

D R A F T

Proposed Inpatient Mental Health Quality Assurance Standards

Thank you for taking the time to review and comment on these proposed inpatient mental health quality assurance standards. These proposed standards were developed through a project funded and coordinated by the Alaska Division of Mental Health and Developmental Disabilities (DMHDD). Project oversight was conducted through a Steering Committee composed of the following individuals:

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This draft is being widely distributed to outpatient and inpatient providers to allow for examination and comment. As a part of the review process, several public forums will be conducted. For details on the dates and times of the forums, you can contact:

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You may obtain an additional copy of this document by contacting either individual listed above or by downloading from the web site www.csmgt.com. (Adobe Acrobat format)

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Preface

- Timeline: Comment period June 1 – July 15, 2000
Modifications: July 15 – July 31, 2000
Submission of Draft Standards to Director, DMHDD: August 1, 2000
(Submission to Health & Social Services Commissioner and other state entities will occur following review and modification by DMHDD Director)
- Applicability: These standards are intended to apply to Alaska Psychiatric Institute as well as other hospitals that provide designated evaluation and treatment, designated evaluation and crisis stabilization, and designated evaluation that is funded by DMHDD.
- Implementation: It is envisioned that these standards will be used as a tool for site reviews although this process has not been developed.
- Format: The format for these standards was modeled after the format used by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The content and wording were, where possible, drawn from JCAHO.
- Content: The standards apply in the following areas of concern:
- Use of Restraints and Seclusion
 - Patient and Family Member Involvement in Treatment/Discharge Planning
 - The Availability of Neuroleptics and their Use
 - Clinical Appropriateness of Treatment
 - Use of Behavior Management Plans
 - Management of Patient Assaultive Behavior
 - Use of a Level System of Patient Safety Evaluation
 - Admission/Discharge Interaction between Inpatient and Outpatient Providers

Use of Restraint and Seclusion

RS 1.0 *Restraint or seclusion use will be limited to emergencies in which there is an imminent risk of an individual physically harming himself, staff, or others, and non-physical interventions would not be effective. Non-physical techniques are the preferred intervention in the management of behavior.*

Type of Facility

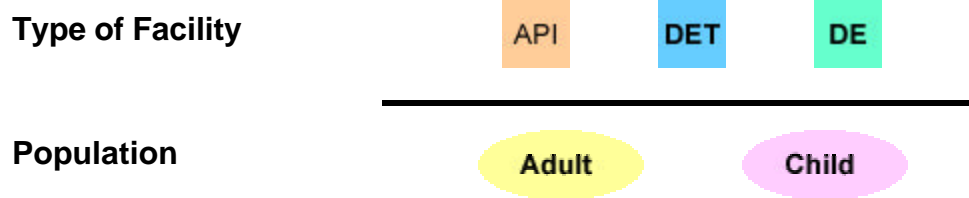


Population



Discussion. Non-physical techniques are always considered as the preferred intervention. Such interventions may include redirecting the individual's focus or employing verbal de-escalation. Restraint or seclusion will only be employed when non-physical interventions are ineffective or not viable, and when there is an imminent risk of an individual physically harming him or herself, staff, or others. The type of physical intervention selected takes into consideration information learned from the individual's initial assessment. The organization will not permit use of restraint or seclusion for any other purpose, such as coercion, discipline, convenience, or retaliation by staff. The use of restraint or seclusion will not be based on an individual's restraint or seclusion history or solely on a history of dangerous behavior.

RS 2.0 ***The initial assessment of each individual at the time of admission or intake assists in obtaining information about the individual that could help minimize the use of restraint or seclusion.***



Discussion. The initial assessment of an individual who is at risk of harming him or herself, staff, or others, will identify:

- Techniques, methods, or tools that would help the individual control his or her behavior. When appropriate, the individual and/or family assist in the identification of such techniques;
- Pre-existing medical conditions or any physical disabilities and limitations that would place the individual at greater risk during restraint or seclusion; and
- Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint or seclusion.

Also at the time of assessment:

- The individual and/or family will be informed of the organization's philosophy on the use of restraint and seclusion to the extent that such information is not contraindicated.
 - The role of the family, including their notification of a restraint or seclusion episode, is discussed with the individual and, as appropriate, the individual's family. This is done in conjunction with the individual's right to confidentiality.
 - The organization will determine whether the individual has an advance directive with respect to behavioral health care and will ensure that direct care staff are made aware of the advance directive.
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RS 3.0 *A licensed independent practitioner will order the use of restraint or seclusion.*

Type of Facility

API

DET

DE

Population

Adult

Child

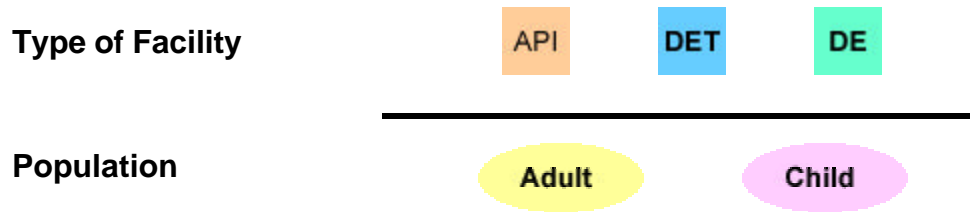
Discussion. Because restraint and seclusion use is limited to emergencies (in which a licensed independent practitioner may not be immediately available), the organization may authorize qualified registered nurses or other qualified, trained staff members who are not licensed independent practitioners to initiate the use of restraint or seclusion before an order is obtained from the licensed independent practitioner. All restraint and seclusion will be used and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner. As soon as possible, but not longer than one hour after the initiation of restraint or seclusion, a qualified registered nurse or other qualified staff:

- Will notify and obtain an order (verbal or written) from a licensed independent practitioner; and
- Will consult with the licensed independent practitioner about the individual's physical and psychological condition.

The licensed independent practitioner will:

- Review with staff the physical and psychological status of the individual;
 - Determine whether restraint or seclusion should be continued;
 - Supply staff with guidance in identifying ways to help the individual regain control in order for restraint or seclusion to be discontinued; and
 - If appropriate, issue an order.
-

RS 4.0 *A licensed independent practitioner will see and evaluate the individual in person.*



Discussion. The licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner will conduct an in-person evaluation of the individual:

- Within four hours of the initiation of restraint or seclusion for individuals 18 years of age or older; and
- Within two hours of initiation for children and adolescents age 17 and under.

At the time of the in-person evaluation, the licensed independent practitioner:

- Will work with the individual and staff to identify ways to help the individual regain control;
- Will make any necessary revisions to the individual's treatment plan; and
- If necessary, provide a new written order. This order and any subsequent orders follow the time limits cited in Standard RS 5.0.

If the individual is no longer in restraint or seclusion when an original verbal order expires, the licensed independent practitioner will conduct an in-person evaluation of the individual within 24 hours of the initiation of restraint or seclusion.

RS 5.0 *Written or verbal orders for initiating and continuing use of restraint and seclusion will be time-limited.*

Type of Facility

API

DET

DE

Population

Adult

Child

Discussion. Written and verbal orders for restraint and seclusion will be limited to:

- Four hours for individuals 18 years of age and older;
- Two hours for children and adolescents ages 9 to 17; and
- One hour for children under age 9.

Orders for the use of restraint or seclusion will not be written as standing orders or on an as needed basis (PRN).

If restraint or seclusion needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion will be obtained from the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner.

