NURSING POLICY NO. 1205

SUBJECT: **PAIN MANAGEMENT**

Adopted:	November 2002
Revised:	February 2007
Reviewed:	August 2007
Revised:	May 2008
Revised:	October 2008
Revised:	May 2009
Revised:	December 2009
Reviewed:	August 2011
Reviewed:	August 2013
Revised:	July 2014
Revised:	July 2016
Reviewed:	May 2018

POLICY

It is the policy of Central Louisiana State Hospital to assess patient complaints of pain or discomfort, assess treatment alternatives with regard to diagnosis or cause, and provide for the effective management of pain through pharmacologic and/or non-pharmacologic action through multi-disciplinary and interdisciplinary interaction. Treatment addresses the physical, emotional, cognitive and behavioral aspects of pain.

OBJECTIVE

To ensure accessible and effective pain management to all patients through implementation of a pain assessment/management plan, which shall include: availability, assessment, appropriateness, education, and discontinuance planning.

PROCEDURE

1. All patients and/or family members where applicable shall be educated on admission regarding CLSH Pain Program by the Registered Nurse.

2. All patients shall have access to a pain management plan once the presence of pain is assessed.

3. All patients shall be assessed/reassessed by the Registered Nurse. (Refer to algorithm.)

4. All patients shall be provided optimal patient comfort through a proactive pain management plan.

5. All licensed staff shall be competent in Pain Assessment and Management. All staff must be educated on CLSH Pain Management Program at time of employment.

6. All patients requiring Pain Management shall have symptom management addressed as part of the Pain Assessment and/or Progress Notes.

The Mankoski Numeric Pain Intensity Scale of 0 to 10, and the Wong-Baker Faces Pain Rating Scale will be used on patients to describe the subjective experience of pain on admission assessment to evaluate pain history and to evaluate current pain.

- 0 - Pain Free
- No Medication needed.
- 1 - Very minor annoyance - occasional minor twinges.
- No Medication needed.
- 2 - Minor annoyance - occasional strong twinges.
- No Medication needed.
- 3 - Annoying enough to be distracting.
- Mild painkillers are effective (Ex. Aspirin, Ibuprofen).
- 4 - Can be ignored if you are really involved in your work, but still distracting.
- Mild painkillers relieve pain for 3 - 4 hours.
- 5 - Can't be ignored for more than 30 minutes
- Mild painkillers reduce pain for 3 - 4 hours.
- 6 - Can't be ignored for any length of time, but the patient can still perform normal activities, such as work, and social activities.
- Strong painkillers (Ex. Codeine, Vicodin etc.) Reduce pain for 3 - 4 hours.
- 7 - Makes it difficult to concentrate, interferes with sleep. The patient can still function with effort.
- Stronger painkillers are only partially effective.
- Strongest painkillers relieve pain. (Ex. Morphine, Demerol).
- 8 - Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.
- Stronger painkillers are minimally effective. Strongest painkillers reduce pain for 3 - 4 hours.
- 9 - Unable to speak. Crying out or moaning uncontrollably - near delirium.
- Strongest painkillers are only partially effective.
- 10 - Unconscious. Pain makes you pass out.
- Strongest painkillers are only partially effective.

Wong-Baker Faces – Pain Rating Scale

IMPLEMENTATION

1. Availability

   A. Patients admitted to CLSH shall be questioned regarding presence of pain and informed of the right to and availability of a pain management plan.

2. Assessment/Reassessment

   A. Pain history, assessment, and education will be performed by the RN initially on admission-

   B. Patients will be educated on an ongoing basis to report to staff the presence of pain.

   C. The report of pain shall be followed by further assessment as to determine the cause of pain, pain intensity, characteristics of pain, and psychosocial assessment. This will be documented on the Pain Assessment Form using only one form per occurrence of pain.

   D. Patient's report of pain will be accepted and respected as a key indicator of the amount of pain that he/she is experiencing.

   E. The Mankoski Pain Intensity Scale/Wong-Baker Faces pain Rating Scale shall be used as a tool in assessing/reassessment the level of pain in Adolescents and Adults.

3. Pain Management Plan

   A. Management of pain will be individualized to fit the needs of each patient and shall focus on all aspects of pain control, both pharmacologic and non-pharmacologic.

   B. Non-pharmacologic management of pain may include techniques such as psychosocial interventions, such as relaxation, distraction, imagery, support groups, repositioning, pastoral care, etc.

   C. Pain management shall be an ongoing process, and will be adjusted to the needs of each patient.

REFERENCES

(1996) Salerno and Willens. Pain Management Handbook: An Interdisciplinary Approach. Mosby, St. Lovis.

(1991) Clinical Guidelines for Acute Pain Management: Operative or Medical Procedures and Trauma (DHHS Pub. No. (AHCPR) 91-0046). Rockville, Md: Agency for Health Care Policy and Research.

