Review all Policies/Procedures in this Section

COLORADO MENTAL HEALTH INSTITUTE AT FORT LOGAN

POLICY AND PROCEDURE

TITLE: OBSERVATION PRECAUTIONS

PURPOSE: To ensure a safe and protected environment for patients at-risk.

DEFINITIONS:

1. Observation precautions: Risk-specific observations and interventions ordered for patients at risk. These may include environmental restrictions, frequent monitoring, securing of dangerous objects and limitation of personal belongings.

2. Patients at risk: Typically patients who are assessed as actively self-destructive, patients assessed as dangerous to self or others and who are unwilling or unable to contain their dangerous behaviors, and patients with a history of/or potential for elopement who present an immediate threat.

POLICIES:

1. Observation precautions require a physician's/LIP order. In an emergency, the Registered Nurse (RN) may initiate observation precautions without a physician's/LIP order, but must obtain a verbal/phone Physician's order within one (1) hour to be followed by a written physician's order within twenty-four (24) hours. Orders will be obtained from either a staff Physician or on-call doctor (OD). These may be written for up to 72 hours by the attending psychiatrist/LIP.

2. Only a physician/LIP may discontinue observation precautions (in collaboration with staff).
   a. ODs are not permitted to discontinue observation precaution orders without a review with the Psychiatrists On-Duty (POD) for approval.

3. If more specific limitations are needed or any modifications made for certain individual cases, these shall be outlined in the physician's/LIP order.

4. Observation precautions may be utilized with voluntary patients with due consideration for the civil rights implications associated with this procedure. The patient should be placed on a 72-hour hold (under C.R.S. 27-65) only when a voluntary patient refuses to comply with the observation precautions.

5. Observation precautions may involve restriction of a patient's right(s) (e.g., to retain and wear own clothes, keep personal possessions or money, have visitors) and if so, appropriate documentation is necessary per Policy and Procedure 26.28, Patient Rights.

6. Use of the seclusion room as a non-standard room for observation does not require observation protocols. Patients occasionally may be placed in a seclusion room for clinical reasons (e.g., video monitoring). Whenever the rationale for placement is clinical in nature, the clinical staff shall conduct an interdisciplinary assessment of the reasons for this placement. The assessment will reflect consideration of the patient's current clinical condition (psychological and physical), including measures to maintain safety. This assessment will be documented in the progress notes and the patient's Treatment Plan.

Criteria for movement back into a standard patient room will be identified in the Treatment Plan and include the patient's signature upon review.

PROCEDURE:

RESPONSIBILITY ACTION

Team Member

1. Makes an assessment that a patient is at risk, (e.g., suicide risk, elopement risk).

RN in Charge

1. Obtains a Physician's/LIP order from staff Physician/LIP or OD, in an emergency, institutes observation precautions then obtains phone/verbal order within one (1) hour. This is to be followed by physician/LIP assessment and signing of phone/verbal order within twenty-four (24) hours.

2. Initiates Observation Precautions order.

3. Assigns staff member to observe patient. **Acuté Suicide watch requires constant supervision by staff.**

4. Re-evaluate patients on observation precautions each shift for need to continue observation precautions.

5. If clinical situation no longer requires patient to be on a watch, the nurse and other clinical staff will communicate this to the attending Physician/LIP or POD to request an assessment that the watch order be discontinued.

Physician / LIP

1. Assesses patient and writes order for observation precautions for the appropriate watch: Acute Suicide Watch, Stepdown Suicide Watch, Self-harm Watch, Assault Watch, and Elopement Watch (see Observation precautions, Attachment A).

   Note: Any modification in observation precautions protocols or more specific limitations must be outlined in the order (e.g., gowning, strip search etc.). Increased limitations must be justified in the accompanying progress note.

2. If necessary, places patient on an emergency mental health hold per C.R.S. 27-65.

3. Documents necessity for observation precautions, any restriction of rights, and that the patient has been informed of the rationale and implication of the observation precautions. Criteria for discontinuation should clearly be explained to patient and documented.

4. When a patient is assessed by staff and physician to no longer need observation precautions, the physician shall discontinue a previously ordered observation level, by either a written, verbal, or phone order.
   a. ODs are not permitted to discontinue observation precaution orders without a review with the POD for approval.

5. Evaluates the clinical situation of the patient at least every seventy-two (72) hours (per physician LIP order) and documents assessment either in a progress note or in the body of the next required order.

Clinical Staff

1. Are responsible for monitoring the patient on observation level per attached observation level protocol and restrictions.

SIGNED: Nancy Kehiayan RN, VI DATE: 1/29/15
Nancy Kehiayan, Director of Nursing

SIGNED: Bruce Leonard MD DATE: 2/3/15
Bruce Leonard, M.D., Medical Director

APPROVED: DATE: 2/10/15
Christopher Burke, Ph.D., Hospital Director

Observation Precautions – Colorado Mental Health Institute at Fort Logan

Acute Suicide Watch ‡

- Patient in staff sight at all times
- Sleep in open seclusion or monitored in day room
- Patient & Room searched each shift for contraband, no cords, shoelaces, etc.
- Thick bedding – not covering patient's head & neck. Safety blanket, no sheets.
- Assess need for safety smock, gowns or other hospital issued clothing, if not, limit to one set of street clothes per day, no shoes
- Accompanied by 1 staff to essential appointment or off-unit emergency
- Patient constantly observed in shower / bathroom
- Check visitors for contraband, observe permitted visitors carefully. Staff must remain present during visit. Deny visits that have a contra-therapeutic effect on patient, documenting rationale
- Patient restricted to unit

Stepdown Suicide Watch ‡

Requires Psychiatrist order (in collaboration with staff)

- Patient in observable area with 15 minute staff checks
- Sleep in open seclusion or in day room or in "restricted area" or in own room if close to nursing station and a roommate is present
- May retain one set of street clothes per day, no shoes
- Accompanied by 1 staff to essential appointment or off-unit emergency
- May shower and use bathroom alone, after informing staff. May use hygiene items and return to staff upon completion of activity – no razors till off suicide watch
- Visitors – same as Acute Suicide Watch – or as modified by physician's order
- Patient restricted to unit
- Patient and Room search each day

Assault Watch ‡

- Patient on 15 minute checks
- Consider single room, QA, Seclusion, 10 foot restriction, medication change
- Assess safety of patient's belongings
- Keep patient a reasonable distance from other peers
- Accompanied by 2 staff (1 can be SSO) to essential appt or off-unit emergency
- May shower and use bathroom alone, after informing staff. May use hygiene items and return to staff upon completion of activity – no razors till off assault watch
- Visitors - Same as an Acute Suicide Watch – or as modified by physician's order
- Restricted to unit, may participate in programming on unit, no passes
- Patient & Room search each shift – unless increase is needed

Elopement Watch ‡

- Patient on 15 minute checks
- Assign patient room away from exits
- Patient to sleep in room
- Remove car keys and money
- Assess need for gowns/ no shoes, or doctor may write order for one set of street clothes/ no shoes
- Accompanied by 2 staff (1 can be SSO) to essential appt or off-unit emergency
- May shower and use bathroom alone, after informing staff. May use hygiene items and return to staff upon completion of activity
- Visitors - Same as an Acute Suicide Watch – or as modified by physician's order
- Restricted to unit, may participate in programming on unit, no passes
- Patient & Room search each shift

Self Harm Watch ‡

Same as Stepdown Suicide Watch except: may retain shoes, must constantly be observed in shower / bathroom, and patient & room searched each shift.

Grave Disability / Medical Precautions: ‡

To be addressed with individual physician orders.

‡ For All Risk Watches Document 15-min. checks on flow sheet and enter progress note every shift with high risk assessment tool.