Time-limited orders do not mean that restraint or seclusion must be applied for the entire length of time for which the order is written. The standards for periodic assessment, monitoring and assisting, and reevaluation are intended to encourage the discontinuation of restraint or seclusion as soon as the individual meets the behavior criteria for its discontinuation.

When restraint or seclusion is terminated before the time-limited order expires, the original order can be used to reapply the restraint or seclusion if the individual is at imminent risk of physically harming him or herself or others, and non-physical interventions are not effective. A new order for restraint or seclusion, however, is obtained from the licensed independent practitioner who is primarily responsible for the individual's ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner when the original order expires.

RS 6.0 *Individuals who are in restraint or seclusion are regularly reevaluated.*

Type of Facility

API

DET

DE

Population

Adult

Child

Discussion. By the time that an order for restraint or seclusion expires, the individual will receive an in-person reevaluation. This in-person reevaluation will be conducted by:

- The licensed independent practitioner who is primarily responsible for the individual's ongoing care; or
- His or her licensed independent practitioner designee; or
- Other licensed independent practitioner; or
- A qualified registered nurse or other qualified, trained individual who has been authorized by the organization to perform this function (see Standard RS 3.0 for conditions).

If, after reevaluation the restraint or seclusion is to be continued, the licensed independent practitioner, in conjunction with the reevaluation will:

- Give a written or verbal order for continuation that is subject to the time frames defined in Standard RS 5.0; and
- Reevaluate the efficacy of the individual's treatment plan and work with the individual to identify ways to help him or her regain control.

If the licensed independent practitioner, or his or her licensed independent practitioner designee, is not the licensed independent practitioner who gives the order, the individual's licensed independent practitioner will be notified of the individual's status if the restraint or seclusion is continued.

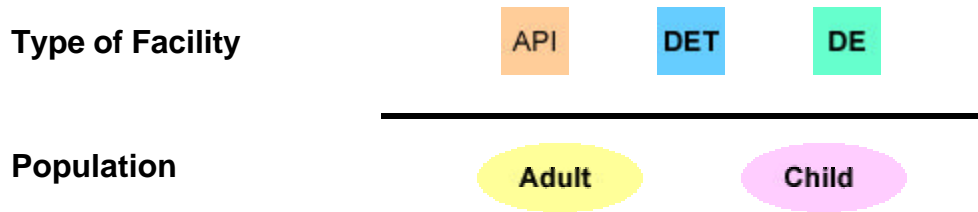
Reevaluation of the individual in restraint or seclusion will take place every:

- Four hours for adults ages 18 and older;
- Two hours for children and adolescents ages 9 to 17; and
- One hour for children under age 9.

The licensed independent practitioner must, in any event, conduct an in-person reevaluation at least every:

- Eight hours for individuals ages 18 and older; and
 - Four hours for individuals ages 17 and younger.
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RS 7.0 *Individuals in restraint or seclusion are assessed and assisted.*

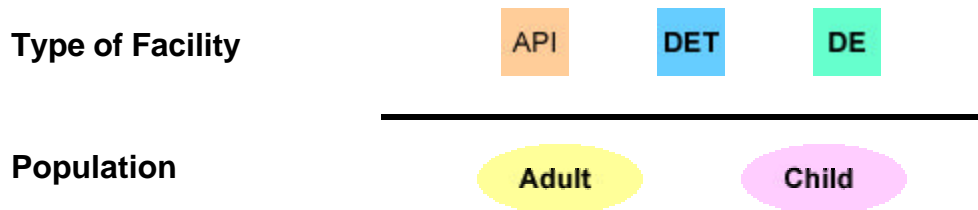


Discussion. A trained and competent staff member will assess the individual at the initiation of restraint or seclusion and every 15 minutes thereafter. This assessment will include, as appropriate to the type of restraint or seclusion employed:

- Signs of any injury associated with the application of restraint or seclusion;
- Nutrition and hydration;
- Circulation and range of motion in the extremities;
- Hygiene and elimination;
- Physical and psychological status and comfort; and
- Readiness for discontinuation of restraint or seclusion.

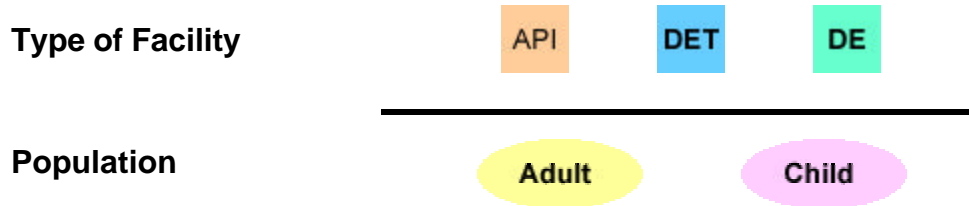
Staff will provide assistance to individuals in meeting behavior criteria for the discontinuation of restraint or seclusion.

RS 8.0 *Individuals in restraint or seclusion will be monitored.*



Discussion. The purpose of monitoring an individual in restraint or seclusion is to ensure the individual's physical safety. Monitoring is accomplished through continuous in-person observation by an assigned staff member who is competent and trained in accordance with the provisions of Standard RS 12.0. After the first hour, an individual in seclusion only may be continuously monitored using simultaneous video and audio equipment, if this is consistent with the individual's condition or wishes. For example, it may be more helpful and less disruptive to the individual if staff does not monitor him or her by physically sitting in the seclusion room or watching through the window into the seclusion room. If the individual is in a physical hold, a second staff person is assigned to observe the individual.

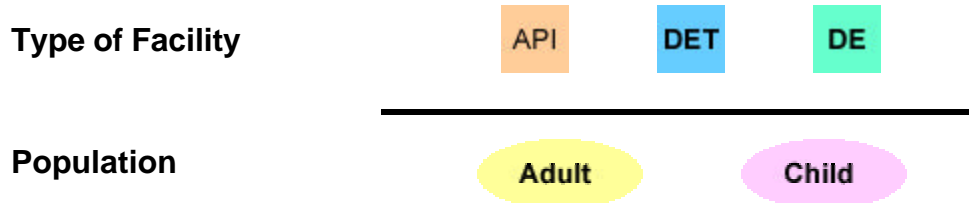
RS 9.0 *Restraint and seclusion use will be discontinued when the individual meets the behavior criteria for their discontinuation.*



Discussion. As early as feasible in the restraint or seclusion process, the individual will be made aware of the rationale for restraint or seclusion and the behavioral criteria for its discontinuation. Restraint or seclusion is discontinued as soon as the individual meets his or her behavior criteria. Examples of behavior criteria include:

- An individual's ability to contract for safety;
- Whether an individual is oriented to the environment; and/or
- Cessation of verbal threats.

RS 10.0 *The individual and staff will participate in a debriefing about the restraint episode.*

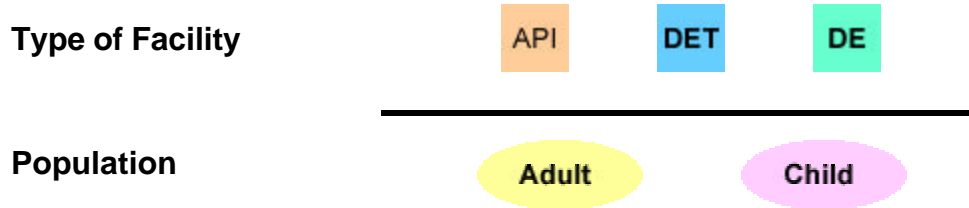


Discussion. Debriefing is important in reducing the use of restraint and seclusion. The individual and, if appropriate, the individual's family, will participate with staff who were involved in the episode and who are available, in a debriefing about each episode of restraint or seclusion. The debriefing will occur as soon as possible and appropriate, but no longer than 24 hours after the episode. The debriefing will:

- Identify what led to the incident and what could have been handled differently;
- Ascertain that the individual's physical well-being, psychological comfort, and right to privacy were addressed;
- Counsel the individual involved for any trauma that may have resulted from the incident; and
- When indicated, modify the individual's treatment plan.