(1990) North American Nursing Diagnosis Association (NANDA). Taxonomy 1-revised 1990. St. Lovis

(1990) Syrjola. Relaxation Techniques. In J. Bonica (Ed.), The Management of Pain (pp. 1742-1750). Philadelphia: Lea and Febiger.

(1992) Bulechek and McCloskey. Nursing Interventions - Essential Nursing Treatments. 2nd Ed, W. B. Saunders Company, Philadelphia.

(1994) Research-Multi-disciplinary. NIH Guides: Symptom Management: Acute Pain

PAIN ASSESSMENT/REASSESSMENT ALGORITHM

Initial Pain Assessment

Admission/Transfer/Annual/Daily Assessment PRN

Identification of Pain

Determine Rating on Pain Scale
(Smiling Faces Chart, Explanation of Rating, Etc.)

Pain Rating

0 - 2

- Vital Signs (Complete)

Complete Pain Assessment Form

- Document
- No Medicines
- Intervention Techniques

Pain Rating

3 – 5

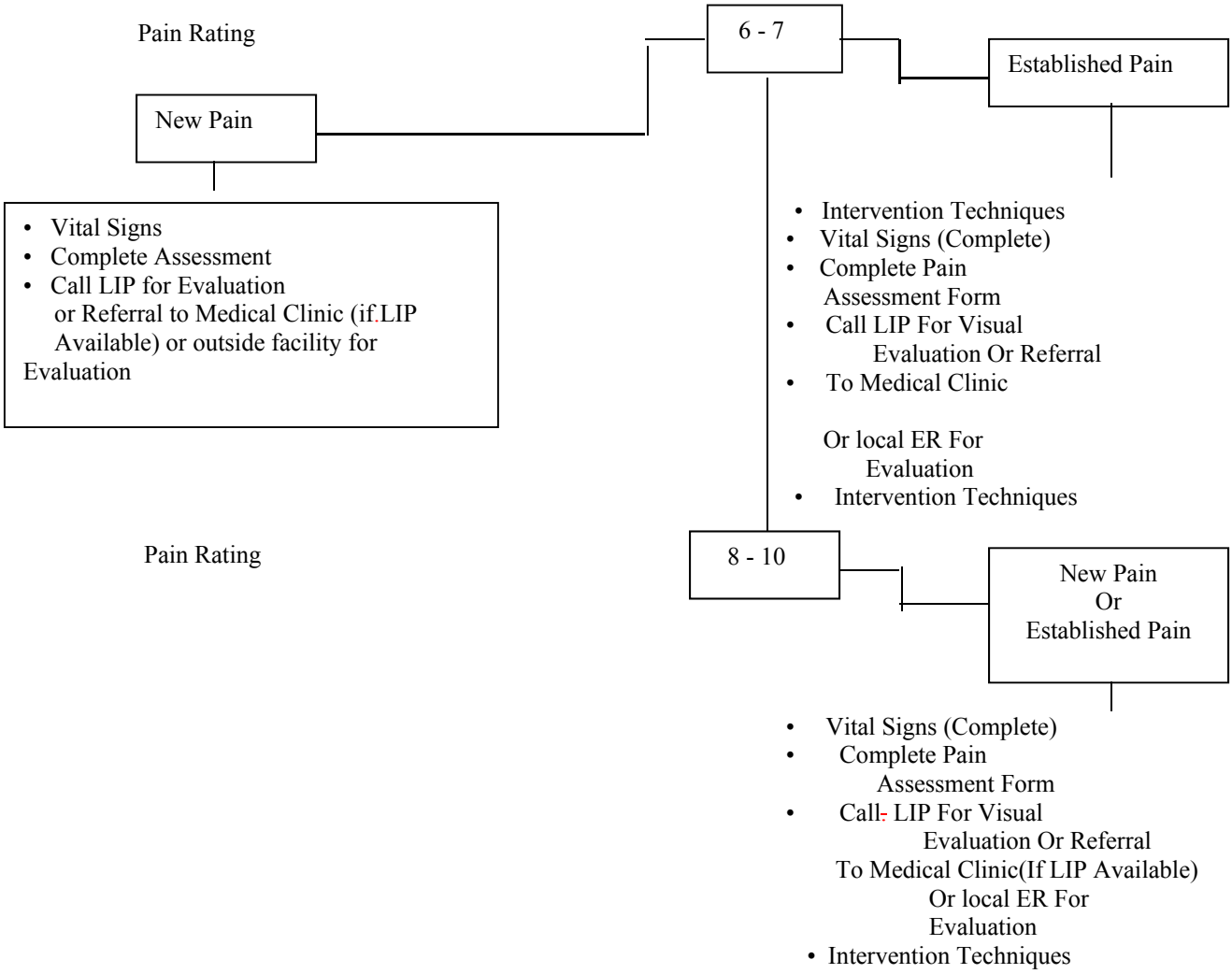
stablished Pain

Vital Signs (Complete)