Observation Precautions – Colorado Mental Health Institute at Fort Logan

	Acute Suicide Watch	Stepdown Suicide Watch	Self Harm Watch	Assault Watch	Elopement Watch	Grave Disability / Medical Precautions
Observation	In staff sight at all times Sleep in QA or monitored in day room. Constantly observed in bathroom/shower.	In observable area with 15 minute checks. Sleep in QA or in day room or in own room if close to nursing station and a roommate is present. May shower & use bathroom alone, after informing staff.	In observable area with 15 minute checks. Sleep in QA or in day room or in own room if close to nursing station and a roommate is present. Constantly observed in bathroom/shower.	Pt. on 15 minute checks. Sleep in single room, QA, Seclusion. May shower and use bathroom alone, after informing staff.	Pt. on 15 minute checks Assign room away from exits. May shower and use bathroom alone after informing staff.	To be addressed with individual physician's order
Risk Items	Thick bedding – not covering head & neck. Safety blanket, no sheets. Pt. & room searched each shift for contraband, no cords, shoelaces, belts, scarves, ties, etc.	May use hygiene items and return to staff upon completion of activity – no razors. Pt. & room searched each day.	May use hygiene items and return to staff upon completion of activity – no razors. Pt. & room searched each shift.	May use hygiene items and return to staff upon completion of activity – no razors. Pt. & room searched each shift – or more if needed.	Remove car keys and money. May use hygiene items and return to staff after completion of activity. Pt. & room searched each shift.	To be addressed with individual physician's order
Visitors	Check visitors for contraband, observe permitted visitors carefully. Staff to remain present during visit. Deny visits with contra-therapeutic effect on pt., documenting rationale.	Check visitors for contraband, observe permitted visitors carefully. Staff to remain present during visit. Deny visits with contra-therapeutic effect on pt., documenting rationale.	Check visitors for contraband, observe permitted visitors carefully. Staff to remain present during visit. Deny visits with contra-therapeutic effect on pt., documenting rationale	Check visitors for contraband, observe permitted visitors carefully. Staff to remain present during visit. Deny visits with contra-therapeutic effect on pt., documenting rationale.	Check visitors for contraband, observe permitted visitors carefully. Staff to remain present during visit. Deny visits with contra-therapeutic effect on pt., documenting rationale.	To be addressed with individual physician's order
Proximity & Passes	Restrict to unit, no passes. Accompanied by at least 1 staff to essential appointments or off unit emergency.	Restrict to unit, no passes. Accompanied by 1 staff to essential appointments or off unit emergency.	Restrict to unit, no passes. Accompanied by 1 staff to essential appointments or off unit emergency.	Keep a reasonable distance from peers. Consider 10' restriction. Restricted to unit, no passes. Accompanied by 2 staff (1 can be SSO) to essential appt. or off unit emergency	Restricted to unit, no passes. Accompanied by 2 staff (I can be SSO) to essential appt. or off unit emergency.	To be addressed with individual physician's order
Dress	Assess for safety smock, gowns or other hospital issued clothing, or one set of street clothes per day, no shoes.	May retain one set of street clothes per day, no shoes.	May retain one set of street clothes per day, with shoes.	Assess safety of patient's belongings.	Assess need for gowns/no shoes, or dr. may write order for one set of street clothing / no shoes.	To be addressed with individual physician's order

COLORADO MENTAL HEALTH INSTITUTE AT FORT LOGAN

POLICY AND PROCEDURE

TITLE: PREVENTION AND MANAGEMENT OF ASSAULTIVE BEHAVIOR

PURPOSE: To prevent and minimize the incidence of assaultive behavior and to establish guidelines for clinical interventions with patients exhibiting threatening and assaultive behavior; to outline what training shall be received by Fort Logan employees in such techniques, and to clarify standards with regard to the maintenance of staff proficiency in such interventions.

DEFINITIONS:

1. Physically assaultive behavior: A visible attack that would, if successful, or does, result in physical contact with a patient, a staff member, or other party within the treatment setting. The degree of severity of the attack may vary significantly, as may any resultant injury.

2. Threatening and/or menacing behavior: Any overt action of a patient, by verbal statement, body posture, gesture or intrusion by proximity, which leads another person to be reasonably in fear of bodily injury.

3. Low level interventions: A verbal intervention, problem-solving, direction or instruction, as well as environmental changes and medication interventions, not requiring a physical intervention with a patient. Effective low-level interventions may prevent the emergence of violent behavior on the part of a patient in the context of an immediate crisis.

4. Physical control intervention: Those clinical interventions by staff that result in physical contact with a patient that forcibly resists the physical assault of the patient, that are designed to prevent physical assault on a third party, self-damaging acts of the patient, or that results in the involuntary movement of the patient to a location prescribed by staff (e.g. a seclusion room, etc.) These interventions, by design and intent, shall not be pain-inducing or injurious. See Addendum E for any exceptions. "Approved physical control interventions" means specific techniques that are sanctioned by Fort Logan for use in interventions with patients by certain classes of employees when criteria for use have been met.

5. Crisis Management Training (CMT): Is the class offered by Staff Development, every month for new employees and yearly for ongoing employees. The Crisis Prevention Institutes program is utilized during this class.

6. Crisis Prevention Institute (CPI): Is the copyrighted, proprietary model of therapeutic interventions with assaultive patients developed and marketed by the Crisis Prevention Institute. The hospital functions as a licensee in the training and application of principles, concepts, and techniques developed by CPI.

7. Certified instructor: A hospital employee who is deemed by the Staff Development Department to be qualified, by reason of experience, specialized training and expertise to conduct training in the prevention and management of assaultive behavior.

8. Certified in those instances involving the use of a copyrighted, proprietary model. In addition to the above definition, that the employee presently is authorized by the proprietary firm to conduct the intended training.

POLICIES:

1. There shall be established at the hospital a uniform model of therapeutic intervention with patients who exhibit assaultive, menacing, or threatening behavior. The Institute presently adopts for this purpose the clinical intervention model developed by and licensed to this agency by the Crisis Prevention Institute (CPI), to be used as a last resort.

2. All direct-care staff shall receive a minimum of eight clock-hours of orientation and training in the prevention and management of assaultive behavior as core training before they can independently function in their job role. This training will consist of Sections I-X of the CPI model plus supplemental instruction regarding seclusion and restraint, as conducted by the hospital instructors certified for teaching the CPI program. see Addendum A for a listing of training requirements.

3. Professional staff (psychiatrists, psychologists, psychology interns, discipline chiefs and administration staff, social workers, social work interns, nursing staff, nurse managers, clinical therapists, nursing administrators and patient rights specialists) conducting their duties in routine proximity to patients shall also receive the full eight hours of orientation in the prevention and management of assaultive behavior (See Addendum A for a listing of training requirements).

4. Employees performing duties in routine proximity to patients, but who are not in direct care roles (e.g. housekeeping staff, facilities staff, Nutrition Services staff, medical services technicians, administrative assistants and program assistants, and switchboard operators) shall receive, as part of New Employee Orientation, a minimum of two hours of orientation in understanding low level intervention, aggressive behavior and personal safety measures. This course shall be based on CPI material selected from the full workshop. See Addendum A for a listing of employee categories and requirements.

5. Employees who are required to receive the full eight hours of orientation are required to receive, at least once yearly thereafter, three clock-hours of "refresher training" which shall be a review of the major elements of the CPI model. The training will be conducted as part of employee annual trainings and will be the responsibility of the Staff Development Department to assign.

6. Employees who are required to attend the two-hour initial orientation are not required to receive yearly refresher training. They are however, eligible to attend a subsequent two hour course or the eight hour course with permission, and/or at the request, of their supervisor. Such requests will be received and approved by the Staff Development and Training Department.

7. The Staff Development Department shall construct a plan to provide orientation and training in the CPI intervention model, in accord with the standards outlined by category of duties, for current employees not having received the training. The goal of the training of both new and existing employees is to promote a significant degree of uniformity in regard to interventions with aggressive and assaultive patients, to promote more effective use of low-level interventions and to minimize the incidence of injury to all parties that may result from physical altercations. It is, additionally, the goal to avoid, whenever possible, intrusive physical interventions that diminishes staff's effectiveness in providing therapeutic services to our patients.

8. Safety/Security Officers shall receive both the eight clock-hours of CPI orientation as well as special training within the Safety department regarding techniques and procedures for the management of extreme risk circumstances. The CPI certified instructor designated by the Staff Development Department shall be responsible for conducting refresher courses in CPI techniques. Each of these courses shall be conducted on a yearly basis. The Chief of Safety shall be responsible for the institution of training in special procedures (see Addendum C for a listing of training requirements and authorized techniques for Safety/Security Officers).

9. The hospital hereby adopts and sanctions for use within the agency, specific techniques to be used in those circumstances requiring physical contact with and control of patients exhibiting violent or significantly aggressive behavior. These techniques are outlined in Addendum B by category of staff. The use of physical control techniques not expressly sanctioned by Fort Logan may be cause for disciplinary action. This policy has been designed to prevent the use of physical interventions that may be injurious and/or not appropriate, relative to the therapeutic mission of the hospital.

PROCEDURE:

RESPONSIBILITY ACTION

Director, Staff Development

1. Shall establish a schedule of training in Crisis Management Training (CMT) every month for new employees and yearly refreshers.

2. Shall be responsible for the approval of course content regarding training in CMT. When proprietary models are involved, the Director shall ensure that all courses conducted under the model comply with agency, as well as the relevant proprietary standards.

3. Shall select and maintain a resource pool of qualified instructors in Crisis Management and will ensure that such instructors meet qualifications for instruction as established by Fort Logan and/or a proprietary firm licensing the intervention model.

4. Will prepare, when appropriate and/or requested, for presentation to the Hospital Management Group, a report of the training activities and impact of such training in reducing or preventing assaultive behavior within the institution.

5. Shall be responsible for notifying all classes of employees that are required to receive CMT training, upon entry to the agency, of the appropriate level of training and orientation necessary to carry out their duties.

6. Will prepare requests for funding of training activities sufficient to carry out the training activity at the agency.

Chief of Safety

1. Shall construct a specialized orientation and training program for Safety/Security Officers in the use of special physical control techniques for exclusive use by those officers (see Addendum C for a list of approved techniques). This training shall occur at least once yearly, or more frequently at the discretion of the Chief.

Trainer, Crisis Management

1. Designated trainers in CMT shall receive training and certification by the agency or a proprietary firm, sufficient to successfully carry out training in Crisis Management.

2. Will share, on a rotational basis, the duty of conducting the basic orientation course in CMT under the core curriculum. Additionally, each trainer shall be responsible for the conduct of training e.g., yearly refresher courses, special assistance to employees at risk, etc.

