

# **Chapter: Patient Management (PM)**

## **Section 1: Off-Unit Patient Activities**

### **Policy**

The Utah State Hospital provides an individualized least restrictive environment possible in treatment of each patient. The unit clinical director, with input and involvement of unit staff, determines when patients participate in on-campus and off-campus activities.

### **Procedure**

1. The unit clinical director writes an order in the patient's chart when the patient is able to participate in on-campus or off-campus activities.
    - 1.1. The patient's risk level for elopement is considered when determining if a patient is able to participate in on-campus or off-campus activities.
    - 1.2. As the patient's status changes, the unit clinical director writes an order reflecting the patient's current level status.
    - 1.3. If a unit has written policies and procedures regarding a level system which includes on and off unit activity privileges, the unit clinical director may write only one order corresponding to a patient's current level status. The order addressing the level system gives approval for on and off unit activities.
  2. The multi-disciplinary treatment team reviews the list of all patients eligible for off-campus activities prior to the activity to approve each patient's participation.
    - 2.1. Each patient's risk level for elopement is considered.
    - 2.2. In absence of the unit clinical director, the treatment team may limit a patient's activities, but may not make them more liberal.
  3. The unit RN may limit a patient's off-unit activity if it is therapeutically contra-indicated.
    - 3.1. Each treatment unit utilizes sign out slips that designate which patient(s) from the unit are going on an off-unit activity.
    - 3.2. The sign out slip contains a description of the patient's clothing, the time they left the unit, their destination, and the time they are due back on the unit.
    - 3.3. All patients are signed in when they return to their unit and roll call is taken.
  4. News media concerns about patient off-campus activities are directed to the Administrator on call.
  5. To ensure the safety of patients, staff and the public; all off campus activities are staffed with a minimum staff to patient ratio of 1:4.
-

- 5.1. If only one patient is accompanied by a staff member, it is expected that they be of the same gender unless otherwise approved by the SMT.
- 5.2. Staff will carry the radio/communication device with them when escorting patients on campus, and a cell phone when escorting patients off campus.

---

*Reviewed: 11-92*

*Revised: 1-93*

*Revised: 9-95*

*Revised: 12-98*

*Revised: 7-01*

*Reviewed: 9-04*

*Revised: 10-05*

*Revised: 11-08*

*Revised: 4-10*

*Revised: 5-13*

---

# **Chapter: Patient Management (PM)**

## **Section 2: Clinical On-Call Procedures**

### **Policy**

Utah State Hospital has 24-hour, seven-day-a-week coverage by a medical services practitioner and a psychiatrist to assure adequate medical and psychiatric care for the patients and to assure that appropriate admission procedures are followed during evenings, nights, weekends, and holidays. On-call for any day, including weekends, extends from 0800 one day until 0800 the following day. (This excludes the normal work week; Monday - Friday 0800-1600).

### **Procedure**

1. In the event that a patient's attending physician/medical services provider is not available, his designee or supervisor is called for medical or psychiatric problems or emergency situations such as seclusion, medication, area restriction, etc.
    - 1.1. During the hours of 1600 to 0800 and on weekends and holidays, the on-call physician is available.
    - 1.2. The switchboard operator has an on-call schedule for authorized on-call personnel.
  2. During off hours, the registered nurse assigned to the unit calls the switchboard operator stating his/her name and the unit and requests the on-call psychiatrist, medical services practitioner, administrator, or lab technician be contacted.
    - 2.1. The unit RN notifies the Shift Supervising Registered Nurse (SSRN) of any issues being referred to on-call personnel.
      - 2.1.1. The switchboard operator may also notify the SSRN of unusual events on the units.
  3. The operator records information on the switchboard call record and pages the appropriate person(s).
    - 3.1. If no response is received after attempts to contact the on-call person by using numbers for the mobile device and a land line twice each, the switchboard notifies the SSRN and contacts other personnel.
  4. The on-call person is responsible to respond in a timely manner to the switchboard.
    - 4.1. The call is forwarded to the RN on the unit.
  5. The registered nurse accesses the chart and provides the following information to the on-call physician:
    - 5.1. identity of the patient;
    - 5.2. chief complaint or reason for contact;
-

- 5.3. current psychiatric and medical diagnoses;
- 5.4. current psychiatric and/or medical problem;
- 5.5. medications and allergies;
- 5.6. brief history associated with current problem; and
- 5.7. what action is suggested for the situation.

---

*Implemented: 2-26-86*

*Reviewed: 4-5-88*

*Reviewed: 12-90*

*Reviewed: 9-92*

*Revised: 8-95*

*Revised: 11-98*

*Revised: 7-01*

*Revised: 4-05*

*Revised: 4-07*

*Revised: 5-09*

*Revised: 5-12*

---

# Chapter: Patient Management (PM)

## Section 3: Pass Structure

### Policy

The Utah State Hospital utilizes passes as a vital part of the therapeutic process. Passes offer patients an opportunity to learn skills as they transition back into the community. Passes are used to identify patients with on-grounds and off-hospital grounds privileges who are not being escorted by staff.

### Procedure

1. Each patient treatment unit identifies, as part of their unit program, criteria by which patients will be assessed and may be granted the privilege of using an on-grounds or off-grounds pass.
  - 1.1. The unit treatment team considers the elopement risk when considering a patient for a pass.
  - 1.2. Units orient pass holders regarding the rights and limitations associated with their passes, including specific boundaries to which the patient is allowed or not allowed to enter.
2. Unit guidelines are consistent with the hospital structure and will only be utilized as outlined in USHOPP.
3. Each pass represents a different level of privilege(s) allowed to the patient while using their pass.
  - 3.1. White Pass: Patient is cleared to escort themselves to and from therapeutic activities such as industrial assignment, excel house, school, OT, PT, etc.
    - 3.1.1. The unit staff are responsible to notify the staff of the area to which the patient is going at the time the patient leaves the unit.
    - 3.1.2. This process occurs in reverse when the patient leaves the area to return to the unit.
    - 3.1.3. The staff member receiving the patient notifies the unit staff when the patient has reached his/her destination. If the patient has not reached their destination in a time frame considered adequate to escort themselves, the unit is also notified that the patient did not arrive.
  - 3.2. Red Pass: A patient may have on-grounds privileges for up to an hour. They must be with another Red, Blue, or Green pass holder.
  - 3.3. Orange Pass: A patient may be off-unit, but must remain in the building.

- 3.4. Blue Pass: A patient may be on-grounds for up to an hour by themselves.
- 3.5. Green Pass:
  - 3.5.1. A patient may be off-grounds for up to twelve hours by themselves for therapeutic reasons including vocational rehabilitation, education, and transitional skill building experiences. It is not for leisure activity or walks.
  - 3.5.2. SMT will submit green pass request to Superintendent for review and notification.
4. Patients are required to wear their passes while off the unit and on hospital grounds, unless escorted by staff.
5. Each patient treatment unit utilizes sign out slips that designate which patient(s) from the unit is using their pass, the description of their clothing, the time they left the unit, their destination if indicated, and the time they are due back to the unit.
  - 5.1. Patient care units use sign-out slips or a log system for the patients to sign in and sign out when leaving the unit.
6. Each patient unit will have a structure in place which designates a staff member to check the pass slips not less than every 30 minutes to monitor the patients using their passes. Units may have the option to check these more frequently per their unit structure.
7. Patients are not to be off-unit using pass after dark. Exception for green pass holders returning from work/school may be approved by SMT.

---

*Implemented: 1-27-86*

*Revised: 4-5-88*

*Revised: 9-14-92*

*Reviewed: 1-10-95*

*Revised: 6-13-95*

*Revised: 11-98*

*Reviewed: 6-01*

*Revised: 10-04*

*Revised: 11-08*

*Revised: 11-10*

---

# **Chapter: Patient Management (PM)**

## **Section 4: Disposition of Personal Patient Property**

### **Policy**

Utah State statutes require the state to dispose of personal property left in the care of the agency within seven years. The statute does not require agencies to keep the property for seven years; personal property may be disposed of after a reasonable effort is made to contact the owner. Employees do not retain, use, or sell personal property of patients either as gifts from patients or as abandoned property.

### **Procedure**

1. Clothing: Clothing left by a patient may be disposed of after an effort to contact the patient is made.
  - 1.1. Thirty days after notification, if unclaimed, the clothing may be given to other patients or disposed of by the unit.
    - 1.1.1. Efforts of notification are documented in the patient's medical record.
2. Money, rings, earrings, watches, radios, TVs, wheelchairs, special equipment, *etc.*: Items such as these that are left by patients may be disposed of after every effort to contact the patient or the patient's family has been made under the supervision and direction of the unit SMT. Efforts to contact the patient or family are documented in the patient's medical record.
  - 2.1. If the patient is not located within 90 days, an itemized list is prepared and submitted to the Business Office.
    - 2.1.1. The Business Office will dispose of the items in accordance with state policy.
    - 2.1.2. Patient funds/accounts are transferred to the State Treasurer's Unclaimed Property Fund in accordance with state policy if the patient and/or patient's family cannot be contacted.

