VPCH Escort Personnel:

- At least two (2) ProACT trained personnel should be assigned to off-site escorts when VPCH personnel are also providing the transportation; one driver and at least one additional escort unless otherwise specified by written provider order. Careful consideration shall be given to orders indicating fewer than two (2) transporters.
- A cellphone is provided to the assigned escort personnel for the duration of the escort.
- The person hospitalized shall be seated in the rear passenger-side seat of the transport vehicle with an escort personnel seated next to them and behind the driver.
- VPCH escort personnel shall use VPCH Fleet Vehicles in accordance with applicable State Policy (found here: https://bgs.vermont.gov/gbs/fleet/operations) to transport hospitalized persons; those vehicles shall be scheduled with the VPCH Staffing Office. Personal vehicles are NOT permitted for the transportation of hospitalized persons.
- Use of the fleet vehicles shall be coordinated with the VPCH Staffing Office. The assigned driver shall show a current, valid driver's license to a Staffing Coordinator. This process shall be documented on the Transport Acknowledgement form.
- Smoking and use of tobacco products is prohibited in VPCH vehicles.
- The assigned driver is responsible for conducting a safety survey before and after vehicle use and bringing any necessary documents or items (face sheet, consult documentation, cellphone, etc.).
- Stops other than the identified destination or necessary stops to refuel shall be generally avoided. If needed, a to-go meal for the hospitalized person shall be arranged.
- If an unplanned stop is required, escort personnel are entrusted to maintain care and surveillance of persons hospitalized in a manner that aims to maintain the safety of all involved. Consultation with on-duty Nurse Supervisor is encouraged for such circumstances.

If a hospitalized person attempts to elope, VPCH escort personnel shall act to prevent the elopement if this can be done safely. If elopement prevention cannot be done safely, escort staff shall follow the procedures as described in the VPCH Elopement Policy. If elopement or other emergency circumstances do occur during an off-campus transport, the VPCH escort personnel shall notify emergency responders (911) to report the condition. Escort personnel shall then contact the VPCH Admissions Office to notify the hospital of the emergency.

APPENDIX C
Vermont Psychiatric Care Hospital
Transport Acknowledgement Form

Instructions: Review information below, sign, date, and return to the Staffing Office.

I have reviewed the following policies:

- Escort – Unsecure and Off Campus Locations Policy
- Elopement Policy

I understand and acknowledge the following key points regarding the transportation and escort of persons hospitalized:

1. The Staff Transport Information form is to be completed for each hospitalized person I transport.
2. I am not authorized to utilize physical restraint as an intervention for individuals I am transporting.
3. If a situation escalates, I will utilize ProACT evasion and crisis communication techniques and/or emergency services as needed.

Each time you sign out a state vehicle for the purposes of transporting persons hospitalized, you must show a current, valid driver's license to a Scheduling Coordinator.

- ☐ I have signed a phone out from Admissions.
- ☐ I have verified with the Nurse that the individual I am transporting has been assessed by a physician.

_____ _____

Signature Print Name

_____

Date

I have reviewed the staff member's current driver's license:

_____ _____

Signature of Scheduling Coordinator Print Name

_____

Date

Form Routing Instructions:
Document shall be archived for three years from the date of signature.
Documents will be periodically scanned and archived digitally in secure folder.
Paper documents will be shredded after scanning.
Digital files may be deleted three years after signature.

Revised October 2022

Appendix H

Vermont Psychiatric Care Hospital Policy and Procedure		
Elopement Policy		
Effective: July 2014	Revised: December 2022	Due to Review: December 2024

POLICY

The Vermont Psychiatric Care Hospital (VPCH) shall take measures to prevent hospitalized persons from leaving the hospital and/or the company of VPCH personnel without authorization and to ensure the safe and timely return of individuals who leave without authorization. The following procedure outlines measures that VPCH personnel shall take if elopement has or is suspected to have occurred.

DEFINITIONS

Elopement: When a hospitalized person has or is suspected of having left secure areas of the Vermont Psychiatric Care Hospital without authorization, left the company of authorized personnel, and/or is otherwise unaccounted for.

PROCEDURE

If a hospitalized person attempts to elope from VPCH, personnel shall act to prevent the elopement if this can be done safely. If elopement has occurred or cannot safely be prevented, personnel shall follow the procedures described here forth.