3. Will be responsible, in addition to conduct of training courses and sessions, for the completion and submission of all documentation of such training required by the agency. The Director of Staff Development must be notified immediately if a staff person is unable to meet the requirements of the training session.

Discipline Chiefs/Administration

1. Shall ensure the following:
   a. That all newly-hired employees in designated categories receive CMT prior to the assignment of their job duty, the level of orientation as required for their duties and discipline. This training must be completed before the employee operates independently on the unit.
   b. That the team or Department participate in the required yearly refresher training in Crisis Management within 30 days of the due date of such training.
   c. That the team or Department regularly discuss and review ongoing clinical interventions with aggressive patients and provide corrective and educative feedback to employees in order to improve their intervention skills and techniques and to insure that the most efficacious treatment is provided for the patient.

Staff Members

1. It is the responsibility of all employees, to the normal extent of their duties, and in accord with their training in Crisis Management, to utilize interventions with highly volatile and aggressive patients, those techniques approved for use in this agency.

2. Especially those carrying out duties in clinical care, clinical support and safety, are responsible for the use of the least intrusive interventions that are necessary to reduce the risk of assault and injury to themselves, to the patient, to other patients, and other staff.

3. Are responsible for the provision of direct or supportive care and treatment of patients shall be responsible for acquiring and maintaining, via available training and instruction, those skills essential to therapeutic and safe clinical interventions. Each must be able to meet the requirements of the CPI techniques taught in each class session, in order to function independently on the treatment team.

SIGNED: Kerry Bastian RN DATE: 5/29/15
Kerry Bastian, Director of Staff Development

APPROVED: _____ DATE: 5/29/15
Christopher Burke, Ph.D., Hospital Director

Training Requirements for Assaultive Behavior Management by Category of Duty and Frequency/Intensity of Patient Contact

Category of Duty/Title/Frequency of Patient Contact	Orientation/Training	Refresher
Direct Care -Nursing Staff, all levels -And external pool	Full 8 clock hour course Sections I-X plus seclusion/restraint orientation (CPI model)	CPI 3 hour course, once yearly, team level or centralized, Sections I-V, VII-IX
High Intensity Treatment Support -Safety Officers, including supervisory personnel	Full 8 clock hour course, CPI Sections I-X plus seclusion/restraint orientation Plus Special Techniques for extremely assaultive patients (Departmental Training)	CPI 3 hour course, once yearly, team level or centralized, Sections I-V, VII-IX+ 2 hours Special Procedures
Frequent Patient Contact/Treatment Direction & Support -Discipline Chiefs -Active Medical Staff -Nursing Administration, Nurse Managers -Psychology, and Psychology Interns -Clinical Therapists - Patient Rights Specialist, Admissions -Social Workers and Social Work Interns	Full 8 clock hour course, CPI Sections I-X plus seclusion/restraint orientation (CPI model)	CPI 3 hour course, once yearly, team level or centralized, Sections I-V, VII-IX
Patient Contact, Not Psych Treatment Related -Housekeeping Staff, Facilities -based on assignment -Dietary Deptartment Staff -Switchboard Operators -Administrative Assistants, Program Assistants -Medical Service Technicians -Pharmacy Department Staff -Administration	2 clock hour CPI Course Sections I-VII Can be increased at supervisor discretion Or employee request	Not required; May attend repeat 2 or 8 hour course w/supervisor approval

Techniques for Intervention with Threatening or Assaultive Behavior, Approved for Use at Fort Logan by Category of Staff

Level/Type of Intervention	Indication for Use	Authorized Technique	Personnel Authorized for Use
Verbal/Low Level	Visibly upset or anger by patient w/o threat or menacing; responsive inquiry support and reassurance.	-* CPI Supportive/Verbal	All Listed Personnel
Directive and Environmental	Patient not responsive to support, reassurance and inquiry alone; reduction of overstimulation or fearful.	-* CPI Directive/Verbal - Environmental Change w/o Locked Status - Voluntary Therapeutic Privacy - Involuntary Seclusion w/o Physical Force (physician order only)	-Direct Care Staff -Clinical Support Staff -Active Medical Staff -Safety Officers -Cert. CPI Instructors -Professional Team Staff
Physical (Immediate)	Attempted assault or actual assault by patient, to self or others; responsive only to physical, external controls w/cessation of aggression by pt. evident.	-* CPI Personal Safety Techniques -* CPI Physical Crisis Intervention Techniques - Approved Supplmtal Techniques for Immediate Physical Interventions; See Addendum E - Meds (physician order only)	-Staff Having Completed applicable *CPI training - Direct Care Staff - Freq. Patient Contact Staff -Safety Officers -Clinical Support Staff -Cert. *CPI Instructors
Physical (Sustained)	Overtly assaultive w/sustained risk of repeat assault; history and condition indicate that sustained external control is essential to curtailment of reduction of risk to self and/or others.	- Forceful Involuntary Seclusion (physician order only) - Fixed Restraint 2-4 + Points; Karrol Chair, Posey Belt, Torso Restraint - Walking Restraint; Wrist-to-Waist, Ankle Hobbles (or both) - Mesh Spit Hood	-Staff Physician -Registered Nurse, Direct Care Staff -Assisted by Team Staff -Safety Officers -Cert. *CPI Instructors
Physical (Extreme Circumstances)	Patient is exceptionally combative and not readily or satisfactorily controlled w/usual authorized *CPI techniques.	- See Addendum C	-Safety Officers Only

ALTERNATIVE PHYSICAL INTERVENTION TECHNIQUES UTILIZED BY SAFETY

1. Simple Biceps and Wrist Grab

Description of Hold: The officer takes hold of the patient's wrist with one hand and the biceps with the other hand.

Indications for Use: An escort recommended for less threatening patients. This is a simple non-threatening escort used to move a client from one area to another. The use of this technique is safe for the patient and can easily be transferred into the CPI Escort or the Shoulder Escort.

Limitations: If the patient suddenly and unexpectedly becomes combative it is the least restrictive and easiest escort from which to escape. It can, however, control the less threatening patient and protect them from injury.

2. Under and Over Shoulder Escort

Description of Hold: The officer, standing to the front and side of the patient, slips his hand between the patient's arm and body. He then brings his hand up to the rear of the patient's shoulder and secures the hold by clasping his hands together. Another officer on the opposite side of the patient executes a similar move at the same time. The patient may be bent forward at the waist at this time by exerting downward pressure on his/her shoulders. This movement secures the hold even more.

Indication for Use: When a patient is out of control or shows the potential towards more violent reactions. This escort is perhaps the most effective in terms of control and safety with an easy transition to any control position. It is particularly effective when a patient becomes lethargic, trying to drop to their knees, or becomes combative, attempting to kick out with their feet. It is also highly recommended for use with a restrained patient, offering the maximum amount of control. This escort can be used by one officer while the other uses the CPI Escort because of the similarity in control positions procedures.

Limitations: There are two limitations. The first and most important is this technique should only be used when both officers are familiar with the technique and have been trained in its use. The second limitation occurs when there is a large differential in height between either of the officers and/or patient.

3. Two-Man control position

A. Shoulder control position

1. Cross Face Reverse control position.
2. Under and Over Rollover.

Description of control position: The shoulder control position is accomplished from either a shoulder escort or from a "drag arm" pull to a shoulder escort. The patient is then lowered to the floor face down.

Indications for Use: The shoulder control position is usually employed when a patient becomes combative during an escort or is intent on causing physical harm and is in a combative posture. When the patient is putting up strong resistance a "Cross Face Reverse control position" may be employed where the patient is taken down

onto their back and an Over and Under Rollover technique is employed to get the patient onto their stomach.

Limitations: The Cross/Face Reverse control position is highly effective and best protects the patient but leaves the patient free to kick anyone who is near their feet. The Shoulder Escort and the Shoulder control position have the same limitation. They become less effective when there is a large height differential between any of the participants.

4. Minnesota Shoulder control position:

Description of control position: One officer distracts the patient while the other moves in and secures the patient from behind and around the waist trapping one of the patient's arms to their waist. The other officer then secures the free arm and puts the patient in a Shoulder Escort hold and the patient is lowered to the ground and physically restrained.

Indication For Use: May also be used when a patient becomes combative or is intent on causing physical harm and is in a combative position.

Limitations: The officers are vulnerable during the initial part of the control position. They must depend upon either distraction or a drag pull maneuver to achieve the preferred control position.

5. One Man control position

A. Cornell control position.

Description of control position: The officer secures one arm of the patient, then with a "drag-pull" maneuver moves behind the patient, lowers their body to one knee, pulls the patient back onto their other leg and then to the ground face down.

Indication for Use: When only one officer is present or the officers are involved with more than one patient.

Limitations: One-man control positions are both less effective and not as safe for the patient as a two-man control position and should only be employed when there is no additional staff to assist.

6. Physical Restraints - to limit mobility

A. Arm-bar

1. Not less than a 90 degree bend and pressed to small of back.
2. Used when patient is face first on ground, bed or wall.

Description of Hold: Once a patient is physically restrained flat on their stomach, the officers can employ the arm-bar hold of not less than 90 degrees and tightly pressed to the small of the patient's back.