- Complete Pain Assessment Form
- Administer PRN Medication as Ordered
- Reassess in 1-Hour after Medications Administered
- Document Pain Rating
- Reassess in 4-Hours after Medication Administered
  - If pain level 0-2 Stop at This Point.
- If Pain Rating Remains 3-5
- Re-Administer Pain Medication PRN as Needed up to 12 Hours
  - If Rating Remains 3-5 Notify LIP
- Intervention Techniques

New Pain

- Vital Signs (Complete)
- Complete Pain Assessment Form
- Call.LIP

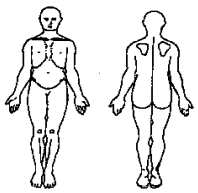

Pain Rating
6 - 7
Established Pain
New Pain
• Vital Signs
• Complete Assessment
• Call LIP for Evaluation
or Referral to Medical Clinic (if LIP
Available) or outside facility for
Evaluation
• Intervention Techniques
• Vital Signs (Complete)
• Complete Pain
Assessment Form
• Call LIP For Visual
Evaluation Or Referral
• To Medical Clinic
Or local ER For
Evaluation
• Intervention Techniques
Pain Rating
8 - 10
New Pain
Or
Established Pain
• Vital Signs (Complete)
• Complete Pain
Assessment Form
• Call LIP For Visual
Evaluation Or Referral
To Medical Clinic(If LIP Available)
Or local ER For
Evaluation
• Intervention Techniques

#4-41-08 (Rev. 2/07)

CENTRAL LOUISIANA STATE HOSPITAL
PAIN ASSESSMENT

Patient's Name_____ Unit_____Date_____Time_____

1. **Chief Complaint**: _____
   a. Location: (Put an X where pain is located and describe site)



2. **INTENSITY** (Rate (circle) pain intensity):

0	1	2	3	4	5	6	7	8	9	10
No Pain		Pain A Little Bit		Pain A Little More		Pain Even More		Pain A Whole Lot		Pain Worst

3. **CHARACTER** (Circle the words that best describes the pain):

Aching	Sharp	Penetrating	Throbbing	Stinging
Tender	Nagging	Stabbing	Shooting	Tingling
Burning	Numb	Tiring	Unbearable	Dull
Exhausting	Miserable	Gnawing	Cramping	Deep
Unable to respond/describe				

4. **NON-PHARMACOLOGICAL INTERVENTION:**_____

5. **QUALITY**: Does your pain effect the following:
   Sleep Y or N If yes, explain_____
   Appetite Y or N If yes, explain_____
   Relationship with other's Y or N If yes, explain_____
   Work Y or N If yes, explain_____
   Emotions Y or N If yes, explain_____

6. **MEDICATION ADMINISTRATION**:

DATE	TIME	VITAL SIGNS	PAIN INTENSITY SCALE RATING	MEDICATION AND DOSE GIVEN	PAIN RATING ONE HOUR AFTER TAKING MEDICATION	PAIN RATING FOUR HOURS AFTER TAKING MEDICATION	SIDE EFFECTS N=NONE Y= SEE PROGRESS NOTES	NURSE SIGNATURE

Addressograph

CENTRAL LOUISIANA STATE HOSPITAL
PAIN HISTORY/EDUCATION

Patient's Name_____CLSH#_____Unit_____ Date_____

HISTORY

1. Have you had pain in the past 6 months? Y or N If yes, explain_____
_____

2. Medications/Non-Pharmacological Interventions used in the past to effectively manage pain_____
_____

3. Did your pain interfere with any aspects of your daily routine? Y or N If yes, explain_____
_____

PAIN MANAGEMENT PROGRAM

Pain management education is provided on an on-going basis. Pain experienced at any time should be reported to staff. Pain will be managed in the most safe, therapeutic, and effective manner to obtain optimal relief.

1. Patient/Family, if appropriate, educated on CLSH Pain Management Program. Y or N

2. Patient/Family, if appropriate, verbalize understanding. Y or N Comments_____
_____
_____

RN Signature_____ Date_____ Time

File behind Initial Nursing Assessment

NURSING POLICY NO. 1302

SUBJECT: **MONITORING FIRST DOSE OF NEW MEDICATION**

Adopted:	April 2004
Revised:	November 2005
Reviewed:	August 2007
Revised:	May 2008
Reviewed:	April 2010
Reviewed	March 2012
Revised:	May 2014
Reviewed:	August 2016
Reviewed:	September 2018
Reviewed:	January 2019

POLICY:

1. The effects of medications on patients are monitored to assess the effectiveness of medication therapy and to minimize the occurrence of adverse events. Each patient's response to medication administered is monitored according to his or her clinical needs. Ongoing patient medication monitoring will use a collaborative approach between patient care providers, physicians, pharmacists, and the patient, family or caregiver.

2. Monitoring will address the patient's response to the prescribed medication and actual or potential medication-related problems. The results of patient medication monitoring will be used to improve the patient's medication regimen and/or other clinical care and treatment processes.

PROCEDURE:

1. The RN/LPN will monitor and assess the effect of medications on the patient. Monitoring and assessing the effect of the medication includes, but is not limited to:
    A. Direct observation of the patient during assessments, evaluations or other patient contact to determine the patient's physiological response to the medication administered and any problems or adverse effects associated with the medication.

