

Chapter: Special Procedures (SP)

Section 1: Strategies to Manage Patient Safety

Policy

Utah State Hospital will strive to minimize the use of seclusion and/or restraint. Alternative strategies provide therapeutic options to manage patient safety.

1. When a patient is agitated or upset and exhibits a potential for causing harm to self or others, the strategies described in this policy are considered prior to the use of seclusion and/or restraint.
2. Exceptions to Special Procedures, and not regarded as restraint, include use of safety devices used to support physically incapacitated patients, such as orthopedic appliances, surgical dressings, bandages, and posey belts used to prevent patients from falling out of wheelchairs, shower chairs, or beds and conditions that require intervention by health care professional such as holding individuals to administer medication by injection, placement of nasogastric tube, catheterization, etc. (See Nursing Policy and Procedure Manual.)
 - 2.1. In the event that patient actively resists such interventions, the hold or use of the safety device is documented as a restraint.

Strategies

1. Use of de-escalation procedures collaboratively identified by the patient and staff.
2. Time-Out : ___ Time-out is brief (not to exceed 30 minutes), voluntary time in an unlocked room. The purpose is to decrease stimulation in order to allow the patient to calm down. Each time-out is recorded in the progress notes documenting rationale for the use of time-out and the length of time patient spent in time-out.
3. One-to-One (1:1): One staff to one patient ratio of monitoring. Interactive 1:1 allows for staff-patient communication. The staff member must remain with the patient, within a reasonable distance as required by the circumstances, at all times. The patient's head and hands must be in full view. A 1:1 requires a doctor's order stating the rationale for its use. A registered nurse (RN) may initiate a nursing order for a 1:1 based on a nursing assessment; the RN must call the physician for a formal order. A 1:1 requires the RN to make a note at least once a shift indicating the patient's status. A staff member assigned to do a 1:1 watch is not to leave their 1:1 patient assignment or engage in distracting activities. Orders of 1:1 are not to exceed 7 days without renewal.
 - i. Two-to-One (2:1): Two staff to one patient ratio of monitoring. The higher ratio of staff to patient monitoring is utilized when clinically necessary to manage patient safely.
4. Non-Interactive one-to-one (1:1): One staff to one patient ratio of monitoring. A non-interactive 1:1 restricts communication between the staff member and the patient. The patient is informed of the reasons for the order prior to initiation of the order. Orders for non-interactive 1:1 are not

to exceed 7 days without renewal.

5. Direct Observation Status (DOS): DOS requires a staff member to maintain continuous, in-person visual observation of one or more patients. DOS requires a doctor's order. DOS does not automatically limit the patient to an area. A patient on a DOS watch is not restricted from treatment programming. The RN writes a data note on a DOS patient at least once per shift including a statement as to why the patient is on DOS. Staff on a DOS watch are not to leave the patient until they are replaced by another assigned staff. The order remains in effect until the physician orders a discontinuation.
6. DOS on Camera: DOS on Camera means a staff person watches the patient on camera instead of in-person. This watch is done with both audio and visual modalities. A specific order for DOS on Camera is required and determined by clinical needs. If the patient being monitored on camera leaves the area, DOS in person is initiated. The order remains in effect until the physician orders a discontinuation.
7. Safety Smock: A safety smock is a specialized clothing item made from tear resistant material used for the protection and safety of a patient who is demonstrating unsafe behaviors such as active suicidal behavior, persistent self-harm behavior, misuse of clothing in a dangerous manner, or concealment of objects in clothing for the purpose of self-harm. A safety smock can be used with or without a safety blanket made of tear resistant material. A safety smock requires a doctor's order per use including the rationale for its use. Order for Safety Smock is not to exceed 24 hours without renewal. The smock and/or blanket is to provide additional safety and is combined with a level of monitoring. Patient's dignity is maintained during safety smock use. The RN writes a data note each shift that includes the rationale for use, nursing assessment, and what efforts are made to maintain patient dignity.
8. Area Restriction (AR): AR is the restriction of a patient to a given area within the patient community with limited access to the milieu or restriction of the patient's access to a certain area. AR requires a doctor's order including the rationale for the order. An area restriction order is not to exceed seven (7) days without renewal. If the patient leaves the assigned area, direct supervision is dictated by clinical needs per doctor order. Patients on AR are to be involved in treatment and programming to the extent possible. If DOS, DOS on Camera, and/or safety checks are necessary, a separate order for each in addition to the area restriction order is required. The RN writes a data note each shift that includes a statement as to why the patient is on AR.
9. Safety Checks: A safety check is ordered for observation of patient within a defined period. Safety checks should be no more than 15 minutes apart. The RN writes a data note each shift.

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Section 2: Person to Person Restriction

Policy

When it is in the best interest of maintaining safety on the unit, patients may be restricted from being in close proximity and communication with one another via a doctors order.

Procedure

1. Each patient who is to be restricted from another has a physician's order written in their chart, specifying the first name and last initial of the person from whom they are restricted.
2. The reason for the restriction is explained to each patient involved before the order is implemented.
3. Each person to person restriction order is valid for a maximum of 30 days, at which time the restriction may be re-written for cause.
4. When a person to person order is discontinued, the discontinuation is communicated to the patients involved.

Implemented: 8-13

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Section 3: Restraint and Seclusion

Policy

The Hospital uses restraint or seclusion safely and only when clinically justified and warranted by patient behavior that substantially threatens the immediate physical safety of the patient, staff, or others. A patient's rights, dignity, and well-being are protected during and after the use of seclusion or restraint.

Definitions

1. Restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint is also a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
2. Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving (seclusion is used only for the management of violent or self-destructive behavior).

Procedure

Restraint and/or Seclusion is implemented under the following procedures:

1. The Attending Psychiatrist or Designee:
 - 1.1. Conducts a clinical assessment of the patient to ascertain that the restraint and/or seclusion are necessary. If the psychiatrist is not present the unit charge nurse performs this assessment and reports it to the psychiatrist. The psychiatrist determines if the restraint/seclusion was necessary and remains necessary, if it was necessary and is no longer necessary, or if it was not necessary and is to be terminated.
 - 1.1.1. Provides an order for the seclusion or restraint, to include the requirement that restraint or seclusion is discontinued at the earliest possible time. USH does not use PRN orders for seclusion or restraint.
 - 1.1.1.1. The necessity for seclusion or restraint is documented in the Activity Description of current patient condition section of the PIRS, and is completed by the assigned RN.
 - 1.1.2. Assesses and reviews with staff the physical and psychological status of the individual, and documents this status in the Patient Incident Reporting System.