Information obtained from debriefings will be used in performance improvement activities.

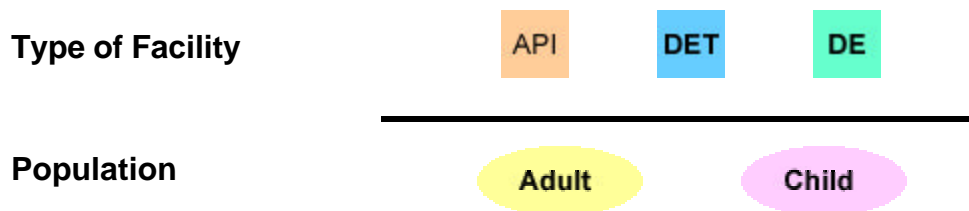
RS 11.0 *Staffing levels and assignments will be set up to minimize circumstances that give rise to restraint or seclusion use and to maximize safety when restraint and seclusion are used.*



Discussion. The organization will base its staffing levels and assignments on a variety of factors, including:

- Staff qualifications;
- The physical design of the environment; and
- Diagnoses, co-occurring conditions, acuity levels, and age and developmental functioning of individuals served.

RS 12.0 *Staff will be trained and competent to minimize the use of restraints and seclusion, and in their safe use.*



Discussion. The organization will educate and assess the competence of staff in minimizing the use of restraint and seclusion and, before they participate in any use of restraint or seclusion, in their safe use.

Training Requirements for all Direct Care Staff. In order to minimize the use of restraint and seclusion, all direct care staff as well as any other staff involved in the use of restraint and seclusion will receive ongoing training in and demonstrate an understanding:

- Of the underlying causes of threatening behaviors exhibited by individuals they serve;
- That sometimes an individual may exhibit an aggressive behavior that is related to a medical condition and not related to his or her emotional condition, for example, threatening behavior may result from delirium in fevers, hypoglycemia;
- Of how their own behaviors can affect the behaviors of individuals they serve;

- Of the use of de-escalation, mediation, self-protection, and other techniques, such as time-out; and
- Recognizing signs of physical distress in individuals being held, restrained, or secluded.

Training Requirements for Staff Authorized to Physically Apply Restraint or Seclusion. Staff who are authorized to physically apply restraint or seclusion receive the training and demonstrate the competence required for all direct care staff defined above, and also receive ongoing training in and demonstrated competence in the safe use of restraint, including:

- Physical holding techniques;
- Take-down procedures; and
- The application and removal of mechanical restraints.

Training Requirements for Staff Authorized to Perform 15 Minute Assessments. Staff who are authorized to perform 15 minute assessments of individuals who are in restraint or seclusion receive the training and demonstrate competence required for all direct care staff and those staff authorized to physically apply restraint or seclusion, as defined above, and along receive ongoing training and demonstrate competence in:

- Taking vital signs and interpreting their relevance to the physical safety of the individual in restraint or seclusion;
- Recognizing nutritional and hydration needs;
- Checking circulation and range of motion in the extremities;
- Addressing hygiene and elimination;
- Addressing physical and psychological status and comfort;
- Assisting individuals in meeting behavior criteria for the discontinuation of restraint or seclusion;
- Recognizing readiness for the discontinuation of restraint or seclusion; and
- Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services in order to evaluate and/or treat the individual's physical status.

Training Requirements for Staff Authorized to initiate Restraint or Seclusion and/or Perform Evaluations/Reevaluations. Staff who, in the absence of a licensed independent practitioner, are authorized to initiate restraint or seclusion, and/or perform evaluations/reevaluations of individuals who are in restraint or seclusion in order to assess their readiness for discontinuation or establish the need to secure a new order, receive training and demonstrate competence required for all direct care staff, staff authorized to physically apply restraint or seclusion, and staff authorized to perform 15 minute assessments as defined above, and are also educated and demonstrate competence in:

- Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual reacts to physical contact; and
- The use of behavior criteria for the discontinuation of restraint or seclusion and how to assist individuals in meeting these criteria.

Training in First Aid, Cardiopulmonary Resuscitation, and Emergency Medical Services. An appropriate number of staff who are competent to initiate first aid and cardiopulmonary resuscitation will be available at all times. The organization will have a plan for the provision of emergency medical services.

Involvement of Individuals who have Experienced Restraint or Seclusion. The viewpoints of individuals who have experienced restraint or seclusion will be incorporated into staff training and education in order to help staff better understand all aspects of restraint and seclusion use. Whenever possible, such individuals who have experienced restraint or seclusion will contribute to the training and education curricula and/or participate in staff training and education.

RS 13.0 *The individual’s family will be promptly notified of the initiation of restraint or seclusion.*

Type of Facility



Population



- Discussion. In cases in which the individual has consented to have the family kept informed regarding his or her care and the family has agreed to be notified, staff will promptly attempt to contact the family to inform them of the restraint or seclusion episode.

RS 14.0 *Medical records will document that the use of restraint or seclusion is consistent with organization policy.*

Type of Facility

API

DET

DE

Population

Adult

Child

Discussion. The use of restraint or seclusion will be recorded in the individual's medical record. The focus of the entries will be on the individual. The clinical record will document:

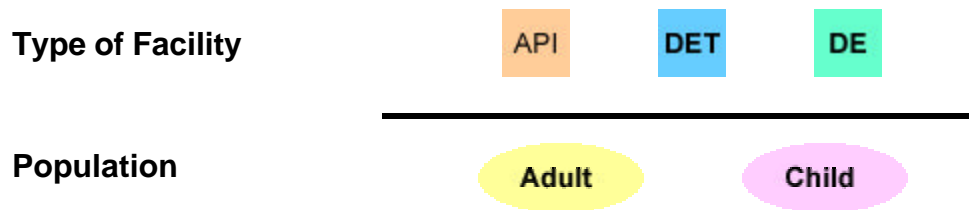
- That the individual and/or family was informed of the organization's policy on the use of restraint;
- Any pre-existing medical conditions or any physical disabilities that would place the individual at greater risk during restraint and seclusion; and
- Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint or seclusion.

Each episode of use will be recorded. The documentation will include information about:

- The circumstances that led to their use;
- Consideration or failure of non-physical interventions;
- The rationale for the type of physical intervention selected;
- Notification of the individual's family, when appropriate;
- Written orders for use;
- Behavior criteria for discontinuation of restraint or seclusion;
- Informing the individual of behavior criteria for discontinuation of restraint or seclusion;
- Each verbal order received from a licensed independent practitioner;
- Each in-person evaluation and reevaluation of the individual;
- 15 minute assessments of the individual's status;
- Assistance provided to the individual to help him or her meet the behavior criteria for discontinuation of restraint or seclusion;
- Continuous monitoring;
- Debriefing of the individual with staff; and
- Any injuries that are sustained and treatment received for these injuries or death.

Documentation will be accomplished in a manner (such as restraint and seclusion log) that allows for the collection and analysis of data for performance improvement activities.