---

*Implemented: 3-16-83*

*Revised: 12-20-85*

*Reviewed: 4-5-88*

*Revised: 9-14-92*

*Reviewed: 8-95*

*Revised: 11-98*

*Reviewed: 6-01*

*Reviewed: 9-04*

*Revised: 9-07*

*Reviewed: 6-09*

---

---

*Reviewed 6-12*

---

# Chapter: Patient Management (PM)

## Section 5: Psychiatric Care of Patients

### Policy

The attending psychiatrist is responsible for the psychiatric care of patients on the treatment unit. Psychiatric care of patients is the ultimate responsibility of the attending psychiatrist, supervising psychiatrist assigned to the area, and the Hospital Clinical Director.

### Procedure

1. The attending psychiatrist treats the psychiatric problems of patients on his/her assigned unit.
  - 1.1. On evenings, nights, weekends, and holidays, the on-call psychiatrist on duty is notified of any significant concerns about each patient's psychiatric problems by the unit registered nurses, based on their professional nursing judgment, and treats identified problems until the return of the unit psychiatrist.
    - 1.1.1. Verbal orders for seclusion or restraint given on evenings, nights, weekends, and holidays are signed by the attending physician or the on-call designee within one hour.
    - 1.1.2. All other verbal orders are signed within thirty (30) calendar days by the attending physician or designee. State Administrative Rule 432-100-33(3)(d).
2. The attending physician communicates with the Director of Medical Services and/or Medical Services practitioner assigned to the unit, as often as necessary to facilitate coordination of care.
3. If a psychiatric order is questioned, the following steps are taken to clarify the order prior to implementation.
  - 3.1. The psychiatrist who gave the order is contacted for clarification.
  - 3.2. The Shift Supervising Registered Nurse (SSRN)/Unit Nursing Director is consulted about the order.
  - 3.3. The appropriate supervising psychiatrist is consulted about the order.
4. Orders for medications state the indication for use, and are reviewed in a MDTAN at least every thirty (30) days.

---

*Implemented: 5-26-87*

*Reviewed: 4-5-88*

*Reviewed: 12-90*

*Reviewed: 9-14-92*

*Reviewed: 9-95*

*Revised: 2-99*

---

---

*Revised: 9-04  
Revised: 4-07  
Revised: 2-11*

---

# Chapter: Patient Management (PM)

## Section 6: Medical Care of Patients

### Policy

Medical Services is responsible for the medical care of patients on the treatment units. The medical care of the patient is the shared responsibility of the medical services practitioner and psychiatrist assigned to the case, and their supervisors.

### Procedure

1. Unit registered nurses report to the medical services practitioner assigned to the unit significant concerns about each patient's non-psychiatric medical health, based on the registered nurses' professional nursing judgment.
2. The medical services practitioner treats medical problems for patients on his/her assigned unit, under the supervision of the Director of Medical Services or designee.
  - 2.1 On evenings, nights, weekends, and holidays, the medical on-call handles medical problems by telephone, and may visit the units to provide services.
  - 2.2 Telephone orders given on evenings, weekends, and holidays are signed within thirty calendar days by the attending practitioner or designee.
3. The medical services practitioner assigned to the unit reviews the medical care of each patient as necessary with the Unit Clinical Director, to facilitate the coordination of care.
4. If a medical order is questioned, the following steps are taken to clarify the order prior to implementation.
  - 4.1 Documentation in medical services section of e-chart is reviewed (MSPROG).
  - 4.2 The APRN or physician who gave the order is contacted for clarification.
  - 4.3 The Director of Medical Services is consulted about the order if the question cannot be resolved with the initial attempts at clarification.
5. Orders for medications state the indication for use, and are reviewed in a MDTAN at least every thirty (30) days.

---

*Implemented: 5-26-87*

*Reviewed: 4-5-88*

*Reviewed: 12-90*

*Reviewed: 9-14-92*

*Revised: 11-98*

*Revised: 2-99*

*Revised: 9-04*

*Revised: 9-07*

*Revised: 7-09*

*Reviewed: 8-12*

---

# **Chapter: Patient Management (PM)**

## **Section 7: Smoking Regulations**

### ***Policy***

Utah State Hospital is a tobacco-free facility.

### ***Procedure***

1. Patients and families are informed on admission that the campus is tobacco free.
2. Patients and staff are offered education and support to abstain from the use of tobacco.

---

*Implemented: 10-23-85*

*Revised: 2-22-88*

*Revised: 11-25-88*

*Revised: 6-20-89*

*Revised: 11-26-90*

*Revised: 4-92*

*Revised: 8-95*

*Revised: 11-98*

*Revised: 7-00*

*Reviewed: 2-05*

*Revised: 9-07*

*Reviewed: 5-09*

*Reviewed: 5-12*

---

# Chapter: Patient Management (PM)

## Section 8: Assessment

### Policy

The assessment aspects of the psychiatric record are the foundation for the formulation of an individualized treatment plan. The hospital is organized into service areas with unique program emphasis, resulting in varying assessment responses.

### Procedure

1. At admission, the assigned treatment team is responsible for conducting an integrated assessment of each patient, including clinical consideration of the patient's needs.
    - 1.1. The assessment includes, but is not limited to physical, emotional, behavioral, social, and, when appropriate, legal, occupational, recreational, and vocational needs.
    - 1.2. Clinical consideration of each patient's needs includes a determination of the type and extent of special clinical examinations, tests, and evaluations necessary for a complete assessment.
      - 1.2.1. It is determined at admission which laboratory and/or special clinical examinations each patient needs.
  2. A physical history and examination is completed within 24 hours of admission for each patient.
    - 2.1. The physical exam is documented in e-chart and signed off by the examiner within two regular business days of admission.
      - 2.1.1. Until the physical exam is signed off in e-chart, a complete handwritten and signed worksheet in the hard copy chart is appropriate.
      - 2.1.2. At the time the e-chart exam is electronically signed, an automated e-mail notification is sent to the unit secretary and the secretary pulls the worksheet and discards it within one business day.
  3. A psychosocial assessment of each patient is completed and entered in the patient's record. The assessment includes, but is not limited to:
    - 3.1. a history of previous emotional, behavioral, and substance abuse problems and treatment;
    - 3.2. the patient's current emotional and behavioral functioning;
    - 3.3. a direct psychiatric evaluation within 24 hours of admission;
-

- 3.3.1. The psychiatric evaluation is documented in e-chart and signed off by the examiner within two regular business days of admission.
      - 3.3.2. Until the psychiatric evaluation is signed off in e-chart, a complete handwritten and signed worksheet in the hard copy chart is appropriate.
      - 3.3.3. At the time the e-chart exam is electronically signed, an automated e-chart notification is sent to the unit secretary and the secretary pulls the worksheet and discards it within one business day.
    - 3.4. a mental status examination appropriate to the age and circumstances of the patient, and
    - 3.5. when indicated by screening criteria, psychological assessments.
    - 3.6. A nursing assessment of each patient is completed within 8 hours of admission which includes information relating to the following areas:
      - 3.6.1. physical, psychosocial and environmental aspects of the patient;
      - 3.6.2. self-care, patient education, and discharge planning factors;
      - 3.6.3. input from the referring agency and the patient's family members or significant others, when feasible.
  4. A social assessment of each patient is completed, within 14 days of admission for civil and forensic patients or 72 hours for ARTC (Adult Recovery Treatment Center) patients, which includes information relating to the following areas:
    - 4.1. environment and home;
    - 4.2. spirituality;
    - 4.3. childhood history;
    - 4.4. military service history;
    - 4.5. financial status;
    - 4.6. the social, peer-group, and environmental setting from which the patient comes;
    - 4.7. the patient's family circumstances, including the constellation of the family group, the current living situation, and social, ethnic, cultural, emotional, and health factors including drug and alcohol use; and
    - 4.8. the educational needs of the patient and family.
  5. An activities assessment of each patient is completed within 14 days, which includes information relating to the individual's current skills, talents, aptitudes, and interests.
  6. A vocational assessment of the patient is completed, as deemed necessary, which includes consideration of the following areas:
    - 6.1. vocational history;
-

- 6.2. educational history, including academic and vocational training; and
  - 6.3. a preliminary discussion between the individual and the staff member conducting the assessment concerning the individual's past experiences with, and attitudes toward, work, present motivations or areas of interest, and possibilities for future education, training, and employment.
7. When appropriate, a legal assessment of the patient is completed which includes the following areas:
- 7.1. a legal history; and
  - 7.2. a preliminary discussion to determine the extent to which the patient's legal situation will influence his/her progress in treatment and the urgency of the legal situation.
8. When appropriate, an occupational therapy assessment is completed which includes the following areas:
- 8.1. self-care knowledge deficits;
  - 8.2. self-care learning needs;
  - 8.3. other areas of skills of daily living.