- 1.2. The attending or on call physician provides an order authorizing restraints and/or seclusion using the Physician's Orders Form (USH 44-0182), when the procedure is required. The order includes, but is not limited to:
 - 1.2.1. Date and time;
 - 1.2.1.1. Each order for seclusion or restraint is authenticated by a physician within one hour of the initiation of the seclusion or restraint.
 - 1.2.2. Start time;
 - 1.2.3. End time;
 - 1.2.3.1. The physician specifies the duration of restraint and/or seclusion within the following limits:
 - 1.2.3.1.1. Not to exceed one hour for patients on children's unit
 - 1.2.3.1.2. Not to exceed two hours for patients on adolescent units-age 9 and over
 - 1.2.3.1.3. Not to exceed four hours for patients on adult/forensic units-age 18 and over
 - 1.2.3.2. If additional time is needed, a new order must be written and documentation must be made justifying continued use.
 - 1.2.4. Requirement(s) for the RN to discontinue seclusion / restraint at the earliest possible time, (see 3.7.4.1), regardless of the expiration time of the order.
 - 1.2.5. The order for seclusion or restraint is contained on a label approved by medical records and gives detail of the type and duration of seclusion or restraint.
 - 1.3. Each patient secluded or restrained has a face to face assessment by a physician within one hour of the initiation of seclusion or restraint.
 - 1.3.1. The face to face assessment includes an evaluation of the patient's immediate situation, response to the intervention, and the patient's medical and behavioral condition.
 - 1.4. At the time of the face to face assessment, the physician:
 - 1.4.1. Works with the individual and staff to identify ways to help the individual regain control.
 - 1.4.2. Authenticates the order. This order and any subsequent orders follow the time-limits addressed in 1.2.3.1.
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- 1.4.3. Determines if the use of this physical restraint is more appropriately considered an application needed in the context of a non-violent, non-self destructive situation. (medical protective device)
 - 1.4.3.1. The psychiatrist documents the reason for this decision in the PIRS report. Medical protective device policy and procedures are followed.
 - 1.4.4. Physicians orders related to the use of seclusion or restraint are considered to be modifications to the patient's plan of care, and may include revised plans for working with the patient as well as modification of criteria for discontinuation.
 - 1.5. The Seclusion and Restraint Incident is documented in the Patient Incident Reporting System (PIRS).
 - 1.5.1. Documentation in PIRS is done by the nurse and physician involved.
 - 1.5.2. The RN states in the PIRS report the specific behaviors or symptoms of the patient which necessitated seclusion and/or restraint.
 - 1.6. The attending psychiatrist or designee is contacted by the charge nurse when an original order for seclusion or restraint is near expiration, and the individual may need to be continued in seclusion or restraint.
 - 1.6.1. The psychiatrist follows the procedures set forth in 1.1, 1.2, 1.3, 1.4, and 1.5.
 - 1.6.2. The psychiatrist conducts an in-person re-assessment of individuals maintained continuously in seclusion or restraint beyond specific time limits.
 - 1.7. To assure that the attending psychiatrist is aware of every incident, upon return from any absence from the hospital, attending psychiatrists review all incidents of restraint and seclusion which have occurred in their absence and document their review in the relevant PIRS report.
 - 1.8. The Hospital Clinical Director or designee reviews all PIRS reports and investigates unusual or possibly unwarranted patterns.
 2. Training: USH trains all staff directly involved in the use of seclusion or restraint at orientation, before participating in the use of restraint, or seclusion, and annually thereafter. This training includes
 - 2.1. Strategies to identify staff and patient behavior, events and environmental factors that may trigger circumstances that require the use of restraint or seclusion.
 - 2.2. Use of non-physical intervention skills (Safety Intervention Training).
 - 2.3. Methods for choosing the least restrictive intervention based on assessment of the patient's medical or behavioral status or condition.
 - 2.4. For those who participate in the application of seclusion or restraint, the safe application of each type used.
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- 2.5. How to recognize and respond to signs of physical distress such as asphyxia and psychological distress such as disassociation related to seclusion or restraint.
- 2.6. Identification of discontinuation criteria being met.
- 2.7. Monitoring the physical well-being of the patient who is restrained or secluded including, but not limited to, constant visualization of the patient, respiratory and circulatory status, skin integrity, vital signs.
- 2.8. Use of first-aid techniques and response to possible cardiopulmonary arrest.
- 2.9. The USH documents in staff records that restraint and seclusion training and demonstration of competence are current.
- 2.10. Psychiatrists are specifically trained in seclusion and restraint procedures and have competency verified at the time of new employee orientation and at least every other year thereafter.

Refer to Nursing Policy and Procedures for nursing documentation requirements.

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Section 4: Staff Support in Traumatizing Events

Policy

Staff support visits may be held following clinical emergencies or following other serious incidents. The intent of the support is to assist the staff to return to productive service as soon as possible.

Definitions

Clinical Emergency: Any incident which may be traumatizing to staff.

Staff Support Visit: A meeting of direct care staff involved in a traumatizing event with a member of the unit SMT or Executive Staff. It is held shortly after the event occurs and is intended to help the staff begin to cope with their stress and facilitate return to effective service.

Procedure

1. When a traumatizing event occurs at the hospital during regular business hours, the charge RN supervising the staff involved in the incident immediately contacts the UND (or another member of the SMT).
 - 1.1. After regular business hours (0800-1700) the charge RN notifies the SSRN of such an event immediately following the event.
2. During business hours, the Unit AD talks with the staff members involved in the incident before the end of the shift.
 - 2.1. The SMT or hospital administration may request the assistance of non-unit managers to assist with this process if deemed appropriate.
 - 2.2. If a visit cannot be held with the staff members involved before they leave shift, the SMT follows up with the employee(s).
3. After business hours, the SSRN contacts the Administrator On-Call (AOD) to review the incident and determine the need to initiate a support visit.
 - 3.1. The SSRN, whenever possible, assists the AOD in conducting the support session.
4. Hospital administration and unit SMT members follow up with employees regarding identified needs for support, etc.

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Section 5: Critical Incident Review

Policy

The Utah State Hospital conducts Critical Incident Reviews (CIR) to gather pertinent information, assess effectiveness of staff response, and to assist in the Quality Improvement of patient care. The goal of the CIR is also to:

1. Reinforce the importance of a Therapeutic Environment
2. Minimize incidents of violence
3. Provide learning opportunities
4. Promote positive cultural values
5. Reduce traumatic events to patients and staff
6. Conduct a non-threatening review process to promote healthy change
7. Reinforce staff competence in regards to safety intervention techniques

Definition

A critical incident is any seclusion or restraint episode, Level 3 and 4 injuries, elopements, or any incident that meets The Joint Commission definition for Sentinel Event (See USHOPP Ch: Patient Management, Section 30 Intensive Review of Clinical Incidents).