RS 15.0 *The organization will collect data on the use of restraint and seclusion in order to monitor and improve its performance of processes that involve risks or may result in sentinel events.*



Discussion. The organization will collect restraint and seclusion data:

- In order to ascertain that restraint and seclusion are used only as emergency interventions;
- To identify opportunities for incrementally improving the rate and safety of restraint and seclusion use; and
- To identify any need to redesign care processes.

The hospital leadership will determine the frequency with which data are aggregated. Using a patient identifier, data on all restraint and seclusion episodes will be collected from and classified for all settings/units/locations by:

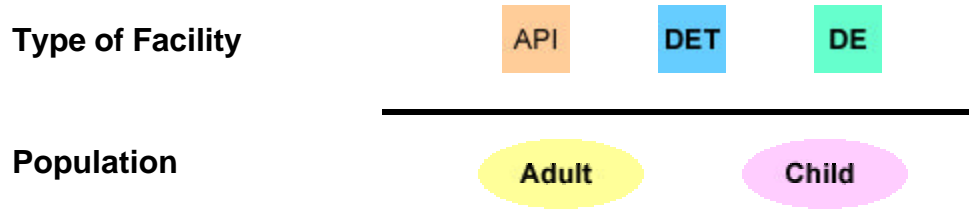
- Shift;
- Staff who initiated the process;
- The length of each episode;
- Date and time each episode was initiated;
- Day of the week each episode was initiated;
- The type of restraint used;
- Whether injuries were sustained by the individual or staff;
- Age of the individual; and
- Gender of the individual.

Particular attention will be extended to:

- Multiple instances of restraint or seclusion experienced by an individual within a 12-hour time frame.
- The number of episodes per individual;
- Instances of restraint or seclusion that extend beyond 12 consecutive hours; and
- The use of psychoactive medications as an alternative for, or to enable discontinuation of, restraint or seclusion.

Licensed independent practitioners will participate in measuring and assessing the use of restraint and seclusion for all individuals within the organization.

RS 16.0 *Hospital leadership will establish and communicate the organization's philosophy on the use of restraint and seclusion to all staff who have direct care responsibility.*

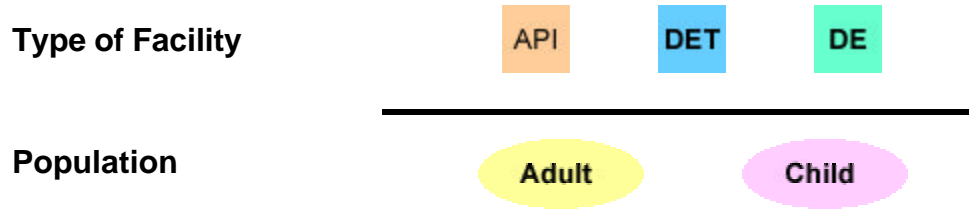


Discussion. At a minimum, the organization's philosophy will address:

- Its commitment to prevent, reduce, and strive to eliminate the use of restraint and seclusion;
- Preventing emergencies that have the potential to lead to the use of restraint or seclusion;
- The role of non-physical interventions as preferred interventions;
- Limiting the use of restraint and seclusion to emergencies in which there is an imminent risk of an individual physically harming him or herself or others, including staff;
- Its responsibility to facilitate the discontinuation of restraint or seclusion as soon as possible;
- Raising awareness among staff about how the use of restraint or seclusion may be experienced by the individual; and
- Preserving the individual's safety and dignity when restraint or seclusion is used.

This philosophy will be communicated to all members of the organization who have direct care responsibility.

RS 17.0 *Clinical leadership will be informed of instances in which individuals experience extended or multiple episodes of restraint or seclusion.*



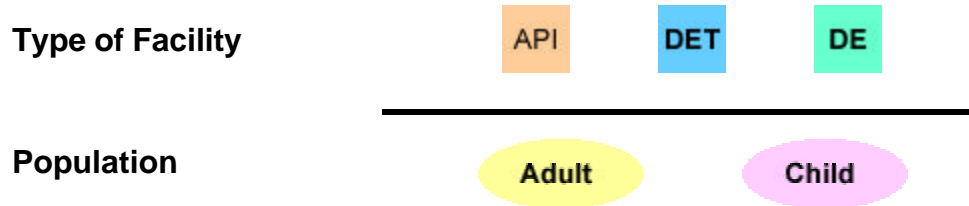
Discussion. The clinical leadership is immediately notified of any instance in which an individual:

- Remains in restraint or seclusion for more than 12 hours; or
- Experiences two or more separate episodes of restraint and/or seclusion of any duration within 12 hours.

Thereafter, the clinical leadership will be notified every 24 hours if either of the above conditions continues. This information will be communicated to the clinical leadership in order for it to:

- Discharge its clinical accountability; and
 - Assess whether additional resources are required to facilitate discontinuation of restraint or seclusion; or
 - Minimize recurrent instances of restraint and seclusion
-

RS 18.0 *Organization policies and procedures will address the prevention of the use of restraint and seclusion and, when employed, guide their use.*



Discussion. Organization policies and procedures will include appropriate detail that addresses:

- Staffing levels;
 - Competence and training of staff;
 - The initial assessment of the individual;
 - The role of non-physical techniques in the management of behavior;
 - Time-out;
 - Limiting the use of restraint or seclusion to emergencies;
 - Notification of the individual's family when restraint or seclusion is initiated;
 - Ordering of restraint and seclusion by a licensed independent practitioner;
 - In-person evaluations of the individual in restraint or seclusion;
 - Initiation of restraint and seclusion by an individual other than a licensed independent practitioner;
 - Time-limited orders;
 - Reassessment of an individual in restraint or seclusion;
 - Monitoring the individual in restraint or seclusion;
 - Post-restraint and seclusion practices;
 - Reporting injuries and deaths to the organization's leadership and to the appropriate external agencies consistent with applicable law and regulation;
 - Documentation; and
 - Data collection and the integration of restraint and seclusion into performance improvement activities.
-

Patient and Family Participation in Treatment Planning

PP 1.0 *Patients are involved in all aspects of their care.*

Type of Facility

API

DET

DE

Population

Adult

Child

Discussion. Hospitals shall promote patient and family involvement in all aspects of their care through the implementation of policies and procedures that are compatible with the hospital's mission and resources, have diverse inputs, and guarantee communication across the organization. Patients should be involved in at least the following aspects of their care:

- Giving informed consent;
- Making care decisions;
- Resolving dilemmas about care decisions; and
- Formulating advance directives.

Patients' psychosocial, spiritual, and cultural values affect how they respond to their care. The hospital should allow patients and their families to express spiritual beliefs and cultural practices, as long as these do not harm others or interfere with treatment.