Indication for Use: To limit a restrained patient's mobility and ability to struggle or strike out. The arm-bar technique is also used when restraining a less threatening patient against the wall for searching or gowning procedures. The safest way to use

the "wall restraint" is to press the patient tightly against the wall and block their feet securely against the wall, thus keeping the patient from kicking.

Limitations: When applying the arm-bar, caution must be taken never to put the patient in jeopardy by bending the arm less than 90 degrees. The arm-bar used properly will enable staff to safely limit the patient's mobility while he/she is placed into mechanical restraints or until the patient becomes less agitated. When used to restrain a patient against a wall, caution must be taken to protect the patient's face and head. This technique is only recommended for less resistive and/or threatening patients.

7. Arm-bar and leg tuck

Description of Hold: In addition to the arm-bar the officer may further limit the struggling of the patient with a leg tuck. This is accomplished by bending the patient's lower leg up and holding it with their upper thigh.

Indications for Use: When the arm-bar is not sufficient to control the struggling of the patient.

Limitations: None

8. Wall restraint (arm-bar or CPI escort hold with leg restriction).

A. For searching, gowning, and less threatening patients.

Description of Hold: See 7

Indication for Use: See 7

Limitations: none

9. Mechanical Restraints

Description: The patient is placed in four or five point restraints by restraining the patient on a bed. One officer maintains physical control with an arm-bar hold while the other places the cuffs and belts onto the patient and attaches them to the bed. When the patient becomes less aggressive, the restraints may be loosened or removed.

Indications for Use: If physically restraining a patient is not enough to stop the threat of aggression, mechanical restraints will be employed.

Limitations: Caution must be taken to secure the patient without cutting off his/her circulation.

DEFINITIONS

1. Mechanical Restraints - The application of any physical device to the body of a patient in such a way as to limit or control the physical activity of the patient. Restraints are utilized when the patient is exhibiting extremely aggressive and assaultive behavior and is in imminent danger of hurting her/himself or others, and other less restrictive means cannot produce the control necessary (supportive or protective devices utilized for the confused and/or weak patients are distinguished in writing in Policy 26.34 - B).

2. Ambulatory Restraints - Allows the patient to remain ambulatory while restricting movement to some degree. Types of ambulatory restraints are:
    a. Mesh Hood - This is a well-vented, see-through hood that is placed loosely over the head of a patient during escort or physical intervention to discourage spitting and biting. It is made of thin, nylon mesh. There is a single layer at the top, to allow the patient to see clearly and permit the staff to observe the patient completely. There is a second layer of extra-fine nylon mesh that is sewn inside at the mouth area to prevent spitting through it. The sides of the laundry bag-shaped device are cut from the bottom to halfway up, so that it goes over the head easily, falls over the shoulders and does not gather around the neck area. It washes easily between uses and is durable. **Note:** The patient will not be left alone with the hood in place.

    Exceptional circumstances - It is recognized that, on occasion, a patient may become exceptionally difficult to restrain with the usual restraining techniques. In these circumstances, the restraint techniques outlined in paragraphs 1-3 may be modified to provide the degree of the necessary security. Modifications must be reviewed by the appropriate Nursing and/or Safety Department. Such modifications must also be approved for use by a physician order.
    b. Hobbles or two-cuff ankle restraints - A cuff is applied to each ankle and attached to a leather restraint belt. The length of the belt between the two ankle cuffs determines the degree of mobility available to the patient. For the safety of the patient the minimum length of the belt left between the two ankle cuffs is 12 inches. **Note:** The patient will not be left alone with the restraints in place.
    c. Wrist-to-waist restraints - A cuff is applied to each wrist and connected by a short leather restraint belt which is secured around the patient's waist. Wrist-to-waist restraints and hobbles can be used simultaneously. **Note:** The patient will not be left unsupervised with the restraints in place.

3. Nonambulatory restraints - Confines the patient to a limited physical area by restraining the patient to a secure object. Types of nonambulatory restraints are:
    a. Five-point, four-point, three-point, diagonal two-point restraints - Ankle(s) and wrist(s) are secured by number of cuffs appropriate to the number of points of the restraint to a bed which is preferably bolted to the floor of a seclusion room.
        i. Avoid pressure on the neck, back, or any areas of the upper torso that may inhibit respiration.
        ii. Reposition the individual as soon as possible to the supine (face up) or side-lying position.
        iii. Continuously monitor the individual's respiration and physical well-being during the entire containment process by a staff person who is not physically participating in the event and who has successfully completed competency-based training in the administration and monitoring of S and R. Document these observations on Form 662 at *least* every 15 minutes.
        iv. Vocalization/speech does not ensure adequate oxygenation /respirations.

    In cases of self abuse such as biting or headbanging, additional restraints may be needed.
    b. Karroll chair- The patient may be confined to the chair by encircling a leather belt around the patient and the chair, using posey belt, or attaching the tray over the chair. One or more limbs may also be restrained to the chair by use of cuffs. For safety, the chair can be restrained to something stationary to prevent the chair from being moved.

Approved Supplemental Techniques for Immediate Physical Interventions

The CPI Personal Safety Techniques and CPI Physical Crisis Intervention Techniques are approved for use at Fort Logan for direct care staff, safety officers, clinical support staff, certified CPI instructors, and all personnel having frequent patient contact and having completed any CPI training (see Addendum B).

In addition, the following two techniques are approved for use at Fort Logan by the above stated personnel:

1. Release from a Forearm Choke

   Description of Hold: A staff member grabs the forearm (wrist, if possible) of the person choking him/her, and turns own face into the crook of the choker's elbow to open an airway. Then, the staff member drops the inside leg back, turns own chin towards the choker's body, pulls down on the forearm/wrist grip with one hand and pushes the choker's elbow up and away with the other hand. Suddenly, the staff member drops own body weight and pulls own head back and through for release and then lets go.
   Indications for Use: When grabbed from behind in a forearm choke hold.
   Limitations: Must be used only for release not continuing restraint or control, i.e., once free of the choke hold, let go.

2. Gentle Trapping Technique

   Description of Hold: Two staff will sit back to back forming a position "A" over a patient who is laying prone on the floor. They will elevate and anchor the patient's arms around their waist using their legs to counter any resistance by the patient and take away his/her arm, leg, and back strength.
   Indications for Use: During an attempt to physically restrain a patient it may become necessary to maintain control of them once they have gone to the ground. This technique is the most effective and safest method for both the staff and patient. It is particularly effective because the patient is expending an inordinate amount of energy while the staff are actually resting. In addition, the staff can easily prevent the patient from banging his/her head by restraining the patient's forehead. Since the patient is prone on the floor he/she is safe from injury that might occur during struggle while standing. Most injuries occur when the patient is going down not when they are already down.
   Limitations: Staff may find that a combative patient ends up on the ground while they are attempting the team control restraint. The Gentle Trapping Technique is an extremely effective way to physically restrain a patient in a safe manner. However, it must be emphasized that staff use this only as a restraint, **NOT AS A CONTROL POSITION.**

3. A **BACKUP** technique for bite release has also been approved for use at Fort Logan by all direct care staff, safety, clinical support staff, certified CPI instructors, all personnel having frequent patient contact and having completed any CPI training. This BACKUP technique does induce pain but it is not injurious if done properly.

   Description of Hold: Application of pressure to either one or both jaws with the knuckle of one's first finger on the jaw, one-half inch below the ear lobe.

   Indications for Use: A patient is biting you, another staff member or another patient **AND** the **CPI** bite release technique did not work.

   Limitations: Used only as a **BACKUP** technique after the **CPI** bite release technique does not work in the situation. Also, apply pressure only until the bite is released, then stop applying pressure.

COLORADO MENTAL HEALTH INSTITUTE AT FORT LOGAN

POLICY AND PROCEDURE

TITLE: RIGHTS OF PATIENTS

PURPOSE: To ensure each patient is accorded all of the rights to which he or she is entitled by law as well as those established by CMHI Fort Logan.

POLICIES:

1. Each patient receiving evaluation, care or treatment will be accorded all rights to which he or she is entitled under the law as defined in the Colorado Mental Health Statute 27-65 as amended, and as described in the "Patient Bill of Rights."

2. Patients additionally have a right to:
   a. Perform or refuse to perform tasks in or for the hospital.
   b. Develop and/ or have their advance directives honored.
   c. Have their symptoms of pain assessed and managed.
   d. Be protected from abuse and neglect.
   e. Be provided care based upon their clinical needs irrespective of their financial ability to pay for services provided.

3. A right may only be denied by an order from the physician, to avoid major adverse impact on a patient's treatment or safety. Furthermore, the organization has adopted and follows a process for implementation of these rights by demonstrating respect for patient needs with primary consideration of confidentiality, privacy, and security.

PROCEDURE:

RESPONSIBILITY ACTION

Admissions Department staff / Admitting Team Staff

1. The Patient Rights document, Form M2 will also be read to patients, in either English of Spanish, requiring their signature for documentation purposes, at the time of admission.

2. Special arrangements will be made for patients whose native language is neither English nor Spanish, will also inform the Patient Rights Specialist of these arrangements.