Procedure

1. Level I - Shift Review
 - 1.1. The Level I CIR is conducted by the Charge RN on the unit/shift where the critical incident occurred.
 - 1.2. The Charge RN supervising the shift is responsible to document the incident in PIRS.
 - 1.2.1. Continuation seclusion/restraint of same incident on the same patient during the same shift are consolidated into one CIR for the shift.
 - 1.3. The CIR is consistent with current TJC standards.
 - 1.3.1. The Charge RN documents pertinent information to assist unit and hospital leadership in Level II and III CIR.
 2. Level II – Service Management Team Review
 - 2.1. Level II CIR is conducted weekly by the SMT
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- 2.2. The CIR is documented in the SMT meeting minutes
 - 2.3. Multiple PIRS on one patient may be reviewed as one CIR.
 - 2.4. The SMT is not required to conduct more than two CIR per week unless it is determined by the SMT to complete additional CIR.
 - 2.5. USH establishes guidelines to assist the SMT to conduct CIR.
3. Level III Critical Incidents are reported by Nursing Administration to the Hospital Clinical Director in 'Morning Report'.
- 3.1. The Hospital Clinical Director or other Executive Staff members may request that Risk Management conduct further Life Safety or Clinical Practice Reviews regarding concerns identified of Critical Incidents.
 - 3.2. The Hospital Clinical Director or other Executive Staff members may request that the Quality Resource Office conduct Root Cause Analysis' regarding Critical Incidents.
 - 3.3. Executive Staff reviews SMT debriefing minutes and other reports regarding Critical Incidents.
 - 3.4 Recognition of Critical Incident Prevention and Positive Response.
 - 3.4.1 USH recognizes individuals whose intervention assisted patient(s) in a positive manner to de-escalate and/or prevent critical incidents from occurring resulting in a safer and more therapeutic environment.
 - 3.4.1.1. Supervisors, co-workers or other USH employees can nominate a person for recognition by completing the "Spirit of Safety Award" nomination form. Criteria for the Spirit of Safety Award is as follows:
 - 3.4.1.1.1. Excellent decision making and intervention skills which redirect a patient from acting out in a violent manner.
 - 3.4.1.1.2. Compassion and a Therapeutic approach which results in a patient being able to work through a difficult issue or situation.
 - 3.4.1.1.3. Effective De-escalation Skills which help to avoid violence and prevent a possible injury, seclusion and/or restraint from occurring.
 - 3.4.1.1.4. Professionalism and competence in regards to helping a patient avoid being re-traumatized during a critical incident.
 - 3.4.1.2 Nominations are sent to the Quality Resource Office or Executive Staff Office.
 - 3.4.1.3 Monthly reviews of nominations are conducted in Executive Staff meeting or designated body and employees receive recognition as determined during the review.

***CRITICAL INCIDENT REVIEW
GUIDELINES FOR SERVICE MANAGEMENT TEAM (SMT)***

1. Staff and patient input is vital to the learning process and is considered by the SMT.
 2. CIR conducted with staff and/or patient input is sometimes conducted using a “Chain Analysis” approach to assist patients and staff in the learning process when clinically indicated to do so.
 3. Critical Incident Reviews may consider the following:
 - 3.1. Events leading up to / contributing to the incident
 - 3.2. Policies (followed or not followed)
 - 3.3. Training needs for staff
 - 3.4. Treatment revisions needed for patients
 - 3.5. Behavior Support/management plan needs
 - 3.6. Preventative mechanisms/concepts to reinforce
 - 3.7. Use or non use of De-escalation techniques
 - 3.8. Perspective of the patient
 - 3.9. Were patients or staff traumatized by the incident
 - 3.10. What went well or not so well overall?
 - 3.11. Systems issues identified contributing to the incident (such as unit temperature, lack of communication, etc.)
 4. The SMT considers a Plan of Action to address identified strengths/weaknesses (i.e. kudos to be given, training, revision to ICTP, etc.)
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Section 6: Aversive Treatment

Policy

Utah State Hospital prohibits behavior modification procedures that use aversive conditioning.

Procedure

1. Utah State Hospital employees are trained in patient rights which prohibit aversive behavior modification treatment.
 - 1.1. Aversive treatment includes, but is not limited to, the following:
 - 1.1.1. Any act or practice that may result in the denial of a nutritionally adequate diet.
 - 1.1.2. Corporal punishment.
 - 1.1.3. Fear-eliciting acts.
 - 1.1.3.1. Fear-eliciting acts are those used to intentionally elicit a fear-type response.
 - 1.1.4. Any other act, procedure, or treatment, which is deemed aversive by the Hospital Clinical Director or Hospital Ethics Committee.
2. The unit psychiatrist approves specific behavior management procedures which are documented in the patient's individual treatment plan.
3. Treatment teams may refer any question as to whether treatment is aversive to the Hospital Ethics Committee.

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Chapter: Special Procedures (SP)

Section 7: Identification of Suicide Risk and Safety Response

Policy

1. The need for suicide precautions for patients at Utah State Hospital is identified and appropriate safety precautions are implemented.