---

*Implemented: 9-16-83*

*Revised: 12-85*

*Revised: 3-15-88*

*Revised: 8-14-90*

*Revised: 12-90*

*Revised: 9-92*

*Revised: 8-95*

*Revised: 12-98*

*Revised: 3-02*

*Revised: 4-03*

*Revised: 3-04*

*Revised: 6-07*

*Revised: 5-09*

*Revised: 5-12*

---

# **Chapter: Patient Management (PM)**

## **Section 9: Individualized Comprehensive Treatment Plan (ICTP)**

### **Policy**

An individualized comprehensive treatment plan (ICTP) is developed for every patient admitted to the Utah State Hospital.

### **Procedure**

1. It is the responsibility of the patient's psychiatrist to supervise the clinical team in developing an ICTP for patients admitted to the hospital. The treatment plan reflects the participation, involvement, and collaboration of staff from various disciplines, patient, and (when appropriate) significant others.
    - 1.1. The clinical staff consists of the psychiatrist, registered nurse, social worker, and other discipline members as indicated by the patient needs (i.e. Recreation Therapy, Psychology, Occupational Therapy, Physical Therapy, Vocational Rehabilitation, Sunrise, etc.)
  2. The ICTP is based on assessments that are completed by the treatment team and the preadmission assessment information whenever available.
    - 2.1. Assessments include, but are not limited to: the pre-admission assessment, initial psychiatric assessment, nursing assessment, and the physical examination.
  3. A provisional treatment plan which includes an objective and modality for psychiatry, social work, and nursing is developed within 96 hours of admission. This is an interim plan that is established to guide the treatment of the patient until a comprehensive plan is established.
  4. A comprehensive treatment plan is established by the patient's clinical treatment team within 14 days of admission.
    - 4.1. The provisional treatment plan for ARTC patients is updated in a treatment plan addendum note within fourteen (14) days of admission.
  5. The ICTP includes reason for admission, Local Mental Health Authority (LMHA) input, patient and family input, discharge planning information, clinical assessments, the patient's diagnosis, patient strengths to be utilized in the treatment process, patient treatment needs, identified problems and discharge goals, baseline descriptions, behavioral and measurable short term objectives, and modalities which include the activity, rationale/strategy, frequency and person(s) responsible for the modality.
    - 5.1. At least every 90 days, the medical services provider reviews / modifies the medical problem list.
-

- 5.2. At the initial treatment planning (ICTP) meeting, the treatment team reviews the patient's use of seclusion and/or restraint during the time period between admission and the ICTP meeting. If the patient has required seclusion and/or restraint more than once during this time period, the psychiatrist addresses seclusion/restraint in the treatment plan.
- 5.3. Objectives are written with the understanding that the time frame to achieve the objective will be at the next scheduled ICTP review, and should reflect the patient's desires, as appropriate.
  - 5.3.1. ICTP reviews are scheduled at least every 30 days.
- 6. The ICTP is a mechanism of multi-disciplinary communication promoting the patient's competence, recovery, and/or development and is a permanent part of the medical record.

---

*Implemented: 9-9-82*

*Revised: 12-20-85*

*Revised: 3-18-88*

*Revised: 7-89*

*Reviewed: 12-90*

*Revised: 9-92*

*Reviewed: 9-95*

*Revised: 11-98*

*Revised: 7-00*

*Revised: 1-02*

*Revised: 1-03*

*Revised: 4-03*

*Reviewed: 2-05*

*Revised: 10-05*

*Revised: 9-07*

*Revised: 5-09*

*Revised: 4-12*

*Revised: 3-13*

---

# **Chapter: Patient Management (PM)**

## **Section 10: Treatment Plan Review**

### **Policy**

Multi-disciplinary clinical staff conferences are conducted on a regular basis to review, evaluate each patient's progress relative to specified objectives and to revise the treatment plan as needed.

### **Procedure**

1. Multi-disciplinary clinical staff conferences are held. Updated assessments and treatment responses are recorded in the patient's treatment plan.
2. The individual comprehensive treatment plan is reviewed and updated by multidisciplinary clinical conferences as frequently as clinically indicated, and at least every thirty days.
  - 2.1. Parts of the treatment plan updates include documentation from the various discipline members' treatment assessment notes.
  - 2.2. Treatment plan updates reflect changes in patients' condition from month to month, including progress toward discharge goals.
  - 2.3. All other components of the Treatment Plan, such as: Diagnoses, strengths and deficits, Discharge Plans, etc., are reviewed and updated as needed at each clinical review.
  - 2.4. The official date of review is the date the attending psychiatrist or designee signs the treatment plan.
  - 2.5. Treatment Assessment Notes (TAN) are written in association with the treatment plan review.
3. Documentation compliance is monitored by:
  - 3.1. Electronic chart programs and reports;
  - 3.2. Treatment unit internal review procedures, which include chart monitors;
  - 3.3. Utilization Review Coordinator/Nurse; and
  - 3.4. Medical Records Department chart review (upon discharge).

---

*Implemented: 9-9-83*

*Revised: 4-2-86*

*Revised: 3-17-88*

*Reviewed: 12-90*

*Reviewed: 9-14-92*

*Reviewed: 9-95*

*Revised: 11-98*

*Revised: 7-02*

*Revised: 10-04*

---

---

*Revised: 6-05*

*Revised: 9-07*

*Revised: 5-09*

*Revised: 4-12*

---

# **Chapter: Patient Management (PM)**

## **Section 11: Progress Notes**

### **Policy**

Specific ongoing documentation in the form of progress notes are kept in the patient's medical record.

### **Procedure**

1. Progress notes may contain documentation of the following information:
  - 1.1. assessment of patient's progress in accordance with original/revised treatment plan;
  - 1.2. treatment rendered to the patient, and medications ordered;
  - 1.3. clinical observations;
  - 1.4. changes in the patient's conditions, including revision of treatment plan as appropriate;
  - 1.5. response of the patient to care;
  - 1.6. consultation report; and
  - 1.7. psychosocial intervention.
2. All progress notes are entered into e-chart.
3. All entries involving subjective interpretation of the patient's progress include a description of the actual behavior observed.
4. The patient's progress and current status in meeting the goals and objectives of his/her treatment plan are regularly recorded in the patient's medical record.
5. The efforts of staff members to help the patient achieve stated goals and objectives are regularly recorded.
6. Progress notes are recorded by the physician, nurse, psychiatric technician, social worker, and, when appropriate, others significantly involved in active treatment modalities.
  - 6.1. Their frequency is determined by the condition of the patient and are recorded at least weekly for the first two months of stay and at least once a month thereafter.
    - 6.1.1. The notes contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

- 6.1.2. The hospital uses a "BIRP" format (Behavior/Intervention/Response/Plan) or "AIRP" (A=assessment) in charting for non-physician disciplines writing progress notes.
- 6.1.3. Medical staff uses structured weekly and monthly notes which include all required elements.

---

*Implemented: 9-19-83*

*Reviewed: 12-20-85*

*Reviewed: 3-18-88*

*Revised: 9-14-92*

*Revised: 8-95*

*Revised: 7-99*

*Revised: 10-01*

*Revised: 10-04*

*Revised: 06-07*

*Revised: 5-09*

*Revised: 5-12*

---

# **Chapter: Patient Management (PM)**

## **Section 12: Therapeutic Leave Status**

### **Policy**

Therapeutic leave is a modality used to assist patients in transitioning to a community based setting. Therapeutic leave status is used only on a limited basis and is approved by the attending psychiatrist on a patient-by-patient basis.

### **Procedure**

1. When used, therapeutic leave is documented in the discharge plan tab of the ICTP and is associated with a relevant objective and discharge goal.
2. The attending psychiatrist approves all patients eligible for therapeutic leave status.
3. The goals of each therapeutic leave are written on the appropriate form prior to the leave. Upon return of the patient to the hospital, nursing staff documents on the form the outcome of the leave in relation to the goals, with the assistance of the patient and significant others.
4. In the event the patient experiences any serious adverse events during therapeutic leave, such as injury or elopement, the unit RN contacts the attending or on-call psychiatrist for consideration of appropriate safety measures upon return of the patient to the unit. If injury related, the unit RN contacts medical services as well.
5. Persons under a criminal commitment are not eligible for therapeutic leave status unless court ordered.
6. Upon the patient's return to the Unit, the charge nurse:
  - 6.1. Contacts the attending psychiatrist or designee for orders pertaining to the safety precautions and the patient's level.
  - 6.2. Has the patient's clothing and belongings searched for contraband and logged in on the patient's belongings sheet.

---

*Implemented: 11-92*

*Revised: 1-93*

*Revised: 8-95*

*Revised: 12-98*

*Reviewed: 10-01*

*Revised: 10-04*

*Revised: 9-07*

*Reviewed: 5-09*

*Revised: 6-12*

---

# **Chapter: Patient Management (PM)**

## **Section 13: Return of a Patient Following Medical Separation**

### ***Policy***

Upon a patient's return to Utah State Hospital after a medical separation, necessary orders are written and the RN makes an entry addressing pertinent medical issues/assessment and any follow-up nursing care needed. The treatment plan is modified as needed.