    B. Information about the patient's own perceptions about medication side effects, and when appropriate, perceived efficacy and/or sensitivities the patient may have to the medication.

2. When the patient is given a medication that is new to the patient, the first dose will be monitored. If it is not identified by pharmacy or readily discernible that a patient has previously been on a medication by review of current medical record it will be treated as a new medication. Patients may experience adverse reactions to medications that are new to their systems. Therefore when new medications are administered to the patient:
    A. The RN/LPN will physically observe and assess the patient within the first hour after the patient receives the medication to assure there is no evidence of adverse effect
    B. The RN/LPN will again physically observe the patient during the next shift to assure the new medication did not produce adverse effects or sensitivities to the patient. (Refer to the First Dose Medication Monitoring Tool)

C. The pharmacy will generate a "New Medication Monitoring" MAR label to be sent to the nursing unit along with the new medication. The label will include a notation for the nurse to assess the patient receiving a new medication in first hour after the first dose, and once on next shift. The nurse will note on the MAR the time of each check and initial. The nurse administering first dose will also document on the PME that the first dose was actually given.

3. The patient may receive a test dose for medications where this is both appropriate and available (i.e., some categories of antibiotics) for medications given on a first time basis in an effort to identify an adverse drug reaction allergy or sensitivity to the medication.

4. Other Clinical Laboratory studies may be ordered as appropriate to monitor the patient's response to medications that are new to his or her system to prevent unnecessary side effects or adverse reactions.

5. Any adverse effects observed or obtained through patient medication monitoring and assessment will be documented in the progress note and referred to the unit physician. The nurse completing the First Dose Medication Monitoring Assessment Tool will send a copy to the pharmacy and file in the patient's medical record with the MAR in the medication section.

Revised 5-01-17 (05-2014)

CENTRAL LOUISIANA STATE HOSPITAL
PINEVILLE, LOUISIANA

FIRST DOSE MEDICATION MONITORING ASSESSMENT TOOL

NAME:_____ **CLSH#**_____

NAME OF NEW MEDICATION:_____

MEDICATION ADMINISTERED Date:_____ **Time:**_____

VITAL SIGNS UP TO 1 HOUR AFTER FIRST DOSE:

B/P_____ **P**_____ **T**_____ **R**_____ **Date:**_____ **Time:**_____

PHYSICALLY OBSERVE AND ASSESS THE PATIENT'S RESPONSE TO NEW MEDICATION:

_____

_____

_____

_____

_____

RN/LPN SIGNATURE:_____

VITAL SIGNS 1ST SHIFT AFTER FIRST DOSE:

B/P_____ **P**_____ **T**_____ **R**_____ **Date:**_____ **Time:**_____

PHYSICALLY OBSERVE AND ASSESS THE PATIENT'S RESPONSE TO NEW MEDICATION:

_____

_____

_____

_____

RN/LPN SIGNATURE:_____

NURSING POLICY NO. 1503

SUBJECT: **ACCOUNTABILITY OF PATIENTS**

Adopted:	
Revised:	May 2005
Reviewed:	August 2007
Revised:	November 2008
Reviewed:	September 2010
Revised:	February 2011
Revised:	October 2011
Revised:	March 2012
Revised:	December 2013
Revised:	June 2015
Reviewed:	October 2015
Revised:	October 2016
Revised:	September 2018
Revised:	October 2018
Revised:	February 2019

POLICY

Accountability of patients is a responsibility of Nursing Personnel and primarily of Psychiatric Aides. Every measure should be taken to maintain good accountability of patients. Patients must be visually (eye to eye) identified when doing accountability.

I. 24-HOUR ACCOUNTABILITY
PAS1 will directly observe PA's doing accountability 3X's per shift.

A. From 7:00 a.m. – 8:30 p.m.:

A nursing staff member will conduct rounds throughout the unit every hour. If patients are off the unit, the nursing staff member will be able to account for their whereabouts (i.e., clinics, therapies, meals, etc.).

B. From 8:30 p.m. - 7:00 a.m.:

1. The Charge Aide will assign one (1) Psychiatric Aide to conduct bed checks every thirty (30) minutes from 8:30 p.m. to 7:00 a.m. When staffing permits, the Charge Aide will assign two (2) Psychiatric Aides to conduct bed checks.
2. **Nursing staff conducting rounds will visualize each patient and determine if the patient is in his/her assigned bed.**
3. If the patient is not in his/her assigned bed, the assigned staff will locate the patient for visual accountability. If the patient cannot be located, initiate unit search per policy and elopement procedures if indicated.
4. The Charge Aide will assign a Psychiatric Aide to conduct hall monitoring from 8:30 p.m. to 7:00 AM. Evidence of hall monitor assignments will be documented on the daily assignment sheet by the Charge Aide. The Charge Aide will be specific as to who is assigned and for what time periods. The hall monitor will not leave his post of duty without relief.