Procedure

1. All USH clinical staff are sensitive to the possible risk of patients to suicide and take appropriate steps to assess safety.
 - 1.1. At the time of admission, the admitting psychiatrist assesses and documents risk in the Psychiatric Initial Assessment (IA) using the Psychiatrist Suicide Risk Assessment Form. (attached)
 - 1.2. Patients are periodically reassessed by the assigned psychiatrist for suicide risk when clinically indicated.
 - 1.3. RN staff report to the attending psychiatrist or designee promptly whenever the patient exhibits potential suicide warning signs.
 2. Safety Responses
 - 2.1. In an emergency, a registered nurse may initiate suicide precautions. The emergency utilization of suicide precautions may also include moving a patient to a more restrictive precaution based on the registered nurse's judgment. The registered nurse obtains a psychiatrist's order for the suicide precautions as soon as possible. A less restrictive intervention requires a physician's order.
 - 2.1. A clinical assessment of the patient and the order for the suicide precautions is documented in the patient record as needed. A registered nurse may initiate suicide precautions when less restrictive intervention techniques are inadequate. The nurse obtains a physician's order for a more restrictive intervention and documents the need for the intervention in a progress note.
 - 2.2. Nursing Service records the use of suicide precautions in the manner described for each precaution.
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3. One-to-one Suicide Precaution:
 - 3.1. Criteria: Those patients with suicidal ideation or severe self injury behavior who after assessment by the treatment team, present clinical symptoms that suggest a clear intent to follow through with self injury or suicide.
 - 3.2. Nursing Care: One-to-one continuous nursing staff observation is always within line of sight and at arms length unless otherwise specified by a physician. The patient's head and hands must be in full view. Nursing assessment and documentation are completed on every shift.
 - 3.2.1. If the physician orders the one-to-one to be carried out in a designated area, staff thoroughly searches the designated area and removes dangerous items.
 - 3.2.2. Continuous observation is required when the patient is awake, asleep, in the bathroom, taking a shower, or any other place on the unit.
 - 3.2.3. Potentially harmful items are removed from the patient's access e.g. belts, drawstrings, scarves, underwear, shoelaces, cords, pens, or other items considered to be a danger to the individual patient.
 4. Direct Observation Status Suicide Precaution:
 - 4.1. Criteria: Those patients with suicidal ideation and who, after assessment by the treatment team, present clinical symptoms that indicate potential for harm without clear intent.
 - 4.2. Nursing Care: Continuous nursing staff observation is required as outlined in USHOPP policy (USH: OPP Special Treatment Procedures Chapter Section 1). A designated area may be identified for safety reasons.
 - 4.3. If the physician orders DOS with AR to be carried out in a designated area and additional order for AR is obtained, staff is aware of potentially dangerous items in the environment and respond accordingly.
 - 4.4. Potentially harmful items are removed from the patient's access e.g. belts, drawstrings, scarves, underwear, shoelaces, cords, pens, or other items considered to be a danger to the individual patient.
 - 4.5. Continuous observation occurs at all times, including when the patient is awake, asleep, in the bathroom, taking a shower, or any other place on the unit.
 - 4.6. DOS on camera is ordered if clinical judgment notes this level of care is adequate to maintain safety.
 5. Fifteen minute check Suicide Precaution:
 - 5.1. Criteria: Those patients who have suicidal ideations and after assessment by the treatment team, are assessed to be safely managed by fifteen-minute checks.
 - 5.2. Nursing Care: Observe the patient a minimum of every fifteen minutes on a random schedule i.e. 5 minutes after the last check, 10 minutes later, never more than 15 minutes between checks 24 hours a day; frequent verbal interactions unless otherwise
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indicated during waking hours. Nursing assessment and documentation are completed every shift by a registered nurse. A physician may order restriction to the unit.

- 5.3. Potentially harmful items are removed from the patient's access e.g. belts, drawstrings, scarves, underwear, shoelaces, cords, pens, or other items considered to be a danger to the individual patient.
- 5.4. Fifteen-minute checks occur at all times, including when the patient is awake, asleep, in the bathroom, taking a shower, or any other place on the unit.

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Psychiatrist Suicide Risk Assessment (Template #160, and MDSRA progress note in echart)

1. Presence of suicidal intent, or plans. Describe the patient's intent to act on these thoughts and the extent of the plan:
 2. Lethality of the plan. (The most lethal means in the hospital are by hanging and suffocation. When the patient is off campus, consider additional means such as firearms, poisons, drugs, and medications.)
 3. Additional mental status risk elements: (please comment on those that apply)
 - Command hallucinations
 - Hopelessness
 - Severe anxiety
 - Flight to health
 - Perceptions of loss or lack of social support
 - Impulsivity
 - Affective lability
 - Agitation
 4. Presence of substance misuse, dependence, or withdrawal:
 5. Patient history of suicide attempts and their seriousness:
 6. Family history of suicide:
 7. Recent exposure to suicide:
 8. Protective factors:
 - Positive relationships
 - Good coping skills
 - Spirituality or preventive religious beliefs
 9. Psychiatrist's clinical judgment of suicide risk:
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Section 8: Medicating Adult Patients

Policy

The hospital respects the patient's right to participate in decisions about his or her care, treatment and services. The hospital honors the patient's right to give or withhold informed consent. Adult patients (18 years and older) residing at the Utah State Hospital who refuse to consent or are unable to consent to recommended treatment are entitled to due process proceedings prior to being administered involuntary medication.

Individuals to Whom This Policy Applies

This policy applies to adult (18 years and older) patients committed to a local mental health authority pursuant to a court order of Civil Commitment (UCA 62A-12-631), patients committed as Not Competent to Proceed (UCA 77-15-6), patients committed for purposes of Evaluation in connection with a criminal proceeding (Title 77), patients committed as Guilty and Mentally Ill (Title 77, Chapter 16a), patients committed as Not Guilty by Reason of Insanity (UCA 77-16a-302) and Voluntary patients (62A-12-625).

Policy

A. PATIENTS ARRIVING AT USH ALREADY UNDER MEDICATION TREATMENT

1. When a patient is admitted to USH and is already receiving medication treatment, the admitting physician continues such treatment if the following conditions are met:
 - 1.1. The patient suffers from a mental illness.
 - 1.2. Without medication treatment the patient would manifest severe deterioration in routine functioning evidenced by repeated and/or escalating loss of cognitive or volitional control over his/her actions and, without the continuation of such treatment, the patient will not be receiving such as is essential for his/her health or safety; or
 - 1.3. Without continuing the medication treatment, the patient would pose a likelihood of serious harm to the patient, others, or property.
2. The basis for the treating physician's decision is supported by adequate documentation.
3. Within a reasonable time after admission and not exceeding 14 days, the attending physician obtains informed consent or initiates Medication Hearing proceedings.

B. PROCEDURES FOR CONSENT

1. In order to assess the patient's ability to give informed consent, the physician provides information to the patient, assesses the patient's understanding of that information, and the patient's ability to participate in the recommended treatment. The following four questions should be used to determine patient's ability to give informed consent:
 - 1.1 Does the patient acknowledge that he/she has a mental illness which requires treatment?
 - 1.2 Has the prescriber discussed benefits and risks of the proposed medication with the patient, and does the patient acknowledge that he/she may have side effects?
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- 1.3 Has the prescriber reviewed with the patient possible treatment alternatives, and does the patient acknowledge that there may be alternatives, such as no treatment, other medication(s), and non-medication treatments.
- 1.4 Is the patient able to give a description of how he or she reached a conclusion with respect to whether or not to consent to psychoactive medication treatment?
2. This determination is documented in the Consent to Medication Treatment form, which also includes the following information:
 - 2.1. The patient's diagnosis;
 - 2.2. The proposed medication treatment, the method of administration;
 - 2.3. The desired benefits;
 - 2.4. The possible side-effects, if any, of the recommended treatment;
 - 2.5. The likelihood of success of the proposed treatment;
 - 2.6. The possible consequences to the patient if the recommended treatment is not administered, and
 - 2.7. The right to give or withhold consent for the proposed treatment.
 - 2.7.1. When informing a patient of his or her right to withhold consent, the patient must also be informed of the hospital's right to initiate a medication hearing and have a committee determine whether the proposed treatment is necessary.
3. The Medication Treatment form is completed and filed in the medical record. A copy is provided to the Legal Services Office.
 - 3.1. A patient may revoke his/her consent to medication treatment at any time by informing the staff.
 - 3.2. If the patient is able to give consent but refuses to do so, or is unable to give consent the staff may initiate Medication Hearing procedures in accordance with Part "D" of this policy.