### ***Procedure***

1. Immediately upon a patient's return, the assigned medical services practitioner writes orders as necessary concerning any changes in:
  - 1.1. medications;
  - 1.2. treatments;
  - 1.3. restorative and rehabilitative services;
  - 1.4. diet;
  - 1.5. special procedures recommended for the health and safety of the patient.
2. The rationale for the above, plus a description of the patient's condition, is contained in an RN data note.
3. Any modifications needed in the treatment plan are made by the treatment team.

---

*Implemented: 3-16-83*

*Revised: 2-26-86*

*Revised: 3-18-88*

*Reviewed: 12-90*

*Reviewed: 9-14-92*

*Revised: 8-95*

*Revised: 11-98*

*Reviewed: 10-01*

*Revised: 9-04*

*Revised: 9-07*

*Reviewed: 5-09*

*Reviewed: 2-11*

---

# **Chapter: Patient Management (PM)**

## **Section 14: Rapid Readmission Documentation**

### **Policy**

A patient is considered a rapid re-admission if re-admitted to the hospital within thirty days of discharge.

### **Procedure**

1. Admission documentation required by unit on rapid re-admission:
  - 1.1. new Initial Psychiatric;
  - 1.2. new Nursing Assessment;
  - 1.3. new Social History;
  - 1.4. new Physical Assessment (unless completed within past seven days).
  - 1.5. new Recreational Therapy Assessment
  - 1.6. other disciplines by referral
2. A Rapid Re-Admission form is sent to the Administrative Director from the Utilization Review office.
  - 2.1. The Rapid Re-Admission form is to be completed and returned to the Utilization Review office within seven days.

---

*Implemented: 6-16-87*

*Reviewed: 12-90*

*Reviewed: 9-14-92*

*Revised: 6-94*

*Reviewed: 8-95*

*Reviewed: 5-98*

*Revised: 12-98*

*Revised: 1-02*

*Revised: 5-03*

*Reviewed: 2-05*

*Revised: 9-07*

*Reviewed: 5-09*

*Reviewed: 5-12*

---

# **Chapter: Patient Management (PM)**

## **Section 15: Discharge Summary and Aftercare Plan**

### **Policy**

A discharge summary dictated and signed by the patient's psychiatrist is entered in the patient's record within 14 days of discharge.

### **Procedure**

1. The discharge summary includes the reason for the admission.
2. The discharge summary includes a clinical resume that summarizes the following:
  - 2.1. Interventions used for treatment of significant physical and psychiatric findings;
  - 2.2. the course and progress of the patient in the hospital with regard to each treated clinical problem;
  - 2.3. Consultations;
  - 2.4. Assessment of the patient's condition at discharge;
  - 2.5. the recommendations and arrangements for further treatment, including prescribed medications and aftercare.
3. The discharge summary includes the final diagnoses.
4. A written aftercare plan that provides reasonable assurance of continued care is developed with the participation of the appropriate Local Mental Health Authority (LMHA) staff; other professionals in the community who may be involved; the patient; and when indicated, the family or guardian.
5. Discharge summaries and other records are sent to the receiving care provider within 30 days of discharge.

---

*Implemented: 9-15-83*

*Reviewed: 12-20-85*

*Revised: 3-18-88*

*Reviewed: 12-90*

*Reviewed: 9-14-92*

*Revised: 8-95*

*Revised: 6-07*

*Revised: 5-09*

*Reviewed: 5-12*

---

# **Chapter: Patient Management (PM)**

## **Section 16: Caffeine Consumption**

### ***Policy***

Caffeine consumption by patients may interfere with their psychiatric treatment, particularly as it reduces the effectiveness of medications.

### ***Procedure***

1. Caffeinated coffee is available to patients in hospital food services areas on a limited basis as per the direction of each department clinical management team.
2. Individual patients' caffeine consumption from other sources may be limited based on direction of the clinical team.

---

*Implemented: 9-21-89*

*Reviewed: 12-90*

*Revised: 9-14-92*

*Revised: 9-95*

*Reviewed: 6-98*

*Revised: 7-02*

*Reviewed: 1-05*

*Revised: 5-09*

*Reviewed: 5-12*

---

# **Chapter: Patient Management (PM)**

## **Section 17: Immunizations**

### ***Policy***

Child and adolescent patients admitted to the Utah State Hospital will have immunizations current and specific to their age in accordance with CDC immunization guidelines

### ***Procedure***

1. Upon admission, the medical services provider includes dates of age-specific immunizations in the history and physical.
  - 1.1. Children and adolescents must produce documentation of immunizations.
    - 1.1.1. If no documentation of immunizations is available through parent/guardian, the parent/guardian must sign an immunization authorization form.
2. When no documentation of immunizations of children/adolescents is available, booster immunizations are administered according to current childhood immunization guidelines.
  - 2.1. If a parent has a medical, philosophical or religious reason for not wanting the immunization then the parent/guardian follows the Utah Department of Health guidelines for completing the exemption.
    - 2.1.1. Utah State Hospital assists parent/guardian in completing the exemption form.
3. All female patients of child bearing age who require immunizations must have a negative serum HCG before the immunizations are administered.

---

*Reviewed: 9-14-92*

*Reviewed: 9-95*

*Reviewed: 2-02*

*Revised: 6-09*

*Revised: 11-12*

---

# **Chapter: Patient Management (PM)**

## **Section 18: GMI Review and Recommendations for Transfer**

### **Policy**

Guilty and Mentally Ill (GMI) offenders committed to the Utah State Hospital are reviewed at least every six months, in accordance with UCA 77-16a-203.

### **Definitions**

1. Board: Board of Pardons.
2. GMI Offender: Any person committed to the Department of Human Services under UCA 77-16a-103.
3. Hospital: The Utah State Hospital.
4. Review Team: A team designated by the Hospital Clinical Director to review GMI Offenders.
5. UDC: The Utah Department of Corrections.

### **Procedure**

1. The Hospital Clinical Director designates a review team to evaluate the mental status of every GMI Offender receiving treatment at Utah State Hospital.
  - 1.1. The review team consists of three people: at least one psychiatrist and two other staff members with degrees in psychology, social work, or nursing.
    - 1.1.1. If the offender is mentally retarded, the review team includes or will invite an individual who has professional experience in mental retardation treatment.
2. The review team evaluates the mental condition of the offender and makes a report to the Board, UDC, and/or court of jurisdiction which includes the following:
  - 2.1. current mental condition;
  - 2.2. progress since commitment;
  - 2.3. prognosis;

- 2.4. recommendation whether the offender should be transferred to UDC, referred back to court for further disposition, or remain in the custody of the Department of Human Services.
3. The hospital provides to the UDC Medical Administrator a copy of the reviewing team's recommendation and:
  - 3.1. all available clinical facts;
  - 3.2. diagnosis;
  - 3.3. course of treatment received;
  - 3.4. prognosis for remission of symptoms;
  - 3.5. potential for recidivism;
  - 3.6. estimation of the offender's dangerousness, either to self or others; and
  - 3.7. recommendations for future treatment.
4. If the Hospital and UDC do not agree on the transfer of a GMI offender to UDC, the issue is forwarded to the mental health advisor for the Board.
  - 4.1. The hospital provides copies of all reports and recommendations to the mental health advisor for the Board.
5. The Board's mental health advisor makes a recommendation to the Board on the transfer and the Board issues a decision within 30 days.
6. UDC notifies the Board whenever a mentally ill offender is transferred from the hospital to UDC.

---

*Implemented: 7-92*

*Reviewed: 9-95*

*Revised: 11-98*

*Reviewed: 3-02*

*Revised: 1-05*

*Revised: 6-09*

*Reviewed: 6-12*

---

# **Chapter: Patient Management (PM)**

## **Section 19: NGI Continuing Review, Conditional Release, and Discharge**

### **Policy**

In accordance with UCA 77-162-304, Utah State Hospital reviews the status of each NGI defendant receiving treatment at least once every six months.

### **Definitions**

1. Board: The Board of Pardons.
2. Hospital: Utah State Hospital.
3. NGI Defendant: Any person committed to the Department of Human Services as Not Guilty by Reason of Insanity under UCA 77-14-5.
4. UDC: The Utah Department of Corrections.

### **Procedure**

1. The Hospital Clinical Director designates a review team to evaluate the mental condition of every NGI defendant receiving treatment at Utah State Hospital.
  - 1.1. If the defendant is mentally retarded, the review team shall consult an individual who is a mental retardation professional.
  - 1.2. Reviews are conducted at least every six months.
  - 1.3. NGI defendants are reviewed to determine if they are eligible for conditional release, discharge, or if they require further treatment at USH.
2. All committee findings and pertinent data are submitted to the court of jurisdiction, prosecuting attorney, and defense attorney.
  - 2.1. The hospital notifies the court of jurisdiction when a defendant becomes eligible for discharge if the review team finds:
    - 2.1.1. the defendant has recovered from his mental illness; or
    - 2.1.2. the defendant is still mentally ill but does not present a substantial danger to self or others.