C. Any unusual circumstances found at the time of rounds are to be reported immediately to the Charge Aide/designee and Licensed Nurse for assessment. The licensed nurse, in turn, will communicate any unusual circumstances to the RN/Manager-designee or O.D. RN for further immediate investigation.

D. Staff assigned to make rounds will visualize each patient. Staff will document on each client in the Accountability binder utilizing the following codes:
A=Awake (may only be used on 11pm-5am)
B=in bed
C=Courtyard
Cl=Clinic
K=Kitchen

O=Off grounds
P=Pass
S=in bed, appears asleep
T=Therapies (off unit)
U=On unit
N/A=Not Applicable

E. Joint shift change rounds will be made by the off-going and on-coming Charge Aide/designee at the beginning of each shift to check the unit and account for all patients. Evidence that joint shift change rounds were made will be documented on the Patient Accountability Form.

F. PAS1 shall observe staff rounds 3 times/shift per flow sheet.

G. Staff RN will make rounds and visualize each client. This will be documented per flow sheet. RN accountability rounds require visualization of client respirations.

H. Each morning, the 24 Hour Accountability Record Form will be sent, to the Nursing office after being reviewed for completion by the RN Supervisor/Designee day and night nurses.

The RN Manager/Designee will review the 24 hour Accountability sheets in nursing administration. Unit Accountability forms will be maintained on file by the RN Manager.

All deficiencies are reviewed and reported in NEC monthly. Negative trends will be addressed with corrective action plans as indicated.

I. All signatures/initials for accountability will be entered at the time rounds are made. Failure to comply with the above directions will result in progressive disciplinary action up to and including **TERMINATION OF EMPLOYEE**.

II. In addition to the 24 hours established hourly and ½ hour accountability practices, patients will be accounted for at the following times.

A. AT EACH SHIFT CHANGE - Joint rounds will be made by employees going off duty and coming on duty. Account for the whereabouts of each patient. **NOTE:** Look at each patient. If a patient is off the unit for any reason, find out where the patient is (i.e., clinic, therapy, etc), document.

B. **AT MEAL TIMES** - If patients leave a unit in a group for meals, check prior to leaving unit, after entering dining area, prior to leaving dining area and again upon returning to unit. Observe to prevent eloping or wandering away at these times.

C. **UPON EXITING UNIT FOR ATM/ARP** – On the days that the patients attend the ATM/ARP, the **unit nurse that is assigned to the medication room** will make

a round by 0830 (or immediately after the unit is vacated) each day to ensure all patients are off of the unit. This round is to be conducted on the unit that is to be vacant for the day.

D. **AT COURTYARD** - Patients are supervised by two staff members. Accountability is checked when the patients enter into the courtyard and again when they return into the unit. Nursing staff assigned this duty is responsible for continuous monitoring of patients while they are in the courtyard.
Units will utilize a patient's "Sign-Out Ledger" for patient accountability. This applies to the group of patients of the appropriate level who are able to leave the unit WITHOUT staff supervision. Teach patients to sign out when leaving and to sign in when they return. This helps to give patients a sense of responsibility by accounting for their own whereabouts.

When accompanying patients away from the unit, make efforts to be aware of each patient's whereabouts at all times. Upon return to the unit, check that all patients are accounted for. Observe patients closely when taking them to clinics, therapies, on walks, or any other activities, for accountability purposes.

Be certain that patients are on the **correct level** to be able to leave the unit without staff supervision.

It is helpful to have a general knowledge of the usual habits, movements, and behavior patterns of the patients on a unit. It is important for the Psychiatric Aide/designee to maintain a general knowledge of the whereabouts of all the patients on the unit. Any concern that you have relative to a patient's possibility of elopement or wandering off in a confused or disoriented state must be reported to the RN and documented in the medical record. Keep a closer watch on these patients and take whatever action(s) necessary to help prevent an adverse incident. Involving the patient who may elope in activities that are of interest to him/her and/or, keeping him in the company of others, can often be a therapeutic measure.