C. ADMINISTRATION OF MEDICATION UNDER EXIGENT CIRCUMSTANCES

1. A patient may be treated without consent at any time a hospital psychiatrist determines that the condition of the patient constitutes an emergency and that injury is likely to occur to the patient or others if the patient is not immediately treated.
 - 1.1. Orders for medication treatment under exigent circumstances are time limited and a medication hearing must be requested within 48 hours, excluding weekends and legal holidays, unless the patient gives informed consent for the recommended medication(s).
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D. MEDICATION HEARING PROCEEDING

(i) INITIATING A MEDICATION HEARING

If a patient is able to give informed consent to medication treatment, but refuses to do so, or if the patient is unable to give consent, the treating physician may request a Medication Hearing be held to determine if medication treatment is necessary and authorized.

1. The treating physician requests a medication hearing by completing the Notice to Convene a Medication Hearing form and a Request to Convene a Medication Hearing form and submitted to the Utah State Hospital Legal Services Office. Except for medication that is administered pursuant to sections A, B, or C of this policy, no involuntary psychiatric medication treatment occurs prior to the patient being afforded a hearing with a decision on that hearing in accordance with the procedures outlined in this section. The patient receives a copy of the notice at least 24 hours prior to the scheduled hearing.
2. The USH Legal Services Manager/designee facilitates the convening of the hearing by contacting committee members. The hearing is held within a reasonable time after notice has been given to the patient. If the patient refuses to attend the hearing or otherwise waives his/her right to attend the hearing, the hearing is held in the absence of the patient.
 - 2.1. The patient's absence from the hearing does not alter the decision reached with respect to whether or not to proceed with the proposed course of treatment.

(ii) THE MEDICATION HEARING COMMITTEE

1. Medication hearings are conducted before a three-member committee consisting of at least one psychiatrist and two members from other hospital clinical disciplines. At the time of the hearing, the committee members are not involved in the patient's treatment or diagnosis. Committee members who have treated or diagnosed the patient in the past are allowed to participate.
2. The role of the Committee is to render a decision regarding medication treatment based on review of the patient's medical records, information presented at the hearing, and documentation provided.
 - 2.1. The rules of evidence are not applicable.

(iii) THE MEDICATION HEARING PROCEDURE

1. Medication hearings are conducted on the treatment units and are conducted in a non-adversarial manner.
 2. The patient has the following rights at the hearing: (1) to attend the hearing; (2) to present evidence on his/her behalf; (3) to call witnesses; and (4) to question witnesses called by committee members. Because the issue before the committee is purely medical in nature, neither the treating physician nor the patient has the right to legal representation at the hearing. The patient is assisted in their representation by a patient advocate.
 - 2.1. If the patient has a previously appointed legal guardian, the legal guardian is notified of the hearing and is permitted to attend the hearing.
 3. One committee member chairs the committee and conducts the hearing. The chair begins each hearing by informing the patient and others present of the purpose of the hearing and the manner in which the hearing will proceed.
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4. The treating physician attends the hearing and presents the physician's findings and recommendations with respect to the patient's treatment. The committee members and the patient or the patient's lay advisor may question the treating physician.
5. Other staff members may present information. The committee members and the patient or the patient's lay advisor may question staff members who present information.
6. The patient has the right to present information, which may include witnesses. The committee members have the right to question any witnesses called by the patient.
7. If the patient or others become disruptive during the hearing, the chair may warn that person that he/she will be removed from the hearing unless the disruptive behavior is discontinued. If the disruptive behavior continues, the chair may have that person removed. In the event that the patient or others are removed, the hearing continues in that person's absence.
8. Following the presentation of information, the patient, the treating psychiatrist, and others leave the room while the committee deliberates. Upon reaching a decision, the patient and others are permitted to return to the room to hear the committee's decision.

(iv) REQUIRED CRITERIA FOR MEDICATING AN ADULT PATIENT

1. The committee may order medication treatment of an adult patient if, after consideration of the record and deliberation, the committee's psychiatrist and at least one other member find, by majority vote, the following conditions exist:
 - 1.1. The patient suffers from a mental illness as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association (DSM); and
 - 1.2. The patient is, or will be, gravely disabled and in need of medication treatment or continuing medication treatment for the reason that he or she suffers from a mental disorder such that he or she (a) is in or will be in danger of serious physical harm resulting from a failure to provide for his or her essential needs of health or safety, or (b) manifests, or will manifest severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety; and/or

Without medication treatment or continuing medication treatment, he or she poses or will pose a likelihood of serious harm to himself/herself, others, or property. "Likelihood of serious harm" means either (a) a substantial risk that physical harm will occur to the individual as the result of refusal of essential medication or (b) a substantial risk that physical harm will be inflicted by an individual upon his/her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on him/herself, or (c) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which has placed another person or persons in reasonable fear of sustaining such harm, or (d) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; and
 - 1.3. The patient lacks the ability to engage in a decision-making process regarding the acceptance of medical treatment, as demonstrated by evidence of inability to weigh the possible costs and benefits of the treatment; and
 - 1.4. The proposed medication treatment is in the medical best interest of the patient, taking into account the possible side effects as well as the potential benefits of the treatment; and
 - 1.5. The proposed medication treatment is in accordance with prevailing standards of accepted medical practice.

2. Psychiatric medication may also be ordered and administered to a patient committed under Utah Code Section 77-15-6 for treatment to restore competency, if authorized by the order of a court of appropriate jurisdiction subsequent to proceedings co-defined by Section 77-15-6.5, *Petition for involuntary medication of an incompetent defendant*.
 - 2.1. When a court order to medicate is obtained, no USH medication hearing procedures are required, nor is there a right to appeal the decision to the Hospital Clinical Director.
3. The basis for the decision is supported by adequate documentation. The psychiatrist on the committee must be in majority in any decision to medicate a patient.
 - 3.1. In the event that two psychiatrists sit on the committee and disagree whether to medicate a patient, the matter is referred to the Hospital Clinical Director for a decision.
4. If medication treatment is authorized by the committee, involuntary lab work to monitor the safety and effectiveness of the medication is also authorized.
5. The committee members complete and sign a Medication Hearing form at the end of the hearing.
6. Minutes of the hearing are kept and a copy is provided to the patient upon request.