- 2.2. The hospital notifies the court of jurisdiction when a defendant becomes eligible for conditional release if the review team finds:
- 2.2.1. that the defendant is not eligible for discharge, but that his mental illness and dangerousness can be controlled with proper care, medication, supervision, and treatment if conditionally released.
  - 2.2.2. The hospital prepares a conditional release plan that lists the type of care and treatment that the defendant needs and may recommend a treatment provider.
    - 2.2.2.1. The conditional release plan and the review team's report is provided to the court, the prosecuting attorney, and the defendant's attorney.

---

*Revised: 4-99*  
*Reviewed: 1-05*  
*Reviewed: 6-09*  
*Revised: 6-12*

---

# **Chapter: Patient Management (PM)**

## **Section 20: Visitors**

### ***Policy***

Utah State Hospital encourages and supports family, friends, volunteers, and appropriate others visiting patients.

### ***Definitions***

**Weekday:** Monday through Friday.

**Weekend:** Saturday and Sunday.

**Off-Grounds Visit:** An approved visit which occurs off Utah State Hospital grounds.

**On-Grounds Visit:** An approved visit which occurs on Utah State Hospital grounds.

**On-Ward Visit:** An approved visit which occurs in the patient-care building.

**Supervised Visit:** Visit that requires staff supervision.

**Unsupervised Visit:** Visit that does not require staff supervision.

### ***Procedure***

1. Unit weekday visiting hours:
    - 7:00 pm to 9:00 pm - Forensic Unit
    - 3:00 pm to 8:00 pm - Children's Unit (other times may be arranged through the social worker)
    - 6:00 pm to 8:00 pm- Adolescent Unit (other times may be arranged through the social worker)
    - 9:00 am to 9:00 pm - All other treatment units.
  2. Unit weekend visiting hours:
    - 10:00 am to 9:00 pm - Forensic Unit
    - 9:00 am to 8:00 pm - Children's Unit / Adolescent Unit (other times may be arranged through the social worker)
    - 9:00 am to 9:00 pm - All treatment units.
  3. Family, friends, clergy, legal counsel, volunteers, and appropriate others may visit patients.
    - 3.1. Persons desiring to visit minors must obtain approval by the parent/legal guardian and the unit clinical staff.
-

- 3.2. Visits by ex-patients are approved on a case-by-case basis by the patient's physician or physician on call, and upon the physician's written order.
  - 3.3. Forensic visitors must provide picture ID.
  4. Clearance. Utah State Hospital encourages visitors to phone and obtain clearance before visiting.
    - 4.1. Attorneys and clergy visiting patients in an official capacity may visit at times other than the above identified visiting hours.
      - 4.1.1. Attorneys and clergy are encouraged to contact the patient's treatment team prior to visiting.
      - 4.1.2. Attorneys and clergy visiting in an official capacity are encouraged to obtain a "visitor slip."
    - 4.2. Visits that disrupt a patient's therapy program or meals are discouraged.
    - 4.3. Special visits in emergency situations or with extenuating circumstances are accommodated. Those requesting special visits obtain clearance by the patient's physician/on call physician.
  5. Visitor Slip. Upon arrival at Utah State Hospital, visitors (to areas other than the Forensic Building, the Children's Unit, and the Adolescent Units) obtain a "visitor slip" from the switchboard, which is located at the main entrance of the Hening Administration Building.
    - 5.1. The switchboard informs the unit of a visitor's arrival and, upon approval, provides a "visitor slip" to the visitor.
    - 5.2. The visitor presents the "visitor slip" and proper identification upon arrival to the unit.
  6. Forensic visitors go directly to the Forensic Building and are checked in by Central Control. Visitors to the Children's Unit and the Adolescent Units are not required to go to the switchboard. They go directly to the units.
  6. Visitors may obtain a visitor's pass with approval from the patient's physician. Visitors with passes may go directly to the patient's unit and do not need to check in at the switchboard. The physician writes an order in the patient's chart.
  7. Visits may be limited or terminated if deemed non-therapeutic by the unit clinical director or physician on call. Justification for limitation or termination is documented in the patient's medical record. Doctor's orders limiting visits are reviewed every seven days and a new order written if limitation is to continue.
  8. Patients may refuse visits.
    - 8.1. When a patient refuses a visit, visitors will be notified.
    - 8.2. Such an event is documented in the patient's medical record.
-

9. Each unit provides a designated visiting area for visitors and patients.
  - 9.1. Visitors remain in the visiting areas and do not access patient living areas.
10. Restricted Gifts/Items. Visitors desiring to bring gifts/items are encouraged to obtain clearance from the patient's treatment team prior to bringing the gift/item on the unit.
  - 10.1. Weapons or items determined to be "sharps" are not allowed in patient care areas.
  - 10.2. Purses are discouraged in the unit visiting areas, and visitors are encouraged to lock them in their private vehicles.
  - 10.3. Food items to be given to patients require staff clearance prior to visit.
  - 10.4. Money being given to patients is to be brought to the switchboard. The switchboard operator logs and secures the money and gives a receipt to the visitor.
    - 10.4.1. Exceptions may be made on the unit level for small amounts of money to be given directly to the patient.
  - 10.5. Glass containers are not allowed on the treatment units.

---

*Implemented: 9-92*

*Revised: 1-93*

*Revised: 8-95*

*Revised: 6-98*

*Revised: 8-99*

*Revised: 1-05*

*Revised: 6-09*

*Revised: 6-12*

---

# Chapter: Patient Management (PM)

## Section 21: Home Visits

### Policy

Home visit opportunities are provided to patients with input and approval of treatment staff.

### Definitions

1. **Home Visit** - An activity which is therapeutically indicated, is approved by the treating physician and communicated to the responsible Local Mental Health Authority (LMHA), and which allows the patient to leave the hospital grounds under the supervision of approved family or friends for purposes stated in the patient's home visit form. Home visits may be requested by the patient, the patient's family, friends of the patient, or hospital staff. A home visit is an overnight stay.

### Procedure

1. Home visits are requested by the patient, guardian, family, and/or significant others and approved by the unit treatment team.
2. All requests for a home visit are reviewed by the clinical treatment staff for appropriateness.
  - 2.1. Staff review and make sure the home visit form includes the proposed therapeutic goals.
  - 2.2. The unit treatment team considers risks, including elopement risks, when reviewing a request for a home visit.
  - 2.3. Home visits are included as a modality on the patient's ICTP.
3. Home visits are granted when:
  - 3.1. the visit has a therapeutic intent consistent with the goals of the ICTP (*i.e.*, integration into the community, developing relationships with family, etc.);
  - 3.2. the responsible LMHA is notified of home visits as part of the treatment plan at the time of initiation of visits. A crisis safety plan is requested from the LMHA for pediatric visits.
  - 3.3. the visit is incorporated into the patient's treatment plan
  - 3.4. the family is notified when applicable
  - 3.5. Persons on the duty to warn list, if indicated, are notified; and

- 3.6. the treating physician writes an order for the home visit.
4. A Home Visit Form is completed for each home visit.
  - 4.1. The home visit form is completed by the social worker and Registered Nurse and is then signed by the family member / guardian providing the home visits. The social worker initiates and includes objectives on the home visit data sheet.
    - 4.1.1. Nursing staff completes medication information and reviews form with responsible party.
  - 4.2. After the patient returns, the nursing staff completes the form, reporting on the home visit and whether the patient met the goals.
5. Persons providing the home visit are invited to a meeting to discuss the parameters of the home visit, which include: medications; appropriate activities; inappropriate activities; goals; who to contact in case of emergency; and expected time of departure from and return to hospital.
  - 5.1. If the persons providing the home visit are unable to attend the meeting, then parameters of home visit are discussed via phone call.
  - 5.2. Persons providing the home visit receive a Home Visit Data Sheet.
6. Forensic patients are not allowed home visits unless approved by a court order or permission is granted by the Board of Pardons.

---

*Reviewed: 1-93*

*Revised: 8-95*

*Revised: 6-98*

*Reviewed: 10-01*

*Revised: 3-04*

*Revised: 8-09*

*Revised: 8-12*

---

# **Chapter: Patient Management (PM)**

## **Section 22: Patient Death/Immediate Actions**

### **Policy**

The Utah State Hospital implements the following procedures when a patient death occurs. The medical staff informs the Medical Examiner (ME) of all patient deaths. As per Utah Code 26-4-7 (9) the ME has the authority to make the determination regarding autopsy for all USH patient deaths. Permission is implicit by ME determination.