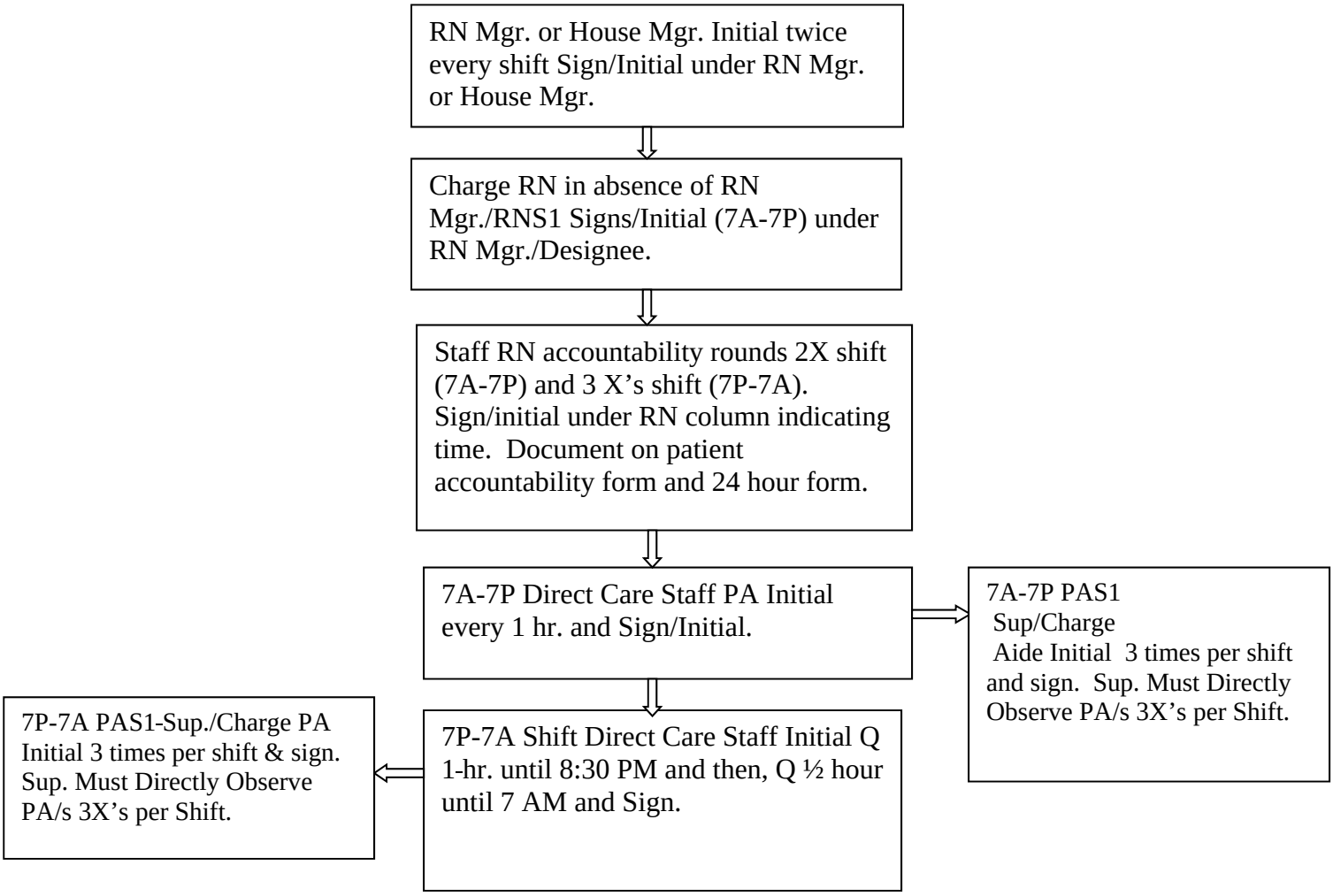
III. SUICIDE RISK REDUCTION/SAFETY ROUNDS

A. In an effort to minimize the risk of suicide and as a part of risk reduction, nursing staff will make rounds down the halls, all exit doors, in the bed areas and in the bathrooms **6 times every hour**. All areas inside the bathrooms and bed areas are to be visualized at each round Make sure all exit doors are locked and secure. Check to ensure that the TV remote control is secured and locked.

B. Staff will make rounds every 10 minutes. Upon completion of round, staff assigned will enter the time the round was made on the suicide risk reduction rounds form (see attached). Staff will place a check mark in the corresponding column to indicate that they have checked those areas indicated. Staff initials will be placed in the last column.

C. All PA staff are to mark their initials with corresponding signature at the bottom of the form. Unit PASI/charge PA and unit RN are to sign the bottom of the form to show that rounds were made as assigned and form is being completed timely.

D. Completed forms are to be turned in to the RN Manager at the end of each shift. These forms will be kept on file for 90 days.



Signatures/Initials will all be completed and legible.

R.N. Manager working as House Manager will initial/sign under House Manager, not R.N. Manager.

<u>All initials will be entered at time of rounds.</u>

2-31-13 (Rev. 4/14)

Joint Shift/RN Reviewed
7 PM - 7 AM RN: _____
7 AM - 7 PM RN: _____

Central Louisiana State Hospital
24-Hour Nursing Accountability Record/Suicide Risk Reduction

Date: _____ RN Manager/Designee
Unit: _____ Reviewed: _____

Joint Shift Rounds 6:45 AM - 7:15 PM

Time	Direct Care Staff Initials Every Hour		PAS1/BSS - Sup/Charge Aide 3X per Shift Must Directly Observe	RN Initials 2X per Shift	RNM/ Designee/ RNHM 2X per Shift Minimum
7:00 AM					
7:30 AM					
8:00 AM					
8:30 AM					
9:00 AM					
9:30 AM					
10:00 AM					
10:30 AM					
11:00 AM					
11:30 AM					
12:00 PM					
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1:00 PM					
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4:00 PM					
4:30 PM					
5:00 PM					
5:30 PM					
6:00 PM					
6:30 PM					