(v) RIGHT TO APPEAL

1. The patient has the right to appeal the committee's decision to the Hospital Clinical Director/designee by completing an Appeal of Medication Hearing form within 24 hours (excluding Saturdays, Sundays, and Legal Holidays) of being informed of the decision. The Hospital Patient Advocate or treatment coordinator may assist the patient in completing the form.
 - 1.1. Reason for automatic appeal include patient is absent from hearing or committee members and/or patient advocate indicate the patient did not comprehend the process.
2. The Hospital Clinical Director/designee reviews the record available and renders a decision within 24 hours of receipt of the appeal, excluding Saturdays, Sundays, and holidays. The Hospital Clinical Director/designee completes and signs a Decision of Appeal of Medication Hearing form which is provided to the patient.
3. If no appeal is requested by the patient or conditions are not met for an automatic appeal, medication treatment ordered by the Committee may be commenced within 24 hours of the Committee's decision. If appealed, medication treatment may be commenced as soon as the Hospital Clinical Director/designee renders his/her decision if he/she agrees with the committee's decision. A treatment unit employee familiar with the patient informs the patient of the appeal decision and documents the presentation of the decision on the appropriate form.

(vi) CONTINUED MEDICATION TREATMENT

1. Medication treatment ordered pursuant to the foregoing procedures may continue with periodic review after the initial hearing.
 2. The Hospital Clinical Director/designee reviews the case within 180 days of the initial hearing.
 3. The Hospital Clinical Director/designee reviews the record and may examine the patient if further clinical information is necessary before rendering a decision whether to continue medication treatment.
 4. The Hospital Clinical Director/designee may order continued medication treatment if he/she finds the following conditions exist:
 - 4.1. Absent continued medication treatment, the patient will experience deterioration making him/her gravely disabled such that he/she (a) will be in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety, or
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(b) will manifest severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety; and/or

4.2. Absent continued medication treatment, he or she will pose a likelihood of serious harm to himself/herself, others, or their property. "Likelihood of serious harm" means either (a) a substantial risk that physical harm will occur to the individual as the result of refusal of essential medication or (b) a substantial risk that physical harm will be inflicted by an individual upon his/her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's own self, or (c) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which has placed another person or persons in reasonable fear of sustaining such harm, or (d) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; and

5. If the Hospital Clinical Director/designee approved continued medication treatment, he/she completes a Review of Continued Medication form, which is maintained in the Legal Services office.

E. PROCESS FOR ADDITION OF MEDICATIONS NOT REQUESTED IN THE ORIGINAL MEDICATION HEARING

1. The physician may prescribe medications in addition to those requested in the original hearing if in the professional judgment of the physician the medication being recommended is medically necessary and the reasonable standard of care and within best practices for the condition being treated. This information will be documented in the "Proposed Addition to Medication Regimen" on the "Medication Treatment Form." This form will be maintained in the patients chart with a copy provided to the Legal Services Department.

1.1 The attending psychiatrist will request a review from the Clinical Director if the additional medication is a drug from a different class or for augmentation purposes.

1.2 A new medication hearing should be requested for substantial changes (purpose of medication is substantially different) to the medication regimen.

Implemented: 12-92

Revised: 5-92

Revised: 3-25-93

Revised: 5-93

Revised: 7-94

Implemented: 1-95

Reviewed: 9-95

Reviewed: 10-96

Reviewed: 7-98

Reviewed: 12-00

Revised: 11-01

Revised: 10-04

Revised: 12-06

Revised: 2-08

Revised: 8-14

Revised: 11-14

Chapter: Special Procedures (SP)

Section 9: Restrictions and Limitations of Patient Rights

Policy

Utah State Hospital upholds and protects the civil rights of patients in its care. Restrictions and/or limitations are implemented for "good cause" reasons and are reviewed at least weekly for necessity and effectiveness.

Definitions

"Good cause" means (1) posing a danger to self or others; (2) behavior that would seriously infringe on the rights of others; (3) posing serious risk of damage to the facility; and/or (4) behavior that is deemed therapeutically contraindicated.

Procedure

1. When any right of a patient is limited or denied, the nature, extent, and reason for that limitation is documented in the medical record and explained to the patient. (UCA 62A-15-641(2))
 2. Restriction may be initiated by the clinical staff if it is determined that such restrictions are necessary for the safety or well-being of self or others and for "good cause."
 - 2.1 Restrictions may include, but are not limited to: visitors, mail, and telephone calls.
 3. Restrictions are implemented with a physician's order.
 - 3.1 Entries are made in the progress notes and/or physician orders sections of the medical record.
 4. All such restrictions on visitors, mail, telephone calls, and other forms of communication are fully explained and determined with the participation of the patient/family, upon request.
 - 4.1 The term "patient/family" takes into consideration the patient's right to exercise personal privacy by withholding consent for family or significant other's participation.
 5. Restrictions are time-limited to seven days and are evaluated every seven days by the treating physician/designee for necessity.
 - 5.1 Rationale for restrictions is documented in the progress notes or order form corresponding to the physicians order.
 6. In no case may a patient be denied a visit with or phone call to the legal counsel or clergy of the patient's choice. (UCA 62A-15-641(2))
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- 6.1 If a visit is delayed, the reason justifying the delay must be documented.
- 6.2 Questions about designation of clergy are referred to the Chaplain or administrator on duty.

Implemented: 9-95

Revised: 1-96

Revised: 11-98

Reviewed: 12-00

Revised: 9-04

Revised: 10-07

Revised: 1-10

Reviewed: 12-12

Revised: 8-13

Chapter: Special Procedures (SP)

Section 10: Safety Intervention Techniques Training

Policy

USH provides Safety Intervention Training to employees to enable staff to manage violent behavior or behavior that presents imminent danger.

Procedure

1. All clinical and direct patient care staff members are trained in Safety Intervention Techniques (SIT).
 - 1.1 Employees are required to attend mandatory follow-up training annually.
 2. All USH staff are required to attend a verbal techniques training as part of mandatory training.
 3. SIT training emphasizes the theories of verbal intervention and escape techniques as outlined in the SIT manual.
 - 3.1 Physical intervention is used **only** as a last resort and only by personnel trained in hospital approved techniques.
 4. Trained staff members only use techniques explained in the SIT manual.
 5. Approved wrist lock holds are used **only** by security staff. (Exceptions when a staff can use a wrist lock are outlined in SIT which would include hair pulls, life saving measures, and when a patient has a weapon).
 - 5.1 This technique is not used on the Geriatric unit.
 - 5.2 This technique may be used only on larger patients on the children's and adolescent units.
 6. When Security personnel arrive on the scene, they guide the staff through the process of implementing safety technique procedures based on their training and expertise in handling security issues.
 7. Physical restraint is initiated only when the RN in charge determines that less aggressive interventions are inadequate for the safety of the patient, staff, and/or others.
 8. The RN is accountable for all situations that occur on the unit and is responsible to make or delegate decisions regarding the use of safety intervention techniques.
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9. Personnel involved in an incident which requires safety intervention techniques document the incident on the Patient Incident Reporting System (PIRS), Progress Notes, and service area reports required by their respective service administrators.

9.1 Such documentation includes a description of the incident and the types of intervention used and which personnel used the techniques.