PP 2.0 *Informed consent is obtained.*

Type of Facility

API

DET

DE

Population

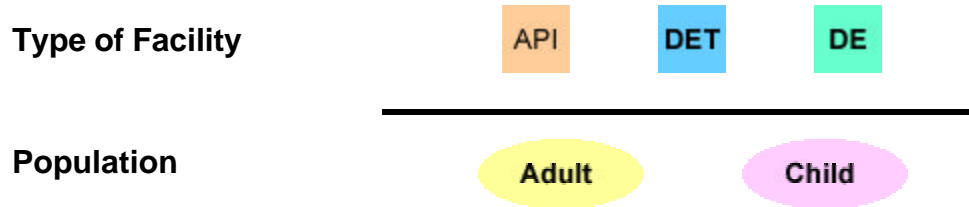
Adult

Child

Discussion. Staff members will clearly explain any proposed treatments or procedures to the patient and, when appropriate, the family. The explanation will include:

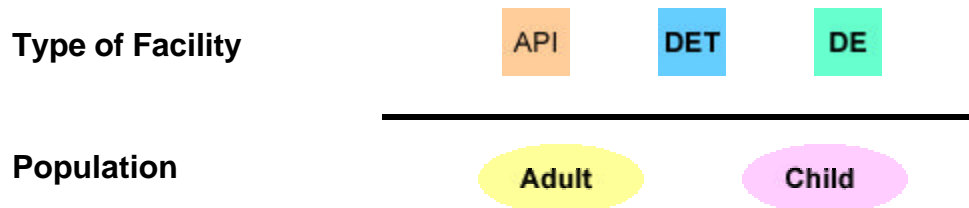
- Potential benefits and drawbacks;
 - The likelihood of success;
 - Possible results of non-treatment;
 - Any significant alternatives;
 - The name of the physician or other practitioner who has primary responsibility for the patient's care; and
 - The identity and professional status of individuals responsible for authorizing and performing procedures or treatments.
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PP 3.0 *The family participates in care decisions.*



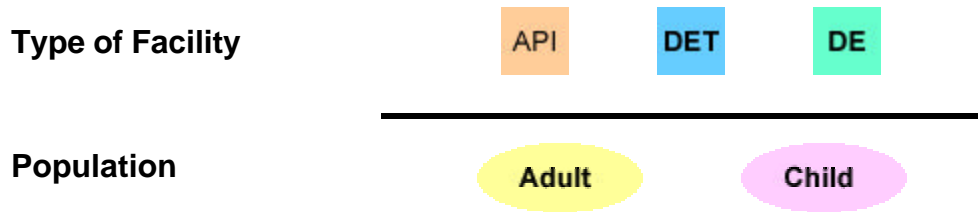
Discussion. Care sometimes requires that people other than (or in addition to) the patient be involved in decisions about the patient's care. This is especially true when the patient does not have mental or physical capacity to make care decisions or when the patient is a child. When the patient cannot make decisions regarding his or her care, a surrogate decision maker will be identified. In the case of an unemancipated minor, the family or guardian is legally responsible for approving the care prescribed. The patient has the right to exclude any or all family members from participating in his or her care decisions.

PP 4.0 *Patients are involved in resolving dilemmas about care decisions.*



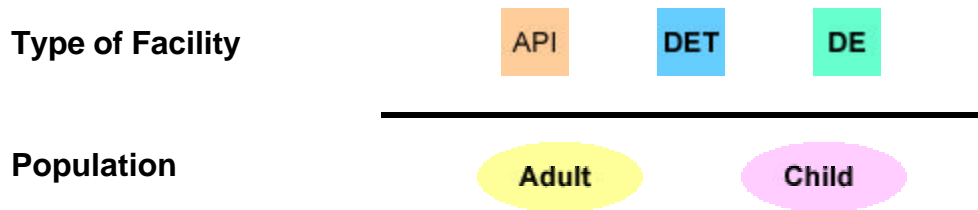
Discussion. Making decisions about care sometimes presents questions, conflicts, or other dilemmas for the hospital and the patient, family, or other decision makers. These dilemmas may arise around issues of admission, treatment, or discharge. These issues can be especially difficult to resolve when the issues involve, for example, involuntary inpatient psychiatric care. The hospital will have a way of resolving such dilemmas and identities of those who need to be involved in the resolution. Patients and, when appropriate, their families, will be afforded the opportunity to substantially participate in the resolution of these issues.

PP 5.0 *The hospital addresses advance directives.*



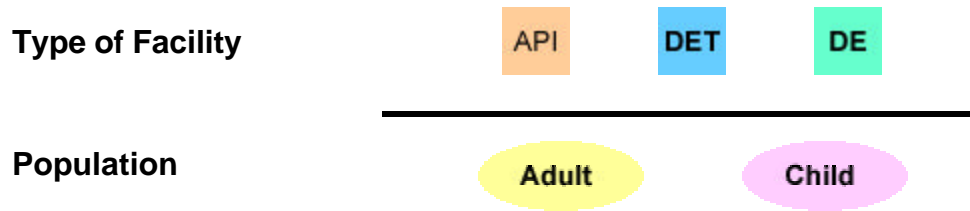
Discussion. The hospital will determine whether a patient has or wishes to make advance directives. The hospital will also ensure that health care professionals and designated representatives honor the directives within the limits of the law and the organization's mission, philosophy, and capabilities. In the absence of the actual directive, the substance of the directive will be documented in the patient's medical record. The lack of advance directives will not hamper access to care. The hospital, however, will provide assistance to patients who do not have an advance directive but who wish to formulate one.

PP 6.0 *The patient's medical record will contain a description of the teamwork involved in the development of the treatment plan and/or discharge plan.*



Discussion. None.

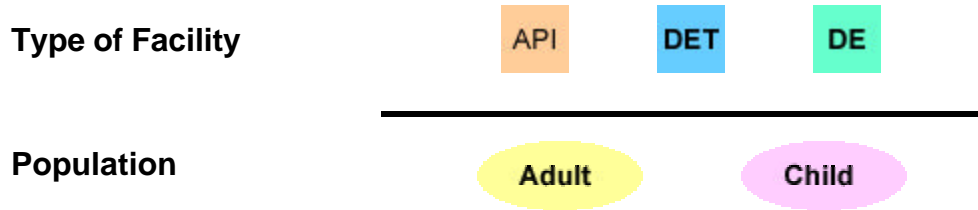
PP 7.0 ***The patient will be allowed, when appropriate, to make choices free from undue external influence or interference.***



Discussion. When appropriate, and within the mission, philosophy, and capabilities of the hospital, the patient and, when appropriate, their family, will be allowed to make choices regarding the services and care they receive. The patient and, when appropriate, their family, will be allowed to make these choices free from undue external pressure or interference.

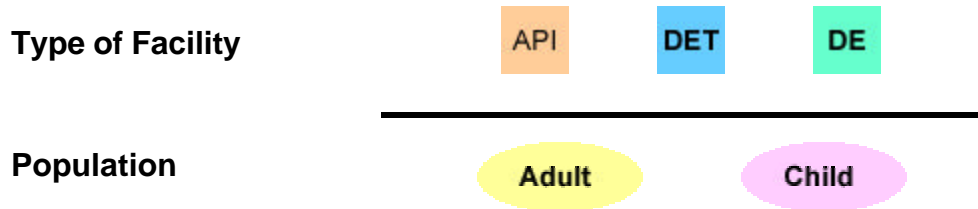
Appropriateness of Treatment

TX 1.0 *Each patient's physical, psychological, and social status will be assessed within a time frame specified by organization policy.*



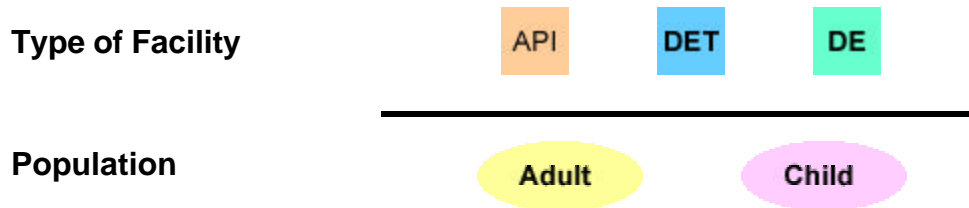
Discussion. Upon admission for inpatient psychiatric care, each patient will be assessed in terms of his or her physical, psychological, and social status. The primary purpose of this assessment is to assist in the treatment planning process. The time period after admission in which this assessment must occur will be specified in organizational policy.