### **Procedure**

1. Once the patient is pronounced dead:
    - 1.1. Hospital Security, Unit Staff and/or Shift Supervisor are called to secure the scene, if death occurs on campus.
    - 1.2. Nursing staff removes all patients from the area.
    - 1.3. Hospital Security restricts all non-essential others from the area.
    - 1.4. In accordance with UCA 26-4-8, Hospital Security immediately notifies the Provo Police of the death (379-6210) and notification is documented in the Security Officer's log.
    - 1.5. The scene and the body are not disturbed until authorization is given by the senior ranking peace officer from the law enforcement agency having jurisdiction of the case and conducting the investigation.
  2. Whether the death occurred on or off USH campus, the unit RN notifies the following (after hours the SSRN is accountable to ensure calls are made by unit RN):
    - 2.1. Switchboard operator.
    - 2.2. The administrator on call.
      - 2.2.1. The administrator on call notifies the Hospital Superintendent and Risk Management.
      - 2.2.2. The Hospital Superintendent notifies the Division of Substance Abuse and Mental Health, the Department of Human Services, and the Attorney General's Office.
    - 2.3. The Hospital Clinical Director.
    - 2.4. The psychiatrist on call.
    - 2.5. The attending physician.
-

- 2.6. The patient's significant other, if available.
    - 2.6.1. The patient's social worker may be asked to notify the family/significant others.
  - 2.7. The Hospital Patient Advocate is notified via e-mail.
  - 2.8. Intermountain Donor Services (1-800-833-6667).
  - 2.9. The State Medical Examiner's Office (1-801-584-8410).
  - 2.10. All contacts are documented in the patient's electronic record.
  3. When contacted by a law enforcement duty investigator, the physician or nurse gives the decedent's name, date of birth, race, next-of-kin, and known circumstances surrounding the death.
    - 3.1. The investigator may conduct an inspection of the decedent and location of the death scene.
    - 3.2. The investigator may request a copy of the decedent's medical chart.
  4. The Hospital Clinical Director/designee contacts the state Medical Examiner's Office to discuss the circumstances surrounding the death (801-584-8410).
    - 4.1. If the Medical Examiner states that an autopsy is indicated, USH provides medical information as appropriate and requests a copy of the autopsy findings.
      - 4.1.1. The Medical Records Manager is responsible to coordinate the release of medical information and the written request for a copy of the autopsy findings.
    - 4.2. If the Medical Examiner does not require an autopsy and USH criteria for an autopsy are met, the Clinical Director/designee informs the Legal Services Manager who makes a formal request seeking permission for an autopsy to the Attorney General for the Medical Examiner's Office.
  5. The Hospital Clinical Director/designee requests an autopsy if one of the following criteria are met:
    - 5.1. Unexpected or sudden death while in apparently good health.
    - 5.2. Deaths in which the cause of death is unknown with certainty on clinical grounds and in which an autopsy could provide valuable medical information.
    - 5.3. To protect the hospital in a potential liability situation.
    - 5.4. The patient's family requests an autopsy.
  6. The law enforcement investigator will inform the unit nurse of arrangements for removal of the body either to a morgue, funeral home, or to the Medical Examiner's Office.
-

- 6.1. Disposition of the body must be approved by the office of the Medical Examiner and the Hospital Medical OD/designee.
7. In the event that a patient expires while on separation from USH, the Hospital Clinical director/designee will contact the physician attending the patient at the time of the patient's death to request that the above procedures are followed.
8. The Hospital Clinical director/designee is responsible to notify the Medical Staff and, specifically, the attending physician when an autopsy is requested. This information is documented in patient chart.
9. If there is a mass fatality event, whether man-made, natural disaster, or pandemic disease Utah State Hospital follows the Mass Fatality Management Procedure.
10. In the event of a patient death related to the use of seclusion or restraint; A member of the hospital executive staff:
  - 10.1. Reports the death to CMS by telephone (303-844-7126), fax, or electronically no later than the close of the next business day following the knowledge of the patient's death.
  - 10.2. When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the hospital does the following:
    - 10.2.1. Records in the PIRS follow-up tab any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient.
    - 10.2.2. Records in the PIRS follow-up tab any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient.
    - 10.2.3. Documents in the patient PIRS record the date and time that the death was recorded.
    - 10.2.4. Documents in the PIRS follow-up tab the patient's name, date of birth, date of death, name of attending physician responsible for the care of the patient, medical record number, and primary diagnosis(es).
    - 10.2.5. Makes the information in the PIRS available to CMS, either electronically or in writing, immediately upon request.

---

*Initiated: 6-96  
Revised: 11-98  
Revised: 1-02  
Reviewed: 1-05  
Reviewed: 5-09  
Revised: 10-10  
Revised: 8-13  
Revised: 8-14*

---

# **Chapter: Patient Management (PM)**

## **Section 23: Industrial Security**

### **Policy**

Appropriate supervision is provided to prevent elopement of patients from industrial assignments.

### **Procedure**

1. All patients being considered for an industrial assignment are screened to determine their level of risk for elopement.
    - 1.1 Supervision to and from industrial assignments may be increased based on a patient's level of elopement risk.
  2. Employees signing out patients for industrial assignments are responsible to call each industrial area as patients leave for an industrial work site to inform the industrial area coordinators that the patient(s) have left the unit.
    - 2.1. If the patient is being escorted by staff, a call is not necessary.
    - 2.2. Units call to inform industrial areas when patients will not be at work or when they will be late.
    - 2.3. If the industrial area cannot be reached by phone, it is the unit's responsibility to escort the patient(s) to the industrial area coordinator, unless the patient has a doctor's order to walk alone to and from work.
  3. Industrial areas inform the unit that a patient has reached his/her industrial assignment area.
    - 3.1. If a patient has not reached the assigned industrial site within five minutes of receiving notification that the patient has left the unit, the industrial area coordinator calls the unit.
  4. Industrial areas call the unit to inform the unit that the patient(s) have completed work assignments and are returning to the unit.
    - 4.1. If the unit cannot be reached by telephone, it is the responsibility of the industrial area coordinator to escort the patient(s) back to the unit, unless the patient has a pass ordered by the attending psychiatrist/designee that allows the patient to walk on grounds without an escort.
  5. Units let the industrial area know when patients have returned to the unit.
    - 5.1. If the patient(s) have not returned to the unit within five minutes of being informed that they have left the work site, the unit calls the industrial area to follow-up.
  6. Elopement procedures are initiated by the unit of origin if the patient is not accounted for promptly.
-

---

*Implemented: 6-15-88*

*Reviewed: 8-92*

*Reviewed: 9-95*

*Revised: 10-01*

*Revised: 1-05*

*Revised: 11-08*

*Revised: 3-12*

---

# **Chapter: Patient Management**

## **Section 24: Use of Restraints for Transportation of Patients**

### **Policy**

All restraints used during patient transportation must be ordered by a psychiatrist.

### **Procedure**

1. Handcuffs are used by security staff only when ordered by a psychiatrist.
2. The need for use of restraint for each transportation event is documented in a doctor's order.
  - 2.1. Occasions may arise when, a patient can not be controlled by using the approved SIT or the ACT techniques, while being transported to the seclusion room or designated area. In these cases an officer, is authorized to apply handcuffs to transport the patient to the seclusion room or designated area. Once the officer arrives to the seclusion room or designated area, and the patient and staff are safe, the officer will remove the handcuffs. When such circumstances arise a doctor's order is required.
3. Transportation of a threatening patient in a vehicle with a cage may be preferred to the use of restraints.
4. A security officer remains with the patient continuously while the patient is in handcuffs.

---

*Implemented: 12-99*

*Revised: 10-04*

*Revised: 05-05*

*Reviewed: 06-09*

*Revised: 04-12*

*Revised: 07-13*

---

# Chapter: Patient Management (PM)

## Section 25: Elopement Procedure

### Policy

The Utah State Hospital provides appropriate supervision of patients to ensure patient and community safety. In the event of patient elopement, hospital personnel follow a facility-wide procedure. Elopement is considered a serious and imminent threat to the health or safety of the individual and/or the public, necessitating the disclosure of limited protected health information to USH personnel during the response.

### Procedure

1. In the event of an elopement from the Utah State Hospital grounds, the person directly responsible for the patient's supervision immediately notifies the Hospital Security Department by radio and the switchboard operator by phone (44222), if unable to locate missing patient within 5 min.
  - 1.1. When reporting an elopement, a brief description of the patient is given, including unit, name, age, gender, hair color, clothing description, last place seen, and location of nearest friend or relative if known.
  - 1.2. The staff responsible for the patient notify the unit charge RN.
  - 1.3. The unit charge RN immediately prints the **ID only** face sheet report from E-chart to disseminate to staff involved in the search.
2. **SWITCHBOARD OPERATOR** makes an overhead announcement, "Attention, Attention, There is a code purple on \_\_\_ unit."
  - 2.1. All available staff report to the supervisor of the area in which the elopement occurs.
    - 2.1.1. If an elopement occurs on a unit, report to the unit RN.
    - 2.1.2. If an elopement occurs on an area other than a unit, report to the supervisor of the area in which the elopement occurs.
  - 2.2. Switchboard operator prints **ID only** face sheet as necessary.
  - 2.3. In the event switchboard receives a phone call reporting a suspected elopement, the switchboard operator immediately obtains details of the report including caller name, title, patient name, gender, clothing, location, etc.
    - 2.3.1. Switchboard operator immediately relays information over security channel 1-A.
    - 2.3.2. Switchboard operator requests caller stay on phone and keep suspected individual in line of sight until USH security, or the police arrive.