Patient Rights Specialist

1. The Patient Rights and Responsibilities, and the picture, name and phone number of the Patient Rights Specialist, in both English and Spanish, will be posted on all Treatment units, the Patient Rights bulletin board in the C hall corridor, Work Therapy and the Admissions office, for patient use.

2. A Patient Right's folder will be given to the patient at the time of admission and reviewed in the orientation and continuing education with the Treatment Unit staff.

Physician

1. The denial or restriction of a patient's rights will be determined by the physician and fully explained to the patient and/or designee of the patient.

2. The clinical rationale for limitations or restrictions of a patient's rights will be documented in the patient's medical record and will be evaluated for therapeutic effectiveness at least every seven days (7) in accordance with CRS 27-65Rights of Patients. The reevaluation will also be documented in the patient's medical record.

Physician / Physician Designee

1. The patient and when appropriate, families or guardians will be informed about expected and unanticipated outcomes of treatment.

REFERENCE POLICY AND PROCEDURES:
Patient Rights and Responsibilities folder
Patient Rights document (M-2)

SIGNED: _____ DATE: 4/3/17
Donna Trowbridge, Patient Rights Specialist

APPROVED: _____ DATE: 4.5.17
David Polunas, MSW, Hospital Director

COLORADO MENTAL HEALTH INSTITUTE AT FORT LOGAN

POLICY AND PROCEDURE

TITLE: USE OF SECLUSION OR RESTRAINTS

NOTE:

1. Any modification in the application of this policy and procedure must have the written approval of the Hospital Director or his designee. The written approval must be entered in the patients chart as part of the treatment plan.

2. Seclusion/Restraint Philosophy Statement: CMHI Fort Logan has the responsibility to protect and maintain the well-being of every individual by striving to create an environment that is non-punitive and coercion free. Further, the hospital acknowledges that many of our patients may have a past history of trauma, which makes them additionally vulnerable to the impact of seclusion and restraint.

   The hospital supports a patient oriented approach to care and treatment that focuses on education, respect, collaboration and inclusion. Patients will receive treatment in the least restrictive manner, which is consistent with humane patient care as well as safety for patients, staff and the public.

   The goal of the hospital is to eliminate all violent and assaultive behaviors in the treatment environment. Review at the patient-team level and by administration is essential in reduction and elimination of seclusion and restraint.

PURPOSE:

1. To integrate policy and procedures on seclusion or restraint (S or R) within the Trauma Informed Care and Recovery Models.
   a. To increase use of proactive interventions to prevent behavioral emergencies that lead to restrictive measures.
   b. To ensure that seclusion and restraint are used only when individuals pose an imminent danger to self or others and after progressive measures have been considered or exhausted.
   c. To document requirements to be followed if and when seclusion or restraints must be used.

POLICIES:

1. All patients will receive a thorough assessment using Patient Safety / Behavioral Advance Directives Form 452.1-2 (A), including relevant history, trauma, warning signs, triggers, methods to prevent escalation, and preferred interventions to avoid the need for S or R.

2. Data from this assessment will be incorporated into the Treatment Plan and used to initiate individualized proactive interventions.

3. All clinical staff will be familiar with prohibited practices, precautions, and contraindications associated with S or R.

4. Seclusion or restraint will be used in the manner consistent with this policy and procedure and only when individuals pose an imminent danger to self or others and after progressive measures have been exhausted or the emergency prevents such measures.

5. Staff will adhere to the requirements pertaining to the Emergency Seclusion and Restraint Intervention Process.

6. A post-incident debriefing will be conducted each time S or R is initiated. These sources of information will be used to update the patient's Treatment Plan as clinically indicated.

7. All staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications or STAT medications will complete competency-based training regarding implementation of associated policies.

8. The hospital will collect, aggregate, analyze, and disseminate data regarding S or R to identify strengths, flag problem areas, benchmark, review unit and/or clinician-based trends, and implement improvements.

9. The misuse of S or R is abuse and will be treated as such. All misuse must be reported as abuse and properly documented on an Incident Report Form.
    a. Examples of misuse of S or R include but are not limited to:
        i. Use for reasons other than imminent danger to self or others.
        ii. Use as punishment.
        iii. Use for staff convenience.
        iv. Failure to attempt less restrictive interventions prior, unless the emergency situation prevents such use.
        v. Failure to release the patient from S or R as soon as no longer an imminent danger to self or others.
        vi. Failure to provide an adequate level of monitoring.

PROCEDURE:

RESPONSIBILITY ACTION

Assessment

Physician, Nursing Staff, Clinical Staff

1. Must utilize the information below on Form 452.1-2(A) for the Initial Integrated Assessment and in developing and revising the Treatment Plan.
    a. Inform the individual of S or R policies and procedures and the hospital's goal to prevent behavioral emergencies that lead to use of restrictive measures.
    b. Provide the individual with the Seclusion/Restraint Philosophy Statement.
    c. Identify pre-existing medical conditions or any physical disabilities that increase risk during S or R.
    d. Identify any history of trauma, including emotional, sexual, and/or physical abuse that might increase psychological risk as a result of S or R.
    e. Identify individual characteristics, stressors, triggers, and environmental factors that may be warning signs of behavioral difficulty or a psychiatric emergency.
    f. Ask individuals for input regarding tools, actions, interventions to manage behavior(s) and have needs met proactively.
    g. Whenever possible, ask the family and other social supports (with permission of the patient) to suggest tools or strategies to use and/or avoid S or R.
    h. Assess the individual's preference regarding means to use to help him/her regain control.
    i. Document on form 452.2 (A.), #4 the individual's preference regarding notification of S or R use.

j. Populate the "What Works – Patient Tool" form for a new patient or review the form with a previous patient.

Prevention and Reduction Strategies

Physician, Nursing Staff, Clinical Staff

Prevention Strategies

1. Teach self-monitoring, emotional regulation, and impulse control skills to both staff and patients.
2. Sensitize staff to the power differential that exists between themselves and the individual(s) they serve to prevent the misuse of power, excessively controlling interventions, and/or the prohibition of the use of coercion.
3. Minimize over-stimulating environmental conditions and excessive limit setting that may lead to conflict or agitation.

Implement other behavioral support techniques as appropriate:

1. Note triggers and precipitants.
2. List warning signs.
3. Note successful interventions.
4. Use positive proactive rapport.
5. Speak calmly; avoid a loud voice.
6. Validate concerns.
7. Provide information.
8. Present safe options.
9. Provide support or assistance to problem-solve.
10. Offer a non-stimulating environment.
11. Separate individuals involved in conflict.

When a denial to a request must be given to an individual with impaired impulse control (done on case by case basis):

1. Prepare in advance.
2. Several members of the team should be present in a calm setting.
3. Decide who informs the individual of a denial to a request. After informing the person of the denial, allow the person to respond before another staff speaks.

4. Recognize and reinforce positive behavior.

5. Check in with the person about their feelings and mental status.

6. Appreciate and communicate that the issue is important to the individual.

7. Give a clear message, including a rationale for the denial. After informing the person of the denial, allow the person to respond before another staff speaks.

8. Provide the individual with specific steps by which they can achieve the desired outcome.

9. Identify one team member that the individual can continue to work with to accomplish their goal.

10. If clinically indicated, offer a voluntary medication (PRN) or as a last resort, if available, administer an emergency medication or court ordered medication (involuntary patients only).

11. Provide individual and family education about when/why S or R are used and prevention methods that may reduce the need for emergency interventions.

Addressing Triggers and Warning Signs
Use the information documented on the Form 452.1-2(A) and the What Works Form to:
1. Minimize the individual's exposure to triggers.

2. Respond to warning signs with interventions of choice and other prevention methods.

3. Develop and implement positive behavior support plans as appropriate.

Special Considerations

Physician, Nursing Staff, Clinical Staff

Prohibited Practices

1. Manual or "physical" restraint of individuals (this does not include any brief physical hold [defined as < 15 minutes] that may occur during a containment event. Special situations may arise where it is clinically safer to maintain the hold for longer than 15 minutes. When this is the case, clinical justification will be provided by the Physician.

2. Overuse of medication or chemical restraint.

3. Use of a pillow, blanket or other items covering the person's face during containment or restraint (excluding a "spit hood" which does not impair breathing).

4. Pain-inducing holds or the use of containment techniques that obstructs the individual's respiratory airways and/or impairs the person's breathing.

5. Containment of an individual in a face down position with both of the individual's hands held behind his/her back.

6. Prone (face down) leather restraints, including transporting prone.

7. Use of S or R for the convenience of staff, in the absence of, or as an alternative to, active treatment or as punishment.

8. Use of S or R as part of a behavioral intervention plan.

9. Threatening the use of S or R in an attempt to gain compliance from an individual.

Special consideration shall be given whenever an individual has a history of a medical/physical condition that would place the individual at greater medical/physical risk.

Special consideration shall be given whenever an individual has a history of a trauma, sexual, physical or emotional abuse that would place the individual at greater psychological risk as a result of seclusion or restraint.