TX 2.0 *Care, treatment, and rehabilitation will be planned and delivered so to ensure appropriateness to the patient's needs, severity of the disease, impairment, or disability.*



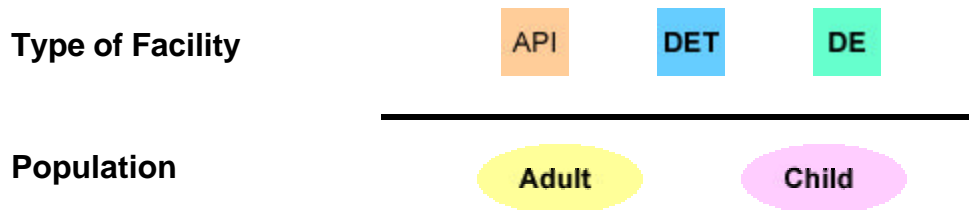
Discussion. Care will be planned to respond to each patient's unique needs (including age-specific needs), expectations, and characteristics with effective, efficient, and individualized care. An essential element in the planning process is assessment of the patient's condition. Patients' care, treatment, and rehabilitation goals will be identified and documented in the individualized treatment plan. Acting on care goals requires deliberate planning. For most patients, meeting the goals requires a variety of services that often can be delivered in multiple settings. For each patient, the most appropriate settings are selected and provided. Care begins when settings and services are identified and planned.

TX 3.0 *Patients' progress will be periodically evaluated against care goals and the plan of care. When indicated, the plan or goal will be revised.*



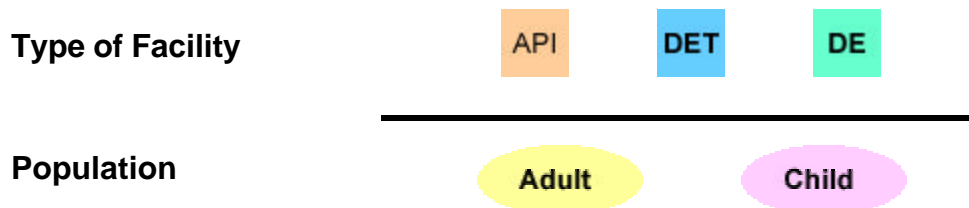
Discussion. Progress will be measured against the plan of care and treatment goals. The frequency of evaluation or reevaluation will be appropriate to the plan of care, services provided, and patient needs.

TX 4.0 *Within the capabilities and mission of the hospital, the patient will have access to the appropriate type of care.*



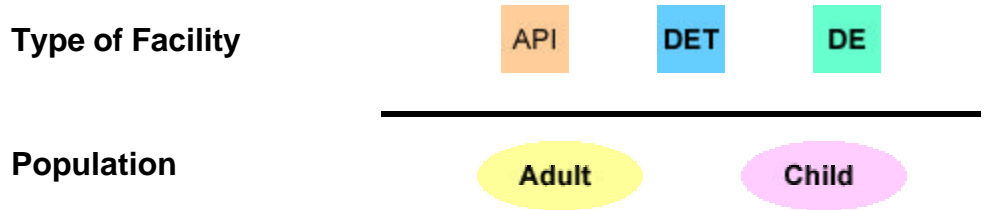
Discussion. None.

TX 5.0 *The decision by a hospital to admit a patient for inpatient psychiatric care will be based on the outcome of its assessment procedures.*



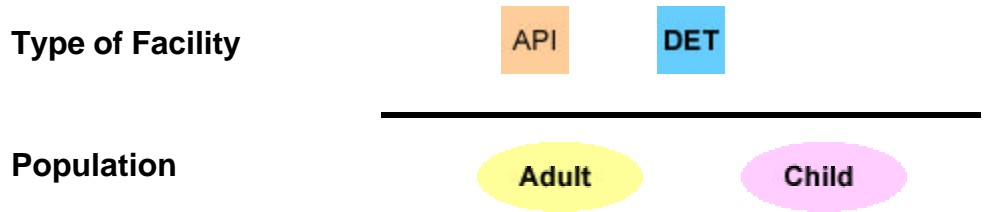
Discussion. Admission to the hospital for psychiatric care, either treatment or evaluation, will be based on the outcome of the assessment process identifying patient needs. The decision will also take into account the mission and capabilities of the hospital.

TX 6.0 *Patients and their families will receive information about proposed care during the entry or admission process.*



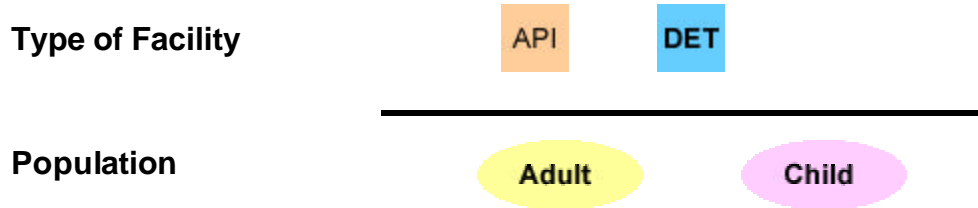
Discussion. When patients are admitted for inpatient psychiatric care, they and, where appropriate, their families, will be provided with information regarding the proposed treatment. To the extent possible, this information will include the nature of the treatment, the licensed independent practitioner responsible for ordering and/or delivering the care, alternative care options, and costs. They will also be provided with information regarding any potential risks as well as the likelihood of success.

TX 7.0 *The hospital will ensure continuity over time among the phases of services to a patient.*



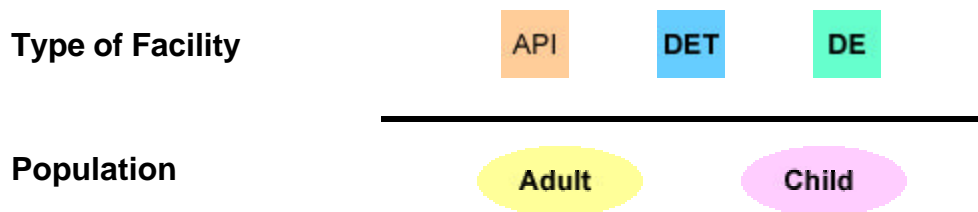
Discussion. When delivery of care spans a period of time longer than two or three days, the hospital will ensure that there is continuity among the various phases of the patient's care and coordination among the professionals delivering the care. This continuity of care will be documented in the patient's medical record.

TX 8.0 *Training for direct service and management level staff will incorporate new paradigms and concepts such as family-centered services, self-determination, community membership, natural environments, and natural supports.*



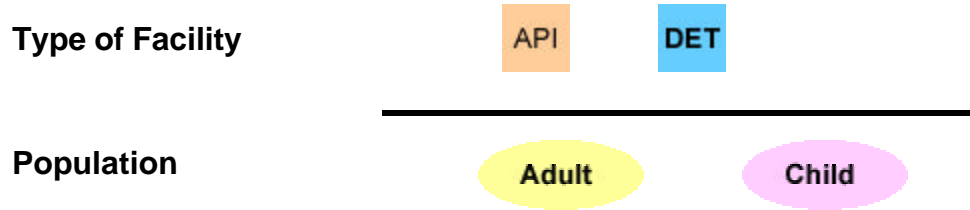
Discussion. Hospitals providing inpatient psychiatric treatment will ensure that direct service and managerial staff are trained in the latest mental health treatment paradigms. An enhanced level of training and knowledge in new methods will provide the hospital with a more diverse set of treatment options and also allow staff to provide the latest information on treatment options to patients and their families.