- 2.3.2.1. Switchboard operator may forward caller to suspected unit if known, to report suspicions to unit RN.
  - 2.3.3. USH security responds to location of report.
    - 2.3.3.1. Security notifies law enforcement agency as necessary.
  - 3. Hospital **SECURITY** immediately oversees the search for the eloped patient(s) and coordinates the search with unit personnel (or SSRN if after hours).
    - 3.1. Security obtains the **ID only** face sheet as necessary.
    - 3.2. Security coordinates with Unit RN to assign available staff to areas of need.
    - 3.3. If the elopement occurs from a location other than the hospital, security notifies the law enforcement agency in that jurisdiction.
    - 3.4. If the patient is suspected to have left grounds or is not located within 10 minutes, hospital security notifies local police.
      - 3.4.1. Security also notifies other police agencies of the elopement when pertinent to the situation, such as police from patient's Local Mental Health Authority (LMHA) catchment area.
    - 3.5. If security is unable to make the calls, they notify SSRN, who will then make the calls.
  - 4. The **UNIT RN** oversees the needs of the unit.
    - 4.1. The RN uses responders from other units to replace core staff acquainted with the patient. The Unit RN will send available core staff to assist security with the search.
    - 4.2. Responding staff who are not given an assignment return to their unit.
    - 4.3. All other available staff (i.e. administrators, support services, etc.) monitor their immediate area for individuals who meet the description provided until otherwise directed.
      - 4.3.1. Responders involved in the search for the eloped patient(s) obtain a copy of the **ID only** face sheet as needed.
      - 4.3.2. All staff members designated to participate in the search report to security channel 1-A by radio to receive assignments.
      - 4.3.3. If during business hours (8 am - 5 pm Monday-Friday), the RN notifies:
        - 4.3.3.1. Unit SMT members
        - 4.3.3.2. USH administration (USH administration ensures that the Superintendent is notified.)
      - 4.3.4. The unit SMT is responsible to notify or designate someone to notify:
-

- 4.3.4.1. LMHA
  - 4.3.4.2. Patient's family members
  - 4.3.4.3. Duty to Warn person(s) if applicable and Legal Services when Duty to Warn person(s) have been contacted.
  - 4.3.5. If after hours, the unit RN notifies:
    - 4.3.5.1. SSRN
    - 4.3.5.2. Unit AD
    - 4.3.5.3. USH Psychiatrist OD
    - 4.3.5.4. LMHA
    - 4.3.5.5. Patient's family
    - 4.3.5.6. Duty to Warn person(s) if applicable
  - 4.3.6. If after hours, the SSRN notifies:
    - 4.3.6.1. Administrator on Call
    - 4.3.6.2. Superintendent
  - 5. The unit RN is responsible to document the completed/attempted elopement incident in the patient's record as well as the Patient Incident Reporting System (PIRS).
    - 5.1. Unit personnel are responsible to document attempts to contact Duty to Warn person(s), family members, and LMHA as outlined in this policy when they have responsibility to notify. The charge RN documents this if the elopement occurs after hours.
    - 5.2. The AD is responsible to complete the administrative follow-up section of the PIRS. The UND completes this if the AD is not available.
    - 5.3. The AD is responsible to return an elopement report to Risk Management.
  - 6. Any updated information regarding the eloped patient(s) (such as information regarding whereabouts, safety concerns, return of patient, or other information) is communicated to USH administration by the SMT or charge nurse depending on the time the information is received. The charge RN keeps the SMT or SSRN (after hours) updated as to the status of the patient.
    - 6.1. When patient is located, the RN follows notification protocols as outlined in # 5 above.
  - 7. The Hospital Clinical Director determines if the elopement qualifies as a sentinel event. If so, the USH QR Director conducts a root cause analysis.
  - 8. Any patient information used in the elopement response is disposed of as per HIPAA guidelines.
-

---

*Revised: 9-92*

*Reviewed: 9-95*

*Revised: 7-99*

*Revised: 10-00*

*Revised: 9-04*

*Revised: 11-08*

*Revised: 6-10*

*Revised: 01-11*

*Revised: 10-12*

*Revised: 11-12*

*Revised: 12-12*

---

# **Chapter: Patient Management (PM)**

## **Section 26: Hospital Cellular Phones and Radios**

### **Policy**

The hospital utilizes cellular phones, 800 MHZ Two-way radios, and talk-about radios to facilitate communication among staff members caring for patients and to ensure safety for staff and patients, obtain quick response to crisis and for other essential needs.

### **Procedure**

1. Cellular phones are used by staff when taking patients off USH campus.
    - 1.1. Employees are given a USH cellular phone when checking out a state vehicle at the switchboard.
      - 1.1.1. Phones must be with employee and turned on at all times.
      - 1.1.2. Phones are used for hospital business and emergency purposes only.
      - 1.1.3. Switchboard maintains a list of each vehicle and the phone number assigned to the vehicle.
    - 1.2. Cellular phones used by the psychiatric and medical physicians on call may be checked out from the switchboard.
  2. 800 MHZ Two-way radios are used by each unit to communicate with each other on-grounds for unit issues or emergencies, notify hospital security of emergencies, and communicate with the hospital while on off-grounds activities within the local community.
    - 2.1. Each unit is issued a specific number of radios based on need.
      - 2.1.1. Additional radios may be signed out from the RT department or switchboard and documented on a sign-out sheet.
        - 2.1.1.1. All radios need to be checked back in by the person responsible for the radios on the sign-out sheet indicating that the radios are returned.
    - 2.2. Each unit is responsible for the radios assigned to that unit.
    - 2.3. Channels are assigned by the hospital to each unit.
    - 2.4. Radios are to be used when escorting groups, high profile patients, elopement risk patients, etc., on-grounds.
  3. Unit administration designates a person or persons responsible for the radios.
-

- 3.1. Designee(s) maintain radios in operable condition and ensure batteries are charged according to manufacturer recommendations.
4. Support services utilize radios for daily work activities and communication needs.
  - 4.1. Support Services administrators designate a person or person responsible for the radios.
  - 4.2. Designee(s) maintain radios in operable condition, and ensure batteries are charged according to manufacturer recommendations.
5. Hospital Wide inventory is performed annually by purchasing department.
  - 5.1. Radios that are not at their assigned location are returned to their assigned location as determined by the purchasing department or designee(s).
6. Talk-about radios are available for CERT team activities, and as needed during a disaster response.
  - 6.1. The talk-about radios are designed for use in ranges of up to 2 miles in open flat areas. Range is decreased by buildings, trees, mountains, foliage, etc.
  - 6.2. Talk-about radios are maintained with CERT supplies.

---

*Implemented: 2-02*

*Revised: 1-05*

*Revised: 7-09*

*Revised: 8-12*

---

# **Chapter: Patient Management (PM)**

## **Section 27: Sentinel Event Reviews**

### **Policy**

Clinical incidents of substantial concern are reviewed intensively so that patient care procedures may be improved.

### **Definitions**

**Sentinel Event:** An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. This includes but is not limited to all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

**Root Cause Analysis:** A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

### **Procedure**

1. A variance from expected patient care procedures and outcomes on a treatment unit is reported by nursing unit staff and reviewed by the service management team (SMT) of that unit.
  - 1.1. All incidents of substantial concern, including all uses of seclusion and restraint, elopements, medication errors, and patient injury are reported through the Patient Incident Reporting System (PIRS)
  - 1.2. The unit staff and shift supervisor reports include significant changes in medical condition such as acute illness, same day surgery, and medical separations.
2. Incidents reviewable by JCAHO are reported to them within 5 working days. These incidents include unanticipated death, major permanent loss of function not related to the natural course of illness, suicide, and rape.
  - 2.1. A unit administrator who becomes aware of a JCAHO reviewable incident brings that incident to the attention of the Quality Resource Director and a member of executive staff immediately.
  - 2.2. Incidents meeting the definition of a Sentinel Event are identified and an assignment is made to do a root cause analysis and action plan.
  - 2.3. The root cause analysis focuses primarily on system and processes, not individual performance.
  - 2.4. The product of a root cause analysis is an action plan which identifies strategies for implementation which reduce the risk of similar events occurring in the future.

- 2.4.1. The plan addresses the responsibility for implementation, oversight, time lines, and strategies for measuring the effectiveness of the actions.
  - 2.4.2. The report identifies changes that can be implemented to reduce risk, or formulates a rationale for not undertaking such changes. These changes are made in a timely manner at the unit level under the direction of the SMT which documents the process in their minutes.
  - 2.4.3. The root cause analysis report is prepared by the Director of Quality Resources (QR).
  - 2.4.4. The action plan is drafted by the SMT of the Unit on which the incident occurred, in consultation with the director of QR, and a member of the Executive Staff.
  - 2.4.5. The QR Director presents the root cause analysis and action plan to the Exec Staff in a meeting of the Exec Staff.
  - 2.4.6. The Exec Staff reviews the Report, makes changes as needed and accepts the plan.
- 2.5. The quality resource director reports findings at least quarterly to the performance improvement (PI) council and executive staff, which may initiate further intense analysis of processes, which lead to trends.
- 2.5.1. Quality Resources provides full documentation of the root cause analysis of reviewable incidents to Joint Commission within 45 days of the self-report or of being placed on Accreditation Watch.
  - 2.5.2. Executive staff logs completion of the action plan in its action register and contacts unit administrators for completion when follow-up reports are deficient.
    - 2.5.2.1. Executive staff logs completion of the follow-up section of PIRS reports and contacts unit administrators for completion when follow-up reports are deficient.