Prone Position Precautions

The prone (face down) position during floor containment is to be avoided to the greatest extent possible in order to prevent the risk of respiratory distress, positional asphyxia, or death. The patient should be moved to a supine position as soon as medically safe to do so. Associated conditions that increase the risk for positional asphyxia include:

1. Asthma.

2. Chronic Obstructive Pulmonary Disease (COPD).

3. Emphysema.

4. Overweight/Obese.

5. Anatomical abnormalities (e.g. one lung, enlarged heart, chest deformities).

6. Other variables that can affect risk associated with prone positioning include:
    a. Pregnancy.
    b. Individual's level of agitation.
    c. Length of time of extreme exertion/resistance by the individual.
    d. Number of staff involved in the containment.
    e. Positioning of staff on or around the individual's body in a manner that restricts thorasic respiratory movement.
    f. The patient's ability to vocalize/speak does not insure adequate respirations.

Standard Contraindications

1. The individual's behavior can be controlled with less restrictive measures.

2. The "imminent danger" has subsided and the emergency condition no longer exists.

3. The release criteria for S or R have been met.

Emergency Restraint and Seclusion Intervention Process

Physician, Nursing Staff

Establishing When an Emergency Exists

1. The decision to use S or R must be initiated by a Physician/Psychiatrist or RN and must be based on the current presentation of dangerous/violent behavior where serious bodily harm or loss of life to the individual or others is imminent without immediate physical intervention.

2. All other attempts to diminish dangerous behavior must have failed or been determined to be insufficient to prevent serious bodily harm.
    a. There must be documentation in the chart on Seclusion and Restraint Tracking, Form 662 that a progression of less restrictive measures was considered and exhausted.
    b. Unless the clinical situation precludes their use, document the specific Verbal Judo interventions utilized on Form 662.

3. Verbal threats of harm to self or others, the use of offensive language, slamming a fist on a wall or table, kicking chairs, spitting or other similar behavior should <u>not</u> be used as the sole indictor for utilizing S or R.

4. If an assault has occurred, staff must assess if the assaultive behavior is likely to continue (precluding the use of any less invasive de-escalating techniques) prior to moving forward with physical intervention.

Containment Procedures

1. Unless the emergency situation prevents this, request presence of Safety Officer if restraints are to be used and/or if their assistance is required for seclusion. No patients will be utilized to assist placing another patient in S or R.

2. Upon arrival of the Safety Officers or other responding staff to the treatment unit, they will immediately be notified as to the individual (charge RN, other RN, or physician) who will be directing the intervention. That individual will make the determination as to whether S or R is necessary and will collaborate with the Safety Officers to direct the intervention.

3. Contain the individual with the least amount of physical force possible.

4. Contain the individual in a manner that avoids placing him/her face down on the floor. If the prone position is unavoidable in a manual restraint episode:
    a. Avoid pressure on the neck, back, or any areas of the upper torso that may inhibit respiration.
    b. Reposition the individual as soon as possible to the supine (face up) or side-lying position.
    c. Continuously monitor the individual's respiration and physical well-being during the entire containment process by a staff person who is not physically participating in the event and who has successfully completed competency-based training in the administration and monitoring of S and R. Document these observations on Form 662 at *least* every 15 minutes.
    d. Vocalization/speech does not ensure adequate oxygenation /respirations.

5. If the emergency continues after the containment has been accomplished, transport the individual to a restraint room in a supine or non-prone position.

6. Use only hospital-approved restraints.

7. If spitting, biting, urinating or other public health hazards occur, use any type of approved shield i.e. spit hood, for protection from the patient that does not interfere with respiration, vision or the ability to communicate or personal protective equipment for staff.

8. Every instance of S or R requires a physician's order. The RN may take a verbal order for S or R prior to a face-to-face assessment by the physician which must occur within one hour, even if the episode has been terminated, with written justification in the physician's order section of the medical record. PRN orders shall not be used to authorize the use of S or R.

9. Obtain a physician's order as soon as possible and no later than 15 minutes after application of S or R.

10. Only a physician/psychiatrist or registered nurse (RN) can assess the need for seclusion or restraint, contraindications for seclusion or restraint, and the proper application of any restraint. However, any staff member may identify and alert the team regarding contraindications or risks for the specific patient involved.

11. If the RN assesses the need for S or R, the attending or treating physician/psychiatrist must be consulted by the RN as soon as possible after the completion of the assessment. Additionally, the RN is to conduct and document an hourly face to face assessment following the initial assessment.

12. When external control is decreased, it cannot be increased without a new assessment by the RN and requires a new order by the physician. Documentation may continue on the same 662 Form.

13. When a medical/physical condition develops that contraindicates the use of S or R, release the individual and notify the physician/psychiatrist immediately to evaluate the condition of the individual.

Level of Monitoring

1. Individuals in restraints require constant observation (1:1) with the door open.

2. For seclusion, use for behavior that is dangerous to others only; the patient will receive constant observation outside the door for the first hour and then continuously on the monitor until out of seclusion.

3. All individuals who exhibit or are at risk for suicidal or self-injurious behavior, as well as those with seizure disorders, require constant observation.

4. If a medical/physical emergency occurs during the seclusion or restraint episode, the patient will remain under constant observation until evaluated by a physician, and until the 1:1 is terminated by written order.

Physician Responsibilities

Physician

Physician's order will specify the following:

A. Involuntary Patient

1. Type of behavioral S or R.

2. Description of the specific dangerous behavior requiring S or R.

3. The specific communication and/or safe and non-dangerous behavior(s) required before the individual is released from S or R. Generally the specific communication required should not include that the patient give an apology or acknowledge their transgression. Requiring the patient to apologize or

acknowledge their transgression, if clinically indicated, should instead be part of the larger treatment plan, and the patient's inability to do so should not represent justification for continued use of S or R.

4. Length of order for S or R.
    a. Orders (initial and at each renewal) can be a maximum of four hours.
    b. If after eight hours, the RN's reassessment determines that there is a need to continue the S or R episode, the RN shall contact the Physician regarding the need for a new face-to-face assessment and order.

5. Physician's signature.

6. Date and time the order was written.

7. Co-sign, date, and time the original verbal order, if one was given, at the time the face-to-face assessment note is written.

8. Even if the episode has been terminated, complete a face-to-face evaluation of the patient within one hour of initiation. Document in the physician's progress note the patient's specific behavior or risk factor that can only be managed by initiating or continuing S or R.

9. May complete a new physician's order if S or R is to be continued or an individual has been released from S or R and again becomes a danger to self or others.

B. Voluntary Patient

1. Follow Subsection A for Involuntary Patient and # 2 below.

2. 27-65 Regulations require that voluntary patients may be secluded and/or restrained *only* if they have previously given informed consent. If S or R is required, a seventy-two hour hold must be initiated on:
    a. All voluntary patients in S or R who have not signed consent for S or R prior to the episode.
    b. All voluntary patients who specifically withdraw consent for such treatment during the S or R episode.
    c. In no case should consent be sought or accepted during any episode of S or R for that particular episode. This could be construed as intimidation and as such would not be valid voluntary consent.

Safety, Dignity, and Individual's Rights

Nurse Manager

1. Notifying Safety if the room used for seclusion does not meet the following standards;
    a. The room must provide maximum safety
        i. Comfort and freedom of movement for the individual.
        ii. A shatterproof window that permits a view of the room.
        iii. Appropriate light and ventilation.
        iv. Each room is equipped with a functioning audio/visual monitor to decrease risk.
        v. Turn on the audio to monitor a patient.
        vi. The windows and ventilating equipment are covered with detention screens.
        vii. Light fixtures are recessed or covered and indestructible and the light controls are located outside the room.
    b. Ensuring the room has a mattress and/or bed, preferably bolted to the floor.

c. Ensuring the room has an operating fire detection system and that individuals must be restrained in a manner that allows for expedient release in the event of fire or other emergencies.
d. Ensure there is a pair of heavy shears (kept in the nurse's station) for the purpose of cutting restraints loose in case of an emergency.

2. Notifying the Patient Rights Specialist and TIC staff at extensions 7693 or 7897, after each restraint episode. Individuals in S or R retain the right to see the Patient's Rights Specialist and/or file a complaint.

3. The Nurse or Physician involved with the events or orders will notify the person(s) indicated on form 452.1, #4 of the event, and will document such notification or attempted notification in a progress note.

4. During a S or R Nursing Staff are responsible for:
   a. Protecting the patient from unnecessary observation by others.
   b. Ensuring the room is free of any loose objects that could potentially be harmful.
   c. Ensuring that any bathroom that can be reached from within the seclusion room must be kept locked at all times, unless staff is with the patient.
   d. Reporting any episode of S or R to the Attending Licensed Independent Practitioner (LIP). On weekends or holidays, notify the attending LIP via voice mail of each event and document notification in the record.

Release Criteria

Physician, Nursing Staff, Clinical Staff

1. Release the individual from seclusion as soon as the violent or dangerous behavior that created the emergency is no longer displayed. Release is NOT contingent upon the individual's ability to say they recognize what behavior prompted the seclusion or restraint or that they are sorry for their actions.

2. Release should not be contingent on:
   a. The patient is able to contract for safety.
   b. The patient agrees to cease using offensive language and/or making verbal threats.
   c. The patient indicates he/she will be able to be integrated into the milieu.
   d. The patient is able to respond to questions and requests.