- If hospital personnel become aware or suspect that a hospitalized individual has eloped, they shall immediately notify the on-duty Nursing Supervisor and the on-duty Admissions personnel of the known or suspected elopement. This notification shall include a general description of the individual (age, approximate height, weight, complexion, hair color, medical needs, etc.), the individual's likely direction, the clothing the individual was wearing, approximate time of elopement, and any safety concerns for consideration.
- The on-duty Nurse Supervisor shall facilitate a response that includes a hospital wide account of hospitalized individuals and personnel while a search plan is organized and implemented.
    - Consider using teams of 2+ personnel to conduct such searches.
    - Consider developing a strategic search plan beginning with the area last seen and based on the presenting circumstances and available information.
    - Radio communication can be utilized as the on-duty Nurse Supervisor determines is necessary/appropriate.
- Upon notification the on-duty Admissions personnel shall:
    - Alert others as indicated in the Elopement Notification steps of this procedure and report information pertinent to the individual's condition and possible location.
    - Monitor hospital wide cameras as indicated to assist with prompt location of the unaccounted-for individual.

- If the hospitalized person is not located promptly, the on-duty Nursing Supervisor or designee shall notify the individual's physician or the on-duty Physician. Law enforcement should be notified at this point to aid with the search.
- The on-duty Nursing Supervisor will check the person's medical record to determine whether there are others that need to be notified (*i.e.,* guardians, etc.) and will collaborate with the on-duty physician to complete necessary notifications.
    - If there is a concern the elopement may also be a potential duty to warn situation (*i.e.*, the individual presents a serious and imminent risk to an identifiable victim), notification of such shall be immediately conveyed to either the CEO, their designee, or the administrator on call. After consultation with DMH legal, a duty to warn would be made by the CEO, their designee, the administrator on call, or a member of the legal team.
- If the hospitalized person is located outside of a secure hospital area or away from hospital grounds, personnel shall provide verbal encouragement to autonomously return to the secure areas of the facility. The on-duty Nurse Supervisor and Admissions personnel should be notified of the individual's condition and location. If it can be done safely, personnel shall maintain visual contact with the hospitalized individual for the sole purpose of reporting updates on condition and location.

Elopement from Escort

- If escorting personnel become aware of or suspect that an individual has eloped from an off-campus escort, personnel shall immediately call 911, notify the operator of the circumstance, pertinent information including the individual's likely direction, the clothing the individual was wearing, approximate time of elopement, and any safety concerns for consideration, and follow instruction provided by the 911 operator.
- After providing the 911 operator with the pertinent information, the on-duty Nurse Supervisor and Admissions personnel shall be notified and briefed accordingly.
- If there is a concern the elopement may also be a potential duty to warn situation *(i.e.*, the individual presents a serious and imminent risk to an identifiable victim), notification of such shall be immediately conveyed to either the CEO, their designee, or the administrator on call. After consultation with DMH legal, a duty to warn would be made by the CEO, their designee, the administrator on call, or a member of the legal team.
- If the hospitalized person is located by VPCH personnel, personnel shall provide verbal encouragement to autonomously return to the facility. The on-duty Nurse Supervisor, Admissions personnel, and emergency personnel should be notified of the individual's condition and location. If it can be done safely, personnel shall maintain visual contact with the hospitalized individual for the sole purpose of reporting updates on condition and location.

Elopement Notifications

- The on-duty Admissions personnel shall begin documenting the elopement on the *Elopement Form* (available on the VPCH SharePoint site) upon learning that a hospitalized individual is unaccounted for.

- If determined to be prudent, emergency responders shall be notified of the known/suspected elopement.
- The on-duty Admissions personnel shall follow and/or communicate any directions provided by any involved emergency responders.
- The following individuals shall also be notified of any known or suspected elopement as soon as reasonably possible:
    - VPCH Chief Executive Officer or designee
    - VPCH Executive Medical Director or designee
    - DMH Administrator on call
    - DMH Legal
    - If the unaccounted for individual has a guardian, the on-duty physician or the nurse supervisor shall inform the guardian about the suspected elopement.
- Communications about elopements shall be Completed by the Admissions Specialist on duty unless otherwise specified in this policy.

Notification of Elopement to Officials

The Director of Quality, or designee, shall conduct a review of any elopement. The Director of Quality, or designee, shall send a copy of the *Department of Mental Health Critical Incident Reporting Form* (available on the VPCH SharePoint site), to:

Vermont Department of Mental Health
280 State Drive NOB 2 North
Waterbury, Vermont 05671-2010

Patient Safety and Surveillance Improvement System
Vermont Program for Quality in Healthcare
132 Main Street
Montpelier, Vermont 05602

Survey and Certification
Division of Licensing and Protection
1-888-700-5330

No other communication regarding this event should be communicated external to VPCH or DMH. If an external source is inquiring about the event, they should be directed to the DMH Commissioner's office.

Return from Elopement

When an individual returns from elopement or the suspected elopement is otherwise resolved:

- The attending physician or, if applicable, the on-call physician, shall assess the hospitalized person and enter a progress note in the medical record. Personnel shall conduct a safety search pursuant to VPCH policy.