TX 9.0 *The hospital will ensure that treatment planning and delivery of care are sensitive to cultural/religious beliefs and traditions.*



Discussion. As hospitals engage patients and, where appropriate, their families, in the treatment planning process and in the delivery of care, they will ensure that the patients' and their families' cultural traditions and religious beliefs are given consideration.

TX 10.0 *One of the goals of inpatient mental health treatment will be to provide the patient and, where appropriate, his or her family with information about the disease, treatment options, and medications.*



Discussion. Hospitals that provide inpatient psychiatric treatment will ensure that, as a part of the treatment planning process, the goal of patient and family education regarding the disease, treatment options, and medications is included in the care plan.

Discharge and Admission Interaction Between Inpatient and Outpatient Providers

CC 1.0 *The discharge process for continuing care will be based upon the patient's assessed needs at the time of discharge.*

Type of Facility

API

DET

DE

Population

Adult

Child

- Discussion. Patient needs are assessed at the time of admission and consistently reassessed during their stay. As the goals of the treatment plan are achieved and the patient prepares for discharge, a further assessment of continuing care needs will be conducted. Discharge planning will focus on meeting patients' needs after discharge. Discharge planning will identify patients' continuing physical, mental, emotional, social, and other needs and arranges for services to meet them.

CC 2.0 *Hospitals will enter into a written agreement with community mental health centers regarding appointment scheduling and ongoing psychiatric care.*

Type of Facility

API

DET

DE

Population

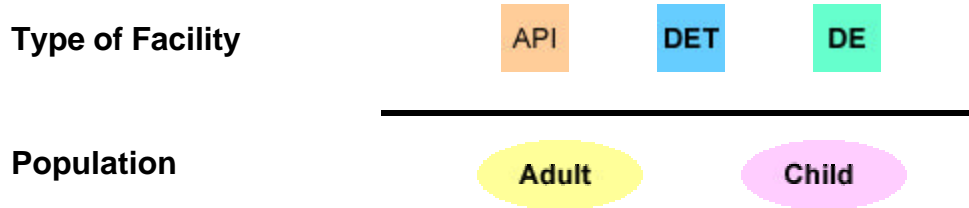
Adult

Child

Discussion. The facility director shall enter into a written agreement with a community mental health center in the area served by the facility to provide coordination and continuity of services related to the admission and discharge of patients receiving inpatient psychiatric care. The agreement must state that the center will schedule an appointment at the center for:

- Clinical services within one week after a patient's discharge from the facility; and;
- Psychiatric services before depletion of any psychotropic medication dispensed or prescribed for a patient upon discharge;

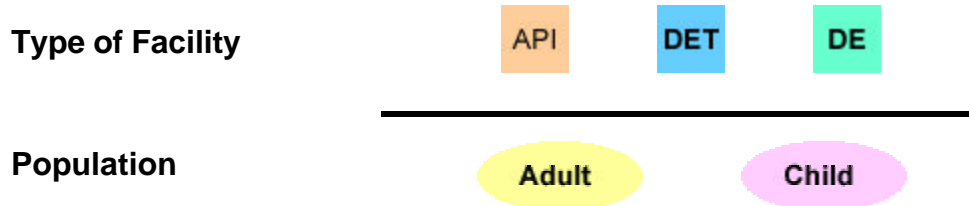
CC 3.0 *The hospital will facilitate and coordinate the transition of patients to continuing care in their community of choice through contact with the appropriate community mental health center and other providers as appropriate.*



Discussion. As a part of discharge planning, the hospital staff will facilitate the contact with continuing care providers, particularly the appropriate community mental health center. Discharge planning for inpatient psychiatric care will include:

- Coordination of post-discharge continuing care with the community mental health center in the patient's home community (or community of choice);
- Maintaining contact with the patient's identified case manager and scheduling of first post-discharge outpatient appointment;
- Obtaining, where possible, appropriate patient release of information forms;
- Providing appropriate medical records to the community mental health center or other provider that will be providing continuing care; and
- Provision of back-up support, information, and expertise to the organization or individual that will deliver continuing care.

CC 4.0 *Hospitals will work with appropriate community mental health centers to ensure smooth transition into the hospital from the community when necessary.*



Discussion. The intent of this standard is that inpatient mental health providers will maintain cooperative working relations and good lines of communication with community mental health centers in order to provide an effective continuum of care for the community. In addition to discharge planning and ensuring a smooth transition for patients back into their community of choice, hospitals will work with community mental health centers to ensure a smooth admission process and transition into the hospitals for patients as the need arises.

CC 5.0 *Hospitals will involve the patient and his or her family in the discharge planning process.*

Type of Facility

API

DET

DE

Population

Adult

Child

Discussion. The intent of this standard is that the patient and his or her family will play a substantial role in the discharge planning process. This involvement will include the following elements:

- Selection of outpatient mental health service providers if appropriate;
- Scheduling of appointments; and
- Selection of treatment approaches and methods.

CC 6.0 *Hospitals will maintain communication and provide information to appropriate outpatient providers during the course of inpatient treatment.*

Type of Facility

API

DET

Population

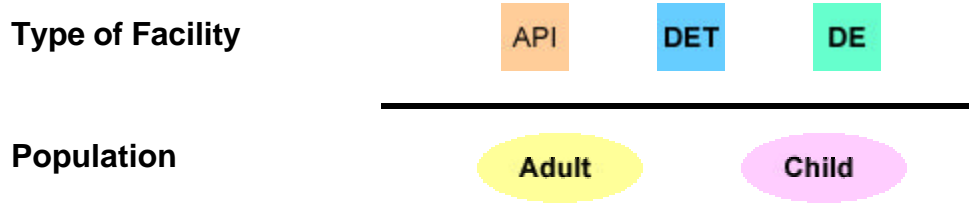
Adult

Child

- Discussion. The intent of this standard is that, where inpatient mental health treatment is being provided, the appropriate outpatient mental health provider or community mental health center will be kept advised of the patient's progress as appropriate. In some cases, where outpatient providers have hospital consulting privileges, this may take the form of case consultation. IN other cases, it may take the form of written or oral reports to the outpatient provider. Any communication with outpatient providers will be subject to the approval and release of information by the patient and/or his or her family.
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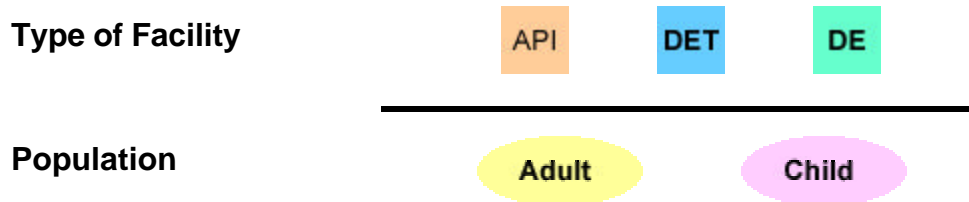
Use of Behavior Management Plans

BM 1.0 *Behavior management procedures are defined as “the use of basic learning techniques such as biofeedback, reinforcement, or aversion therapy to manage and improve an individual’s behavior.”*



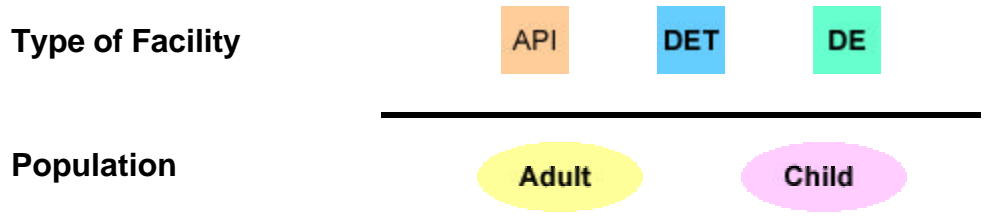
Discussion. This definition was taken from JCAHO Hospital Accreditation Standards.