Post Seclusion or Restraint Actions

Physician, Nursing Staff, Clinical Staff

1. An RN will complete an Incident Report if there is an injury during S or R.

2. The Team will conduct a post-debriefing after each use of S or R no later than the next working day after the individual's release from seclusion or restraint.

Participation in the debriefing should include:
   a. The individual patient.
   b. The staff members involved in the incident (if reasonably available).
   c. Team Clinical Lead and Nurse Manager.

d. The attending Psychiatrist should be involved if at all possible but do not postpone the debriefing if he/she is not available.
e. TIC staff or Peer Support Specialist if available.

Address the following in the debriefing:

a. The individual's experience of the incident (what happened and why).
b. The individual's feelings before, during, and after the event.
c. What the staff and the individual can do differently to prevent a similar situation.

Use the information obtained during the debriefing to accomplish the following:

a. Determine and implement treatment modification(s) to address triggers and warning signs.
b. Update the "What Works – Patient Tool".
c. Review mental status assessments, de-escalation techniques, unit rules and staff response to individual needs prior to or during the crisis situation.
d. Document the findings from the debriefing on Form 750, Seclusion/Restraint Review.

3. For any individual placed in S or R, the individual's Treatment Team will review the plan within three business days and modify the plan as clinically appropriate. Each review will be documented in the individual's Treatment Plan regardless of whether the Treatment Plan has changed or not.

Administrative

The Hospital Management Group and the Medical Executive Committee

1. Share hospital-wide review and evaluation responsibility for all S or R.

Chief of Psychiatry or his/her designee
On weekends/holidays, the Chief of Psychiatry's designee is the Psychiatrist on Duty.

1. For each twenty-four hour period of continuous S or R, a written review will occur and be documented on the "Administrative Review of Seclusion/Restraint Episode to Exceed 24 Hours" Form.

2. The Hospital will report to CMS and review as a Sentinel Event, any death that occurs while a patient is secluded or restrained, or occurs within 24 hours of the patient being removed from S or R, or within one week of an episode of S or R, if it is reasonable to assume that S or R was a contributing factor, directly or indirectly to the death. The event must be reported by telephone to CMS by the close of business the following business day. Staff must document in the patient's record the date and time the death was reported to CMS.

Training and Education

Staff Development

1. Ensure that any staff member who implements the written order for physical restraints and/or seclusion has received training and demonstrated competency in the proper application of restraints and the use of seclusion, as well as the related Policies and Procedures.

2. Ensure all clinical staff receives training in Trauma Informed Care, Verbal Judo, use of de-escalation method, low-level interventions, and other training as appropriate.

3. All Medical Staff receive orientation regarding the appropriate use of S or R that includes instruction in the proper writing of an S or R order.

4. Document this training in the Tracker Data Base system.

SIGNED: _____ DATE: 7/25/14
Bruce Leonard, M.D., Medical Director and Chief of Psychiatry

APPROVED: _____ DATE: 7/24/14
Christopher Burke, Ph.D., Hospital Director

COLORADO MENTAL HEALTH INSTITUTE AT FORT LOGAN

POLICY AND PROCEDURE

TITLE: QUIET AREA

PURPOSE: To define Quiet Area and its use as a supportive, therapeutic intervention

DEFINITIONS:

1. Quiet Area (QA): A designated place where a patient can be alone for the purpose of decreasing environmental stimulation and/or to regain composure. A quiet area may be a bedroom, hallway, open seclusion room, or any other unlocked, safe area on a unit.

2. Clinical Emergency: Patient behavior which reasonably predicts impending danger to self or others and which persists even though interventions to de-escalate the situation have been attempted.

POLICIES:

1. Patients may be asked or encouraged to take time in a Quiet Area. The patient must go to the area voluntarily.

2. A patient cannot be threatened with a restrictive consequence if she/he exits the Quiet Area.

PROCEDURE:

RESPONSIBILITY	ACTION
Registered Nurse	1. Will discuss and encourage the patient to take time in the Quiet Area to assist with de-escalation.
	2. When the patient is escorted to the Quiet Area, is responsible for negotiating with the patient a reasonable period of time in the Quiet Area. Time in the Quiet Area should be as short as is therapeutically indicated. However, the patient may be told that if she/he leaves the Quiet Area before the negotiated end time, an assessment will be made about his/her ability to be safe in the milleu.
	3. If the patient agrees to remain in the Quiet Area, is responsible for negotiating the period of time the patient is in the Quiet Area. Time in the Quiet Area should be as short as is therapeutically indicated. However, the patient may be told that if she/he leaves the Quiet Area before the negotiated end time, an assessment will be made about his/her ability to be safe in the milieu.
	4. If the patient must be physically transported to the Quiet Area against his/her will, this is considered a manual restraint. If the patient refuses to remain in the Quiet Area voluntarily, will initiate an assessment of whether or not a Clinical Emergency exists.

Registered Nurse, Safety Department Staff

1. If the assessment is that the patient meets criteria for seclusion and/or restraint, the appropriate measures will be instituted per Hospital Policy and Procedure 26.34, Use of Seclusion and/or Restraints.

Registered Nurse

1. If the assessment is that the patient does not meet the criteria for seclusion and/or restraint, the patient will be allowed to return to the general treatment environment immediately.

REFERENCE POLICY AND PROCEDURES:

Policy and Procedure 26.34, Use of Seclusion and/or Restraints
Policy and Procedure 26.28, Rights of Patients

SIGNED: _____ DATE: 4/3/17
Ashley Bittle, LCSW, PsyD, Director of Psychology & Internship Training

APPROVED: _____ DATE: 4-5-17
David Polunas, MSW Hospital Director

COLORADO MENTAL HEALTH INSTITUTE AT FORT LOGAN

POLICY AND PROCEDURE

TITLE: GENERAL STAFF RESPONSIBILITIES ON TREATMENT UNITS AND WITH PATIENTS

PURPOSE: To state general expectations of treatment staff

POLICIES:

1. The Hospital's treatment teams shall be maintained 24 hours per day, 7 days a week. Staffing on nights, weekends, and holidays will be such to maintain necessary treatment programs for all patients.

2. Staff shall have a working knowledge of the Hospital Policy and Procedures Manual and the policies and/or procedures of the service, and work unit to which they are assigned.

3. Staff shall be familiar with their specific discipline's Service Manual.

4. Staff shall be familiar with the Patient's Rights Pamphlet and ensure that patient rights are respected and protected.

5. Staff shall recognize that all medical record data is confidential and may only be released according to the Policy and Procedure 34.03, Release of Information to the News Media /Interviewing and/or Photographing Patients. Confidential material shall be discussed only for work-related purposes, and out of the hearing of patients and visitors.

6. Will not post any information regarding patients or hospital activities on any social media web sites.

7. Staff shall at all times, conduct themselves in a professional manner and maintain professional boundaries with patients. Relationships with patients shall be professional relationships in nature and it is expected that staff will follow the expectations as listed in General Expectations in Working with Patients (attachment A).
    a. Staff will make known to supervisors and/or the administrative staff, any pre-existing relationship with patients.
    b. Staff-initiated contact of a patient or patient's family after discharge or transfer from a team is prohibited unless such contact is of a professional nature and cleared by their discipline director in advance.

8. Staff on duty are representatives of the hospital with the community. Inquiries received from visitors and the community and the responses made to these should be considered for their broader implications for the hospital's relationship within the community. When in doubt, any staff member should seek consultation as per Policy and Procedure 34.03.

9. Staff is responsible for meeting the medical records charting requirements as prescribed by the medical staff, hospital administration, and for keeping their records completed on time per hospital policy and procedure.

10. Every staff member has supervisory assistance and specific consultation available in any emergency or questionable situation. All staff members shall be familiar with the on-call schedules and after hour organization of the Institute. Each staff member must recognize his/her own limitations as well as his/her own ability and freely seek the help: medical, administrative, supervisory, and/or consultative necessary to provide the most effective care for our patients. Each unit has its own on-call arrangements for staff who can be consulted. The on-call physician, on-call staff psychiatrist, on-call nursing supervisor, and the Administrative OD are available at all hours and should be used when needed.

11. The Patient Safety Officers are in constant radio contact with the switchboard and are available through the switchboard in any emergency. In addition, there is an alarm system in the nursing stations, which notifies adjoining units and the switchboard that immediate assistance is needed. A unit, upon receiving such an alarm signal, should immediately respond with all personnel who can possibly be spared to assist in the emergency. The last RN will not leave the team when patients are present unless the emergency is a "Code Red."

12. Staff members are expected to wear identification when on duty.

13. Locked doors.
    a. All units are locked.
    b. The doors on units will be locked at all times.
    c. The doors to the nursing station must be locked at all times when no staff member is in the station.
    d. The door or doors to the medication room or medicine cabinet must be kept locked when the room or cabinet is not in use. Medication keys are to be in the possession of the medication nurse only; see Policy and Procedure 28.16, Ordering Supplies for Medication and treatment procedures and Maintenance of Medication Room.
    e. The doors of all vacant patient sleeping rooms and vacant seclusion rooms must be kept locked.
    f. The doors of any patient rooms that have a Medical Bed, shall be locked when the patient is not in their rooms; see Nursing Policy and Procedure 5.12, Use of Medical Bed.