- If circumstances are such that the individual is not returned to VPCH, discharge procedures may commence.
- The on-duty Admissions personnel shall inform previously notified parties that the individual has been returned to VPCH or that the elopement has been otherwise resolved.

Documentation

- The on-duty Nursing Supervisor or designee shall ensure that a *Patient Event Report* is completed.
- The on-duty Nursing Supervisor or designee shall ensure that a High-Risk Event note with a complete description of the event is documented.
- Admissions personnel shall provide the original completed *Elopement Form*.
- A documented debrief with staff and other stakeholders as deemed appropriate by the on-duty Nurse Supervisor.
  All documents/documentation relevant to the elopement shall be provided to the VPCH Quality Director or their designee.

References:

18 V.S.A. § 7105, the Arrest of eloped persons.
https://legislature.vermont.gov/statutes/section/18/171/07105

Approved by	Signature	Date
Emily Hawes Commissioner Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	12/5/2022

Appendix I

Vermont Psychiatric Care Hospital Policy and Procedure		
Visitors		
Effective: July 2014	Revised: October 2022	Due for Review: October 2024

POLICY

The Vermont Psychiatric Care Hospital (VPCH) recognizes that visitors are valued members of our health care and operational teams, and it is our priority to facilitate hospital visits while protecting the health and safety of those we serve, our personnel, our visitors, and our community. Visitors under 18 years of age shall be pre-approved by a hospitalized person's multidisciplinary treatment team and the Chief Executive Officer, or their designee. VPCH reserves the right to deny visits and limit visiting times.

DEFINITIONS

Visitor: A hospital visitor is defined as any individual who cannot access the facility using their own state issued identification badge and keys. Under unique circumstances, certain visitors may be issued temporary badge access and VPCH keys as deemed appropriate by the Chief Executive Officer, or their designee, (*i.e*., hospital volunteers, practicum nursing students, nursing instructors, etc.) and access areas of the hospital without an escort. For the purpose of this policy an individual who is issued badge/key access is no longer considered a visitor.

PROCEDURE

- VPCH will make every effort to accommodate any visit, however it is preferable for non-professional visits to be pre-scheduled and arranged to occur during hospital-identified hours of visitation.
- Hospital visitors shall generally enter through our hospital's main entrance.
    - Alternative access points may be arranged to meet safety and operational needs (*i.e*., emergency personnel, maintenance, or delivery personnel, etc.).
- Hospital personnel shall maintain the confidentiality of persons hospitalized consistent with applicable VPCH policy and procedures and HIPAA. Hospital visitors that may become privy to confidential information during a visit shall sign the *Visitor Acknowledgement Regarding Hospitalized persons Rights to Privacy and Confidentiality* form before entering.
- Personnel welcoming visitors shall confirm whom the visitor intends to visit, verify a government issued form of identification (ID), document required information in accordance with the *VPCH Visitor Log*, complete the applicable acknowledgement and confidentiality forms, and provide temporary visitor badges. Visitors shall be instructed to wear their visitor badge in a visible location throughout the entire visit.
    - Should a visitor not have an ID, the on-duty Nursing Supervisor shall be consulted to review the situation and decide as to whether the visitor shall be admitted.

- Personnel welcoming visitors shall notify the on-duty Charge Nurse that an identified hospitalized person has a visitor. The hospitalized persons will be notified that they have a visitor and asked if they would like to see the visitor.
    - If the hospitalized person declines to see the visitor, the visit should not proceed.
    - If the hospitalized person would like to proceed with the visit, the Charge Nurse or designee will inform personnel welcoming the visitor, and the rest of this procedure shall be followed.
- Personnel welcoming visitors shall conduct a safety search prior to visitor entry – see APPENDIX A for detailed safety guidance for conducting visitor safety searches.
    - If at any time during a safety search personnel believes the risk to their safety or the safety of others is imminent, they should immediately vacate the area to a safe location and notify the authorities of the emergency condition. The Nursing Supervisor on duty shall also be made aware of the circumstances so that proper internal emergency protocols can be enacted as needed.
- Items the visitor will retain, or items intended for the hospitalized persons shall be searched again by assigned direct care personnel.
- Visitors shall be escorted by assigned personnel throughout the duration of the visit.
    - In the event of an emergency, visitors shall follow the directions of VPCH personnel.
- When a visit concludes, assigned personnel shall escort visitors back to the front entrance vestibule, collect any issued badges/locker keys/ hospital keys, and remind visitors to retrieve any belongings in the lockers.
- Assigned personnel are responsible for visitor(s) throughout the entire visit and are required to escort them within areas of the hospital as necessary. Visitors may not be left unattended.

Visitors Under Age 18:

- Visitors under 18 years of age must be pre-approved by the hospitalized person's multidisciplinary treatment team and the Chief Executive Officer, or their designee.
- Visitors under 18 years of age, if authorized, must always be supervised by an accompanying adult visitor. VPCH personnel shall not be responsible for supervising visitors under 18 years of age.
- Visitation with individuals under 18 years of age shall occur off-unit.