BM 2.0 *Behavior management procedures will be used as a part of the patient’s treatment plan.*



Discussion. The intent of this standard is that behavior management procedures will not be used with punitive or retaliatory intent or for the convenience of the staff. They will be used when clinically indicated and to prevent harm to the patient, other patients, or staff. When used, they will be documented in the patient’s plan of care.

BM 3.0 *The use of behavior management procedures will conform to hospital policy. All behavior management procedures will be reviewed, evaluated, and approved by qualified staff.*



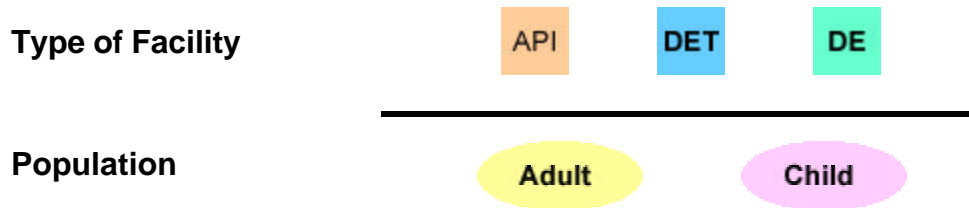
Discussion. The hospital will define staff roles and responsibilities for all appropriate disciplines involved in using special procedures. When behavior management plans are used, they will be included in the patient’s plan of treatment. Hospital policies will describe:

- Under what conditions specific behavior management procedures can be used and when they should not be used; and
- Requirements of approval of behavior management procedures in a patient’s plan of treatment.

The hospital will use educational and positive reinforcement techniques (for example, alternate adaptive behaviors) wherever possible. When more restrictive techniques are clinically necessary, the least restrictive alternative will be used to avoid harm to the patient. Time-out and procedures using restraining devices or aversive techniques are used only consistent with the patient’s plan of treatment, policies and procedures, and state and federal laws. The hospital will protect the patient’s nutritional status and physical safety (for example, from corporal punishment). Other patient’s may assist in implementing a patient’s behavior management program only if:

- It is conducted as a part of a structured treatment plan;
 - It is conducted under the supervision of qualified staff;
 - It is limited to empowering patients to provide positive reinforcement; and
 - It does not become abusive.
-

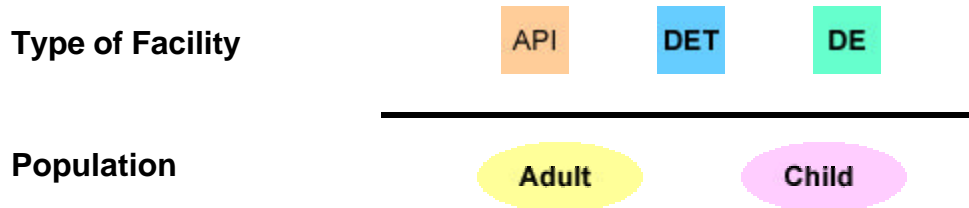
BM 4.0 *The hospital will ensure that all staff receive training appropriate to their roles and responsibilities with regard to patients.*



Discussion. Hospital staff members will receive training that is appropriate for their roles and responsibilities as applied to patient contact. This training will include:

- Training to develop appropriate interactions with patients; and
- Protection, security and observation of patients.

BM 5.0 *Patients and their families will be involved in the development of behavior management plans as a part of their involvement in the treatment planning process.*

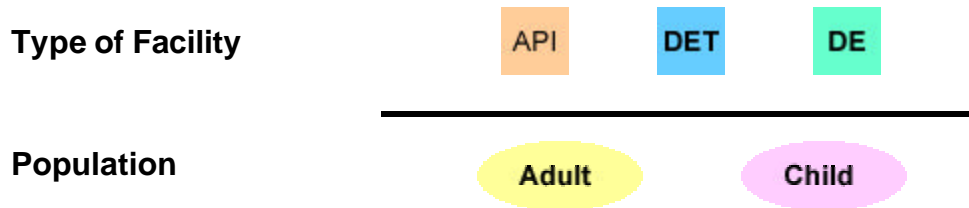


Discussion. To the extent possible and practicable, patients and their families will be allowed to participate in the development of behavior management procedures as applied to their specific plan of care. This involvement may include:

- Identification and, to the extent possible, compliance with patient and/or family desires regarding the methods of behavior management; and
 - Setting of treatment goals regarding behavior and behavior management.
-

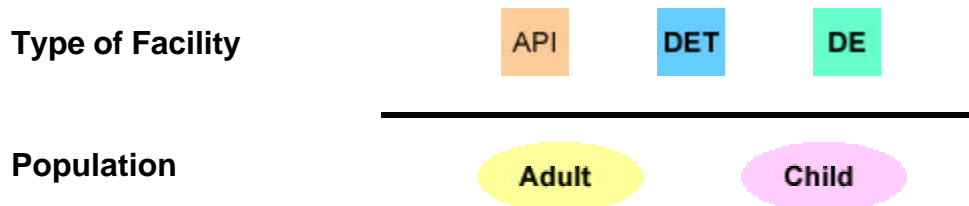
Management of Patient Assaultive Behavior

AB 1.0 *Hospital staff will receive appropriate training, relevant to their duties, on patient behavior management with particular emphasis on prevention of assaultive behavior.*



Discussion. The intent of this standard is that staff will be trained with an emphasis on prevention of behavior before it escalates. The training will be relevant to staff responsibilities and duties. The standards, required competencies, and frequency of training should be defined in hospital policy.

AB 2.0 *The hospital will have policies and procedures that define a range of less restrictive alternatives to prosecution of patients for assaultive behavior.*



Discussion. Hospitals will define, in policy, the range of alternatives for dealing with assaultive behavior. This may include consequences ranging from no action or verbal reprimand up to an including the filing of charges against the patient. The decision to file charges against a patient for assaultive behavior will, as a minimum, take the following factors into account:

- The nature and severity of the assault;
- The behavioral history of the patient;
- The circumstances and context in which the assault occurred;
- The patient's diagnosis and the extent to which the behavior is symptomatic of their disorder; and
- The patient's treatment plan and the extent to which it has been followed.

The decision by a hospital to accept a patient with past history of assaultive behavior will, as a minimum, consider the following factors:

- The nature and severity of past assaultive behavior;
 - The capabilities and physical security arrangements of the hospital; and
 - The nature of the patient's disorder and current circumstances.
-

AB 3.0 *The hospital will not interfere with the individual staff rights to file charges against patients for assault.*

Type of Facility

API

DET

DE

Population

Adult

Child

Discussion. Individual staff members have the right to file charges against patients who assault them. Assistance provided to staff members by the hospital in filing charges will be in accordance with hospital policy as well as local, state, and federal law. Any assistance provided in the filing of charges will protect patient confidentiality with regard to diagnosis, treatment history, and other personal information.