Initials	Signatures

6:45 AM - 7:15 PM	Initials
PAS1/BSS - Sup. Signature/Charge Aide	
Licensed Personnel Signature	
RN Manager/Designee/RN House Manager	

Joint Shift Rounds 6:45 PM - 7:15 AM

Time	Direct Care Staff Initials Every Hour 7 PM - 8:30 PM Every 1/2 hour 8:30 PM - 6:30 AM		PAS1/BSS - Sup/Charge Aide 3X per Shift Must Directly Observe	RN Initials 3X per Shift	RNHM 2X per Shift Minimum
7:00 PM					
7:30 PM					
8:00 PM					
8:30 PM					
9:00 PM					
9:30 PM					
10:00 PM					
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Initials	Signatures

6:45 PM - 7:15 AM	Initials
PAS1/BSS - Sup. Signature/Charge Aide	
Licensed Personnel Signature	
RN House Manager	

7P-7A Shift **Unusual Circumstances Observed/Found**

7A-7P Shift **Unusual Circumstances Observed/Found**

CLSH/NPPM
7 AM-7 PM Shift **Unit**

Accountability/Courtyard/Meals

Date: _____

	7:00	Unit	Kitchen	Kitchen	Unit	8:00	9:00	CYP	CYP	10:00	11:00	Unit	Kitchen	Kitchen	Unit	12:00	1:00	2:00	CYP	CYP	3:00	Level Store OUT	Level Store IN	4:00	5:00	Unit	Kitchen	Kitchen	Unit	6:00	CYP	CYP	7AM-7PM	
Patient Name		OUT	IN	OUT	IN			OUT	IN			OUT	IN	OUT	IN				OUT	IN						OUT	IN	OUT	IN		OUT	IN	RN Initial	Time
Staff Initials																																		

Key

B= In Bed **C= Courtyard** **U= On Unit** **Cl= Clinic** **K= Kitchen** **O= Off Grounds** **P= Pass** **S= In bed, appears asleep** **T= Therapies (off Unit)** **N/A= Not Applicable**

CENTRAL LOUISIANA STATE HOSPITAL
SUICIDE RISK REDUCTION STRATEGY ROUNDS FORM
NURSING DEPARTMENT ~ RANDOM ROUNDS 6 TIMES EVERY HOUR ~ EVERY 10 MINUTES

DATE: _____ **SHIFT:** 7 AM **UNIT:** _____

TIME	BATH ROOMS	BED AREA	EXIT DOOR	SUICIDE ALARM ARMED	REMOTE CONTROL SECURED	MAGNETIC SWEEPER	INITIALS
0700							
0710							
0720							
0730							
0740							
0750							
0800							
0810							
0820							
0830							
0840							
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ITIAL	SIGNATURE	INITIAL	SIGNATURE	INITIAL	SIGNATURE

PA SUPERVISOR/CHARGE AIDE_____ **CHARGE R. N.** _____

SUBMIT COMPLETE FORM TO THE RN MANAGER AT THE END OF EACH SHIFT

CENTRAL LOUISIANA STATE HOSPITAL
SUICIDE RISK REDUCTION STRATEGY ROUNDS FORM
NURSING DEPARTMENT ~ RANDOM ROUNDS 6 TIMES EVERY HOUR ~ EVERY 10 MINUTES

DATE: _____ **SHIFT:** 7 PM **UNIT:** _____

TIME	BATH ROOMS	BED AREA	EXIT DOOR	SUICIDE ALARM ARMED	REMOTE CONTROL SECURED	MAGNETIC SWEEPER	INITIALS
1900							
1910							
1920							
1930							
1940							
1950							
2000							
2010							
2020							
2030							
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0630							
0640							
0650							

ITIAL	SIGNATURE	INITIAL	SIGNATURE	INITIAL	SIGNATURE

PA SUPERVISOR/CHARGE AIDE_____ **CHARGE R. N.** _____

SUBMIT COMPLETE FORM TO THE RN MANAGER AT THE END OF EACH SHIFT

NURSING POLICY NO. 1515

SUBJECT: **FALL POLICY/FALL RISK REDUCTION**

Adopted:	August 2006
Reviewed:	August 2007
Reviewed:	November 2009
Revised:	November 2011
Reviewed:	October 2013
Reviewed:	January 2014
Revised:	January 2016
Reviewed:	February 2017
Reviewed:	February 2019

REFER TO Clinical Policy #97. Fall Reduction Program

NURSING POLICY NO. 1525

SUBJECT: **PORTABLE GLUCOSE MONITORING**

Adopted:	August 2004
Revised:	April 2006
Revised:	September 2007
Revised:	June 2008
Revised:	October 2008
Revised:	April 2009
Revised:	June 2010
Revised:	February 2011
Revised:	June 2012
Revised:	March 2013
Revised:	March 2014
Revised:	January 2015
Revised:	May 2015
Revised:	March 2016
Reviewed:	March 2017
Revised:	January 2019

POLICY

CLSH has identified two tests that meet the requirements of "waived tests" under the CLIA law:

1. Portable Glucose Monitoring using an approved glucose monitor
2. Fecal Occult Blood Testing (Physician Performed Only)
3. Pregnancy-Urine HCG (Physician Performed Only)

PORTABLE GLUCOSE MONITORING

I. Portable glucose monitoring will be used to determine the patient's whole blood glucose as a definitive finding to treat hypoglycemia or hyperglycemia in the care and treatment of diabetic patients. Patient results <50 mg/dl or >250 mg/dl will be immediately reported to LIP unless otherwise specified per physician's order. (See Hypoglycemia/Hyperglycemia protocols that follow.)