---

*Initiated: 06-99  
Revised: 8-01  
Revised: 3-04  
Revised: 12-04  
Revised: 6-07  
Reviewed: 5-09  
Reviewed: 5-11  
Revised: 6-12*

---

# **Chapter: Patient Management**

## **Section 28: Sharps Policy**

### ***Policy***

Utah State Hospital maintains a safe environment for patients, employees and visitors. Procedures are in place to limit and track sharps that enter campus and patient care areas.

### ***Definition***

Sharps: Knives, glass/ceramic items, scissors, electronic disks, aluminum cans, razors, clippers, tweezers, and other items as identified that are deemed harmful by service areas available in patient access areas.

Patient Access Areas: Areas within buildings which patients have open access or may freely enter, such as unit common areas, treatment mall, occupational therapy, physical therapy, recreational facilities, cafeteria.

Sharps Count: A physical count of all sharps by oncoming staff member and exiting staff at the beginning and ending of each shift on a Sharps Log Form.

### ***Procedure***

1. On admission and throughout treatment the treatment team assesses each patient for risk of dangerousness.
  - 1.1. The clinical assessment includes risk of harm to self and/or others.
  - 1.2. Safety precautions are established based on clinical evaluations. Clinical needs, therapeutic value, and safety risks are included in the assessment.
2. Staff checks patients and their belongings for sharps upon admit, return from home visits, off grounds and on grounds. See treatment area specific addendums.
  - 2.1. All sharps found that are not approved for patient use are secured by staff and placed away from patient access areas or sent home with family.
3. Staff monitors use of approved sharps.
  - 3.1. Knives
    - 3.1.1. Patients do not use knives
    - 3.1.2. Knives are not allowed in patient access areas.
    - 3.1.3. Hard plastic knives are available in locked unit kitchens in a locked drawer and are only used with supervision.

- 3.1.4. Sharps on Children's Unit used for preparing meals are kept locked and are counted and logged after each meal.
  - 3.1.5. Employees are not allowed to carry pocket knives in patient care areas.
  - 3.2. Glass /Ceramic items
    - 3.2.1. Glass/Ceramic items are used under staff supervision. Items are stored away from patient access areas or in locked display cases.
  - 3.3. Scissors
    - 3.3.1. Non child-safety scissors are not allowed in patient access areas.
      - 3.3.1.1. Non child-safety scissors may be used in staff offices. Staff is responsible for securing any sharps or potentially dangerous items within their office area.
    - 3.3.2. Only child-safety scissors may be used by patients under direct supervision as deemed appropriate by each service area.
    - 3.3.3. Child-safety scissors must be counted before and after each activity and are included in the sharps count.
  - 3.4. Electronic Disks (CD's, DVD's, Game System Disks)
    - 3.4.1. All DVD's and game system disks must be checked in and out by staff.
    - 3.4.2. CD's can only be used under direct supervision.
    - 3.4.3. MP3's and Ipods are preferable for therapeutic and personal use.
    - 3.4.4. Legacy patients may use electronic disks as they are checked in and out. CD's are not included in sharps count.
    - 3.4.5. Staff is responsible to include these items in sharps count.
  - 3.5. Aluminum cans
    - 3.5.1. Aluminum cans are not allowed on units in patient living areas. Aluminum cans are disposed of away from patient living areas.
    - 3.5.2. Drinks in cans will be supervised and staff will dispose of can after patient use, away from patient areas on Legacy.
  - 3.6. Razors
    - 3.6.1. Use of all razors (straight razors and electric razors) must be supervised.
    - 3.6.2. All razors must be included in the sharps count.
  - 3.7. Clippers and Tweezers
-

- 3.7.1. Use of clippers and tweezers must be supervised.
- 3.7.2. All clippers and tweezers must be included in the sharps count.
- 3.8. Each treatment area establishes specific protocols for sharps, for definition of and use of other sharp items such as knitting needles, crochet hooks, hand and garden tools, fishing gear, pens and pencils. See treatment area specific addendums.
- 4. Food Services
  - 4.1.1. Knives used by food service workers are kept in a secured area with a sharps count documented daily.
  - 4.1.2. Patients do not use knives.
  - 4.1.3. Knives are not allowed in the Forensics building, including food service area.
  - 4.2. Recreation Therapy
    - 4.2.1. Knives used by Recreation Therapy staff, during off ground or camping activities, and are kept locked in a shadow sheath and a count is documented after each use.
    - 4.2.2. Each patient is assessed prior to attending any Recreation Therapy activities using sharps.
    - 4.2.3. RT activities which include sharp objects is used under direct supervision. Sharp objects used during activities will be counted before and after each activity and documented.
    - 4.2.4. Patients do not use knives.
  - 4.3. Occupational Therapy
    - 4.3.1. Occupational Therapy uses sharp tools such as hand tools and gardening tools. Each patient is assessed before sharps use for safety.
    - 4.3.2. Patients are assigned tasks dependent upon safety assessment.
    - 4.3.3. Any meal preparation requiring the use of knives is done by staff away from patient areas, with a sharps count documented after each use.
    - 4.3.4. Plastic knives are used for Safety and Motor skill assessments.
    - 4.3.5. Patients do not use knives.
- 5. A sharps count, with the exception of electronic disks, will be completed each shift.

---

*Implemented: 6/11*

---

## **Chapter: Patient Management**

### **Section 29: Accommodations for Patients with a Diagnosis of Mental Retardation**

1. When a patient is admitted with a diagnosis of Mental Retardation the following behavioral interventions or accommodations are implemented:
  - 1.1. The clinical team may invite the unit psychologist to offer recommendations for the treatment plan.
  - 1.2. State Hospital treatment teams negotiate discharge goals with the Local Mental Health Authority (LMHA) liaisons which are behaviorally specific so that all parties easily determine when the discharge goals are met.
  - 1.3. Behavioral interventions may also be used to shape adaptive behaviors to promote increased functional capacity. This may be done through a treatment track, behavioral support plan, or behavioral management plan.
  - 1.4. Service Management Teams (SMT) periodically review the level system and adjust it so that the level system is not a barrier to the progress of the patient with a diagnosis of mental retardation.

---

*Implemented: 4-12*

---

# Chapter:

## Section 30: SHOELACE MANAGEMENT

### Policy

***Shoelaces are restricted from the patient population. Exceptions are made based on medical and therapeutic need. When exceptions are warranted, a rigorous check-in and check-out and other patient safety procedures are followed. Patients require monitoring when exceptions are made.***

### Procedure

1. Prior to admission, patients, patients' families and local mental health authorities are informed that shoelaces are restricted from the patient population. These individuals are asked to provide the patient with alternative footwear that meets USH standards.
  - 1.1. ADT, Forensics, and Pediatrics designate staff to inform patients, families and mental health centers of USH standards for footwear.
  - 1.2. If patients do not have appropriate footwear, approved shoes are provided for them. Patients have the option of wearing their own shoes without shoelaces unless this poses a fall risk to the patient.
2. During the admission process, staff ensure that footwear with shoelaces are removed and stored until discharge or sent home at the patient's request.

### Exceptions

1. Patients determined by medical staff to have medical conditions requiring specialized footwear may do so with a doctor's order.
    - 1.1. Where feasible, shoes with Velcro closures are provided to address stability needs.
    - 1.2. When no other footwear meets the medical needs of the patient, footwear with shoelaces are allowed.
      - 1.2.1. Doctor's orders are required including rationale for the use of footwear with shoelaces.
      - 1.2.2. Patient monitoring involving 15 minute checks are documented on the USH 15 minute check sheets. A specification will be made for the individual patient on the 15 minute check sheet that checks are being performed due to the presence of shoelaces. This process cues staff performing checks to look for the presence of the shoelaces during the check.
      - 1.2.3. Should the unit SMT determine that footwear with shoelaces need to be checked in when not in use, footwear is stored in a secured area. While footwear with shoelaces are stored in a secure area, 15 minute checks for shoelaces are discontinued.
  2. Patients participating in specialized activities may utilize footwear with shoelaces provided the following conditions are met:
    - 2.1. The physical demands of the activity require shoelaces.
    - 2.2. Activities requiring shoelaces have been pre-approved by the SMT.
      - 2.2.1. If the SMT is uncertain regarding the appropriateness of approving the use of shoelaces for an activity, the SMT consults with Executive Staff.
-

- 2.3. Unit SMTs perform a review of the status of activities requiring shoelaces and staff compliance in completing the USH Shoelace Check In/Check Out Form. Results are recorded on the SMT meeting minutes.
- 2.4. The staff providing/supervising the activity will be responsible for checking shoes in and out for the activity and logging this on the USH Shoelace Check In/Check Out Form.
- 2.5. Shoe check in and inspection to determine that shoelaces are still present occurs immediately after the conclusion of the activity.
- 2.6. Once shoes are checked in, they are stored in a secured area.

---

*Implemented: 10-13*

---