Authorized BGS and Delivery Personnel:

Delivery and other service personnel who enter the hospital though the loading dock or storeroom area shall always be accompanied by hospital personnel while in the facility. For these authorized visits, some provisions of this policy and procedure may not apply.

Professional Visitors:

- Professional visitors are also encouraged to schedule their visits in advance, if possible, with the hospitalized person's treatment team and/or the Department of Mental Health Legal team. If the visit is not scheduled in advance, the Nurse Supervisor shall be consulted to determine whether the hospitalized persons is willing and/or able to have a visitor or if the visit might be required (*i.e.*, service of legal documents).
- Hospital personnel or contracted physicians who expect a visitor for a hospitalized persons shall inform Reception and Admissions in advance of the visit.
- If hospital personnel or a contracted physician is not present when their visitor arrives, Reception/Admissions shall call the personnel or contractor to alert them of their visitor's arrival.

Approved by:	Signature:	Date:
Emily Hawes Commissioner Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	10/11/2022

APPENDIX A

Personnel Guidelines for Conducting a Visitor Safety Search

- Visitor safety searches consist of dialogue with visitors about hospital safety, security, and restricted items that visitors may have with them as well as metal detection.
- Visitor safety searches shall generally be conducted in the first vestibule of the main hospital entrance.
- Visitor safety searches should NOT be conducted without the assigned personnel first making a second personnel aware of their location. VPCH personnel shall maintain certification in Professional Adult Crisis Training (ProACT) to sustain the skills necessary to evaluate the level of safety situations may present based on an individuals' verbal and non-verbal cues.
    - If personnel is uncomfortable with carrying out the steps of a visitor safety search due to safety concerns (*i.e.*, visitor is angry, confrontational, confused, threatening, etc.) they should NOT enter the vestibule with the visitor and should call the supervisor or any on duty administrator for assistance in managing the situation.
    - If personnel is in the vestibule and a threat becomes evident, they should excuse themselves, vacate the area, and notify the on-duty supervisor of their concern.
    - If a threat is immediate, they can activate emergency response by pressing the emergency button on the wand and/or on the wall and vacate the area of the immediate threat.
    - If a visitor does not consent to the safety search, assigned personnel shall remove themselves from the vestibule to notify the on-duty Nursing Supervisor. The visitor may be denied access to the hospital until either the person consents to the safety search or the CEO or designee personally reviews the situation and makes a determination.
- To conduct a visitor safety search, assigned personnel shall verbally review applicable VPCH safety process and inquire if the visitor may have items with them that would not be safe to bring into the facility including, but not limited to, the following:
    - VPCH does not generally permit food items. If allowed, food items shall be consumed at the time of the visit and any food items left over shall be disposed of or taken home with visitor.
    - Drinks must be in plastic sealed containers (no aluminum or glass) and no caffeine drinks will be permitted by VPCH personnel before 0500 or after 1300.
    - Lockers are available for any visitor items that are not authorized.
- The search would then proceed to visual examination of contents of containers, bags, boxes, pockets, or other containers that a visitor intends to be brought to the hospitalized persons or on a unit.
- Visitors and items entering the facility are then metal detected. If the metal detector alerts, the assigned personnel shall ask the visitor to make the item visible or may ask for consent to visualize the area/contents in question.
    - If a visitor does not consent to search or to reveal an item that the metal detector alerted to, assigned personnel shall vacate the vestibule and notify the on-duty Nursing Supervisor.

        - The visitor may be denied access to the hospital until such time as either the search is completed, or the CEO or designee personally reviews the situation and makes a determination about the safety of proceeding with a visit.
    - If/when contraband/restricted items are found and not perceived as an immediate threat, personnel shall explain VPCH's contraband policy and ask the visitor(s) to either return their items to their vehicle or secure the items in one of the vestibule lockers.
    - If a personnel member finds a weapon in the person's possession, the personnel member shall leave the potential visitor in outer entrance area and access a safe location to call the nursing supervisor and/or emergency responders.
    - Assigned personnel welcoming visitors shall inform direct care personnel of any items intended for the direct care areas. If the visitor asks to visit the unit or the hospitalized persons before assigned personnel can complete search of items intended for the hospitalized persons, the assigned personnel may leave these items in the Reception area. When the assigned personnel is available, they shall return to the Reception area to continue the search and determine which, if any, items are suitable to bring to the direct care area.
    - The Charge Nurse or designee shall conduct a second review and inventory of these items. 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 departs so items can be taken back with them as necessary.

Note: Personnel shall contact the on-duty nursing supervisor with any questions regarding visitors and/or compliance with this policy.