Initiated: 6-13-95

Revised: 8-96

Revised: 11-98

Revised: 6-03

Revised: 2-04

Revised: 2-10

Revised: 1-13

Chapter: Special Procedures (SP)

Section 11: Judiciously Suspending a Rule

Policy

Staff uses their judgment for the purpose of preventing and minimizing violence by the charge nurse judiciously suspending a rule when doing so would lessen the possibility of immediate violence. This does not apply to elements of the conduct disorder track for pediatric patients, Behavioral Management Plan or Behavioral Support Plan.

Definitions

Rule: A practice or expectation for conduct, written or unwritten.

Procedure

1. Staff are encouraged to take all reasonable steps to prevent or minimize an imminent violent episode.
 - 1.1. When a patient is becoming increasingly agitated over a rule or community expectation, staff are encouraged to temporarily suspend that rule or control procedure, if the suspension will not obviously create an immediately more dangerous situation. (Examples of rules that may be subject to suspension include the manner and times that specific activities take place, and who is involved in these activities).
 - 1.2. When a conflict occurs the staff actively pursues options which will allow the patient to save face without creating an immediate danger to any person.
2. When staff see the need to suspend a rule, they make the recommendation to the charge nurse. The charge nurse may suspend the rule, and communicates this to the staff involved. The nurse then documents the suspension for the treatment team to review.
3. At the next regular treatment team meeting the rule suspension is reviewed and assignments are made to process the suspension with the patient and other individuals affected.
4. The SMT reviews significant rule suspensions as an agenda item in their weekly SMT meetings and documents the outcomes, decisions made, and further plans / recommendations in their SMT minutes.
 - 4.1. A copy of the minutes is forwarded to the assistant clinical director, and Director of Forensic and Safety Services.

*Initiated: 3-04
Reviewed: 4-07
Reviewed: 11-09
Revised: 4-10
Revised: 10-12*

Chapter: Special Procedures (SP)

Section 12: Helping Patients Manage Violent Feelings - Use of De-escalation Information

Policy

Patients are assisted to attain control when becoming upset by staff offering calming techniques which are pre-identified by the patients or significant others. Staff also assists patients to avoid stressful experiences which may trigger aggressive responses towards self and/or others.

Procedure

1. At the time of admission and periodically thereafter, patients and/or their significant others are asked for their preference as to how they would like staff to assist them in achieving control when they are becoming upset.
 - 1.1 Charge nurses assign staff at the time of admission and as clinically indicated to meet with each patient and obtain information called for on the de-escalation form.
 - 1.1.1 These assignments are made and completed prior to the treatment planning meeting.
 - 1.1.2 Individuals that have been identified as becoming aggressive towards self or others have a monthly review of their preferences to deescalate.
 - 1.2 The RN on duty at the time of the clinical brings this information into ICTP meeting for incorporation into the treatment plan.
 2. UNDs maintain a method on their units of keeping de-escalation information readily available to direct care staff so that it may be immediately accessed when a patient is becoming stressed.
 - 2.1 Examples of effective methods are: keeping copies of these completed forms in a centrally located binder, or handing out a sheet of suggested methods for individual patients at the start of each shift.
 3. As a patient is becoming upset, direct care staff reviews these preference and employs them to assist the patient to be in control of his/her behaviors.
 4. As knowledge is increased about what works with each patient, this is recorded and shared.
 - 4.1 At the time of the unit incident reviews and ICTP reviews, the UND or designee adds information to de-escalation forms, indicating what methods have been successful and what triggers to avoid.
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*Initiated: 3-04
Reviewed: 4-07
Reviewed: 10-09
Reviewed: 10-12*

Chapter: Special Procedures

Section 13: Behavioral Management

Policy

Behavior management and treatment interventions are therapeutic interventions that foster adaptive behaviors. They are not used exclusively for behavior control. Consideration of both appropriateness and minimizing restrictiveness of interventions is essential.

Procedure

1. Prior to a physician's order for a Behavioral Management Plan (BMP) or for a Behavioral Support Plan (BSP) the treatment team may hold a problem-solving session involving a psychologist.
 - 1.1. The treatment team reviews the de-escalation plan to ensure that it has been implemented prior to consideration of more extensive behavioral management or treatment interventions.
2. Behavioral management and treatment interventions for Utah State Hospital are employed in the following hierarchical order: 1) simple contingency management, 2) Behavioral Management Plan (BMP), and 3) Behavioral Support Plan (BSP).
 - 2.1. Simple Contingency Management consists of; Implementation of a simple contingency (e.g. specific behavior leads to specific response).
 - 2.1.1. Simple contingency management should focus on reinforcement of adaptive behaviors and adhere to section 3 of this policy.
 - 2.2. Behavioral Management Plan:
 - 2.2.1. BMPs may be preemptive plans, or a plan targeting historical behaviors. These plans are based on behavioral indicators that suggest the possibility of future maladaptive behaviors.
 - 2.2.2. BMPs may be implemented immediately to stop behaviors that may lead to injury. There must be theoretical and empirical rationale for why a BMP is needed (e.g., extinction or stimulus control). This type of BMP is time-limited and self terminating.
 - 2.2.2.1. If a BMP is being implemented in order to stop behaviors that may lead to injury, there is a statement in a Psychology progress note (PSDATA) that a BSP is being developed.
 - 2.2.2.2. If the use of Seclusion and/or Restraint is implemented, a clear rationale for their use must be identified (e.g., behavior intensity, behavior chronicity, behavior lethality). Procedures using restraining devices are used in a manner consistent with the patient's plan of care, policies and procedures, and state and federal laws.

- 2.2.2.3. If the use of Seclusion and/or Restraint is implemented, it is only used when less restrictive interventions are considered inadequate and must be discontinued at the earliest possible time.
- 2.2.2.4. A BMP that includes seclusion and/or restraint requires the approval of the hospital clinical director or designee.
- 2.2.2.5. The use of mechanical restraint and seclusion as treatment interventions is prohibited except for patients who exhibit intractable behavior that is severely self injurious or injurious to others, who have not responded to traditional interventions, and who are unable to contract with staff for safety (that is, understand the concept of, and act on, criteria for the discontinuation of restraint or seclusion). In all cases, seclusion or restraint must be discontinued when the patient's behavior is determined to not meet criteria for such intervention. A low threshold for return to seclusion or restraint based upon the individual patient's history may be implemented to avoid physical injury.