14. Some particular aspects of general staff responsibilities are:
    a. In any circumstance where persons other than work unit staff is to assume responsibility for a patient's care, there shall be clear, concise, adequate communication of all pertinent information to achieve an optimal level of patient care.
    b. Staff members are responsible for milieu management, which includes but is not limited to, ensuring that the environment is safe, paying attention to patients, and limiting distractions.
    c. Staff is expected to monitor patients and the unit milieu closely, and to avoid any personal activities that may distract their attention away from monitoring patients. Distracting activities may include: eating, texting, watching TV or movies, use of personal electronic devices such as cell phones, tablets, or personal computers. Staff personal electronic devices are not allowed in patient care areas.

i. Staff may participate in activities that involve reading or watching TV/ movies if the activity involves the patients. In those situations, it is expected that staff stay vigilant and continue monitoring for patient safety. Staff are not to read non-work related materials during work hours.
ii. Staff may chart in the milieu, but should have a reasonable plan for storing the patient chart in a secure place, should they be required to attend to a patient situation.

d. A minimum of one to two nursing staff will be assigned to remain in the milieu to monitor common areas, hallways, and bathrooms on each treatment team.
e. Patients who require special monitoring will receive such per Policy and Procedure 26.12, Patient Care Monitoring.
f. Charge nurses are responsible for assigning nursing staff to provide care to patient based upon patient needs and unit acuity. Staff assignments will take into consideration patient needs, patient complexity, staff skills, and supervision. (see Nursing Policy and Procedure 1.2 Assignment of Nursing Staff).
g. At least one staff member must be present in the patient care area at all times, including during change of shift reports.
h. A staff member must always be present on the unit when any patient or patients are on the unit. If any patient or patients are to remain while all other staff and patients are to be away, a specific arrangement must be made with another unit for the patient or patients to temporarily stay on the other unit.
i. When staff escorts a patient off of a team they must take a hospital radio communication device with them.

PROCEDURE:

RESPONSIBILITY ACTION

All staff

1. Will read this policy and sign General Expectations in Working with Patients, Attachment A. New employees will review and sign as part of new employee orientation. - All employees will sign initially when hired, and then annually as part of the Annual Orientation Training Fair.
    a. The signed form will be part of the employee's supervisory file.

2. There are several sources of written guidelines with additional information:
    a. Code of Ethics for the following disciplines:
        i. Principles of Medical Ethics, American Psychiatric Association.
        ii. American Nurses' Association Code of Ethics for Nurses.
        iii. National Association of Social Workers Code of Ethics.
        iv. The American Psychological Association Code of Ethics.
        v. Occupational Therapy Code of Ethics and Ethics Standards.
        vi. American Therapeutic Recreation Association Code of Ethics.
        vii. American Music Therapy Association Code of Ethics.
    b. The Colorado State Practice Act for your discipline:
        i. CRS 12-36 Medical Practice Act.
        ii. CRS 12-38-117 Nursing Practice Act.
        iii. CRS 12- 43 – Mental Health Practice Act.
    c. CMHI Fort Logan Policy and Procedure Manual.
    d. Discipline-specific Service Manuals.

REFERENCE POLICY AND PROCEDURES:

Policy and Procedure 27.09, Presence of Children and Pets at Work
Policy and Procedure 1.20, Visitors at CMHIFL
Policy and Procedure 1.14, Guidelines for Response to Alleged Sexual Relations between Staff and Patients
Policy and Procedure 26.68, Care and Treatment of Vulnerable Patients
Nursing Procedure 27.0, Guidelines for Response to Alleged Sexual Assault
Policy and Procedure 34.03, Release of Information to the News Media /Interviewing and/or Photographing Patients
Dietary Policy 1106, Staff/Guest Meals

SIGNED: Nancy Kehiaya RN, VI DATE: 9/5/14
Nancy Kehiayan, Director of Nursing

APPROVED: DATE: 9/5/14
Christopher Burke, Ph.D., Hospital Director

Attachment A

COLORADO MENTAL HEALTH INSTITUTE AT FT. LOGAN

GENERAL EXPECTATIONS IN WORKING WITH PATIENTS

It is important to foster therapeutic relationships with patients and their significant others. Within this process, it is essential to maintain appropriate professional boundaries. It is expected that staff working with patients will perform their duties in keeping with their professional code of ethics, Colorado law, and with CMHI Fort Logan policies and procedures. Staff will make known to supervisors and/or the administrative staff, any pre-existing relationship with patients. Staff members are expected to check with supervisory staff about any practice of which you are uncertain.

Staff members are responsible for milieu management, which includes but is not limited to, ensuring that the environment is safe, paying attention to patients, and limiting distractions. Staff is expected to monitor patients and the unit milieu closely, and to avoid any personal activities that may distract their attention away from monitoring patients. Distracting activities include, but are not limited to: eating, texting, watching TV or movies, use of personal electronic devices such as cell phones, tablets, or personal computers. Staff personal electronic devices are not allowed in patient care areas.

Staff may participate in activities that involve reading or watching TV/ movies if the activity involves the patients. In those situations, it is expected that staff stay vigilant and continue monitoring for patient safety. Staff is not to read non-work related materials during work hours. Staff may chart in the milieu, but should have a reasonable plan for storing the patient chart in a secure place, should they be required to attend to a patient situation. Staff is to check with their supervisor if they have any questions about these activities.

Staff will not:

1. Borrow money/goods (e.g. cigarettes, pop) from patients or loan money/goods to patients.
2. Accept gifts from patients or families/visitors of patients. Gifts should be considered in terms of the meaning the gift has for the patient, consult with your supervisor.
3. Give or buy patients clothing, gifts, personal items, etc. Instead, staff can make donations through the Volunteer Auxiliary Donation Protocol.
4. Enter into business transactions with patients including buying or selling goods/services to patients.
5. Discuss significant personal issues (e.g. personal family dynamics, personal problems, and personal medical issues) with patients or among other staff where patients can overhear. If uncertain, discuss with your supervisor.
6. Engage in a social, sexual, romantic, personal or financial relationships with patients while they are in the hospital or even after discharge or staff separate employment.
7. Initiate contact with a patient or their family. Staff-initiated contact of a patient or patient's family after discharge from a team is prohibited unless such contact is of a professional nature and cleared by your discipline director in advance.
8. Share personal email, phone, home address, or social network account information.
9. Invite friends/relatives to join you at activities with patients when you are responsible for patients, whether the activities are on-grounds or off-grounds, except as cleared with your supervisor in advance.
10. Take patients to staff's home or on staff businesses.
11. Transport patients in staff's car.
12. Escort patients to activities or assume responsibility for patients either on-grounds or off-grounds when the employee has clocked out and is off duty.
13. Post any information regarding patients or hospital activities on any social media web sites.

The following additional areas of conduct are highlighted for your review. Please read them over and check with your supervisor if you have any questions concerning them or think of related concerns about which you are uncertain.

Staff are not to:

1. Sleep on duty (or in patient area if off duty). You are always expected to be alert and responsive to patient needs.
2. Use illicit drugs, drink alcoholic beverages, or be under the influence of drugs or alcohol (noticeable by a change in behavior and/or can be detected by others) when one is responsible for patients, whether on-grounds or off-grounds.
3. Make racial, sexual, cultural, or religiously oriented slurs to patients, staff, visitors, or community contacts.
4. Dress inappropriately, i.e. in revealing or potentially provocative manner. Clothing with logos related to drugs, alcohol, smoking, political, or religious issues are not appropriate dress in this setting. Staff will present a neat, professional appearance when working with Fort Logan patients. Staff should check with their supervisor for specifics related to dress code.
5. Behave in a way that is physically, verbally, or sexually abusive of patients, visitors, staff or others.
6. Use Institution equipment and supplies (e.g. medication, food, patient meals, paper supplies, patient grooming items, linens, etc.) for personal use or gain.
7. Attend to personal laundry on duty.
8. Use the telephone extensively for personal calls, whether incoming or outgoing (for example, more than a total of 15 minutes per day). You may not use CMHI Fort Logan phones for long-distance personal calls unless you get permission from the supervisor and make arrangements for payment. No personal use of electronic devices, including cell phones in patient care areas.
9. Attend to non-CMHI Fort Logan business or volunteer work or use of state property for same while on duty, unless otherwise approved by the supervisor.
10. Change the patient's appearance through haircutting (except with a physician's order for medical reasons), hair coloring or giving a "permanent." It remains an expectation that nursing staff will assist with hygiene (assist with shaving, setting hair, etc.).

I have read Hospital Policy 27.99 and have reviewed with my supervisor the General Expectations in Working With Patients.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

COLORADO MENTAL HEALTH INSTITUTE AT FORT LOGAN

ACKNOWLEDGEMENT OF POLICIES/PROCEDURES

- p&p 26.01 Observation Precautions
- p&p 26.26 Prevention and Management of assaultive behavior
- p&p 26.28 Rights of Patients
- p&p 26.34 Use of Seclusion or Restraints
- p&p 26.36 Quiet Area
- p&p 27.99 General Staff Responsibilities on Treatment Units and with Patients

I acknowledge that I have been provided a copy of the listed CMHI_FL policies and procedures. My signature indicates that I have read, understand and agree to follow all policies and procedures.

_____ _____

Name Date