2.3. Behavioral Support Plan:

- 2.3.1. A BSP is implemented to reduce targeted maladaptive behaviors while simultaneously increasing the use of empirically supported adaptive replacement behaviors.
 - 2.3.2. A BSP contains the following elements;
 - 2.3.2.1. Behavioral and cultural background
 - 2.3.2.1.1. Brief description of the behavior(s), the possible motivations for the behavior(s), brief history of the behavior (when did it start, how frequently does it occur, in what settings does it occur, around what other people does it occur), as well as any specific cultural values, traditions or beliefs related to the behavior.
 - 2.3.2.2. Functional analysis addresses;
 - 2.3.2.2.1. Maladaptive behaviors
 - 2.3.2.2.2. Function(s) of maladaptive target behavior(s)
 - 2.3.2.2.3. Adaptive replacement behaviors
 - 2.3.2.2.4. Strengths
 - 2.3.2.3. Baseline behavior frequency
 - 2.3.2.4. Short-term objectives
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- 2.3.2.5. Discharge goals
 - 2.3.2.6. Reinforcers
 - 2.3.2.6.1. Immediate reinforcers
 - 2.3.2.6.2. Short-term reinforcers
 - 2.3.2.6.3. Long-term reinforcers
 - 2.3.2.7. Corrective component
 - 2.3.2.8. Positive/proactive strength- based component
 - 2.3.2.9. Environmental modifications
 - 2.3.2.10. Supplementary therapies
 - 2.3.2.11. Program training and fidelity
 - 2.3.2.12. Data collection:
- 2.3.3. When a BSP is ordered the disciplines involved in the patient's treatment develop procedures to implement the behavioral support plan based on the psychiatrist's order.
3. Behavioral interventions that could induce physical harm or are conducive to psychological risk are prohibited.
4. Precluded mechanisms in behavioral interventions include:
- 4.1. Use of intimidation force or threat
 - 4.2. The denial of basic patient needs (e.g. access to food or water)
 - 4.3. The denial of shelter
 - 4.4. The denial of essential, safe clothing
 - 4.5. Use of corporal punishment
 - 4.6. The use of fear-eliciting techniques
 - 4.7. Use of mechanical restraint and seclusion (absent the criteria noted under section 2.2.2.5 above)
 - 4.8. Any procedure that allows a patient to implement behavior management and treatment techniques on other patients
5. Behavioral interventions are ordered for patients who have a repetitive pattern of aggressive (verbally and/or physically), sexual, self-injurious or treatment interfering behaviors.
- 5.1. Repetitive is characterized by;
 - 5.1.1. Aggressive or other inappropriate behaviors being articulated in the patient's history, or
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- 5.1.2. The usage of PRN medications for behavioral management, or
 - 5.1.3. Youth assessed as high risk, or
 - 5.1.4. Frequent utilization of seclusion and restraint, or
 - 5.1.5. Higher than usual utilization of staff time requiring staff to limit staff/patient interaction, or
 - 5.1.6. Non-progressing patient, or
 - 5.1.7. Cognitive deficits requiring developmentally appropriate adaptations of treatment.
6. Behavioral management and treatment interventions are integrated into the patient's Individualized Comprehensive Treatment Plan (ICTP) and include the following components:
- 6.1. A specific symptom addressing each targeted behavior (e.g. verbal aggression, physical aggression).
 - 6.2. A specific objective with a measurable behavioral baseline that clearly addresses the targeted behavior.
 - 6.3. A specific modality for each targeted behavior.
 - 6.4. 30 day reviews are done by the staff person who wrote the original behavioral plan, or their designee from the same discipline. They detail progress of the specific intervention in comparison to the previous month as well as the baseline. Changes to the identification of symptoms, objectives, and specifics of the treatment modalities are made as indicated, and as often as necessary.
7. Appropriate behavioral accommodations are provided to patients diagnosed with Mental Retardation:

Implemented: 5-12

Revised: 8-13

Chapter: Special Procedures (SP)

Section 14: Alternative Medical Treatment

Policy

Prescribers at Utah State Hospital use evidenced based medical practices in treatment as opposed to alternative medical treatments that are not empirically based, such as nutraceuticals, dietary supplements, or other compounds not regulated by the FDA.

Rationale

Staff of the Utah State Hospital treat the most severely mentally ill persons in the State and have a responsibility to use public resources in the most effective manner.

Procedure

1. Use of FDA approved medications, on and off label, is a cornerstone of treatment for virtually all severe mood disorders and psychotic conditions.
 - 1.1. Use of psychotropic medication is incorporated by attending psychiatrists into the treatment plans of patients.
2. When alternative medical treatments such as the use of nutraceuticals or other unregulated treatments are requested which are not empirically supported by information published in peer-reviewed professional journals commonly recognized by prescribers and pharmacists at USH, the treatment team informs the requesting person(s) that use of such agents is contrary to the policy and procedures of the hospital.

Chapter: Special Procedures (SP)

Section 15: Electroconvulsive Therapy

POLICY

Utah State Hospital offers its patients evidence based practices to maximize treatment benefits. It is the policy of USH to recommend ECT when clinically indicated and only with the consent of patient/ guardian. In pediatric population, the recommendation of ECT is accompanied by a due process hearing as indicated by Utah Code 62A-15-704.

RATIONALE

ECT is generally used to treat several principal diagnostic indications including Major Depression, Mania, and Schizophrenia and may be used for other diagnostic indications including psychiatric syndromes associated with medical conditions and medical disorders.

ECT may be considered as a first-line treatment for persons exhibiting syndromes such as: severe major depression, acute mania, mood disorders with psychotic features, and catatonia and is based on the nature and the severity of acute symptoms in conjunction with an evaluation of risks and benefits. ECT may be the initial treatment of choice when a rapid or a higher probability of response is necessary. ECT may also be considered as a primary treatment when there is a history of good response to ECT treatment and/or poor response to alternate treatments during prior episodes.

ECT is most often used as a secondary treatment when a patient has shown insufficient improvement with prescribed treatment(s), including medications. In addition to lack of substantial clinical response, other reasons to use ECT include intolerance to side effects of medication, deterioration in condition, stupor, extreme agitation, high suicide or homicide risk.

Special population: Adolescents should receive ECT only when clinical criteria involving diagnosis, severity and lack of treatment response is met. Indicated diagnoses include severe depression with psychosis, Schizophrenia, Catatonia, and NMS (neuroleptic malignant syndrome). Intensity of symptoms must be severe, persistent and life threatening, including refusal to eat or drink, uncontrollable mania or florid psychosis. .

PROCEDURE

1. ECT for USH patients is offered off site with qualified providers.
2. The attending psychiatrist collaborates with ECT providers at these facilities to prepare patient for the procedure. Preparation involves:
 - 2.1 Medication changes to improve likelihood of adequate seizure.
 - 2.2 Making arrangements for transportation
 - 2.3 After care and monitoring of patients
3. For pediatric patients, regardless of consent, the due process involves a hearing conducted by 2 NDFF/DE (neutral detached fact finders/ designated examiners). The NDFF/DE are not involved in the care of the patient and one of them must be a physician.