A. Hypoglycemia Protocol
For glucose value of <50 mg/dl:
1. Repeat the glucose result capillary test to rule out procedural error.
2. Notify LIP immediately of glucose result <50 mg/dl or presence of symptoms.

B. Hyperglycemia Protocol
For glucose values >250 mg/dl:
1. Repeat the glucose capillary test to rule out procedural error.
2. Notify LIP immediately of glucose results greater than 250 or of the presence of symptoms.

Further testing, evaluation of current treatment will be determined on an individual basis by the treating physician or designee.

II. Only Registered Nurses or Licensed Practical Nurses may perform portable glucose monitoring of patients at CLSH.

A. All employees performing the tests meet the qualifications and only do tests they are trained and competent to perform.

B. Each employee identified to perform portable glucose testing will be trained and competency maintained by their immediate supervisor. This will be documented on an as needed basis, but not less than annually at the time of their annual evaluation.

III. Specific training for portable glucose monitoring will be documented on each staff member performing the glucose monitoring and demonstration of satisfactory competency levels as outlined in nursing policy and procedures will be maintained in personnel records. Training will be done during orientation at time of hire and at least annually thereafter.

A. Skills will be assessed on an as needed basis, no less than yearly at the time of annual evaluation of job performance and maintained in personnel records.

B. The frequency of skills assessment will be reviewed and assessed by the Laboratory Director in conjunction with nursing administration and Nursing Education Departments.

C. The skills assessment will be based on:
1. Frequency the staff performs the test
2. Technical background of staff
3. Complexity of test methodology and consequences of inaccurate result
4. Emphasized for individuals who perform testing infrequently.

D. Each immediate supervisor will assess current skills by using at least two of the following methods:
1. Performing a test on an unknown specimen
2. Having the supervisor or qualified delegate periodically observe routine work
3. Monitor each user's quality control performance
4. Passing a written test that is specific to the current glucometer

E. Documented competency of waived testing will be maintained in personnel records and a copy of the competency record will be sent to the laboratory to be maintained by the Clinic Director (designee).

IV. The procedures for glucose monitoring are as follows:

A. All glucose readings are documented on the Diabetic Flow Sheet in the patient record. Values are reported immediately to the LIP as described in the hypoglycemia/ hyperglycemia protocol of this policy.

B. Quality control is performed on two levels daily. See the Glucometer Quality Control Decision Tree for remedial action.

C. The Clinic Director or designee will review, revise, and approve policies and procedures on waive tests as needed at least yearly.

V. Quality control will be performed on every glucometer on each day of use. A quality control check alerts you to any meter, test strip or testing technique problem.

1. Quality Controls will be performed according to the manufacturers' guidelines and as outlined below. The quality control results will be documented on the Blood Glucose Monitoring Control Tests Record. A copy of this record is sent to the Clinical Director

and to infection control monthly for review.

2. A quality control check will be done on two levels of control using the High and Low reagents on each instrument on each day of patient testing. The results will be documented on the Blood Glucose Monitoring Control Test Record. Acceptable performance is assured only when the control test result falls within the specific range listed on the test strip container in use. If the equality control fails refer to the Glucometer Quality Control Decision Tree. Quality controls will be performed and documented by the nightshift-licensed personnel.

3. Testing and quality control procedures follow the manufacturers' guidelines, which are kept in the medicine room with the glucometer.

4. Sufficient capillary blood from the fingertip should be used for the glucose test.

5. Do not use a test strip after the expiration date.

6. Store test strips at room temperature between 48-86 degrees F (9-30 C).

VI. Care of the glucometer.

1. The glucometer is stored in a designated covered box on each unit along with clean supplies.

2. Clean the glucometer after each patient use and prior to returning glucometer to the designated storage box using the hospital approved EPA-registered disinfectant wipe.

3. Follow the instructions for the use of the wipe as printed on the container. Take extreme care not to get liquid in the test strip and key code ports of the meter.

4. If blood is visibly present on the meter, two wipes must be used: use the first wipe to clean and remove blood; use the second wipe to disinfect; allow the meter to air dry for the full contact or dwell time listed on the product label prior to returning to storage box with other clean supplies. A quick reference cleaning guide is laminated and stored in the storage box.

VII. Appropriate quality control and test result records are retained for at least two years with the RN Manager.

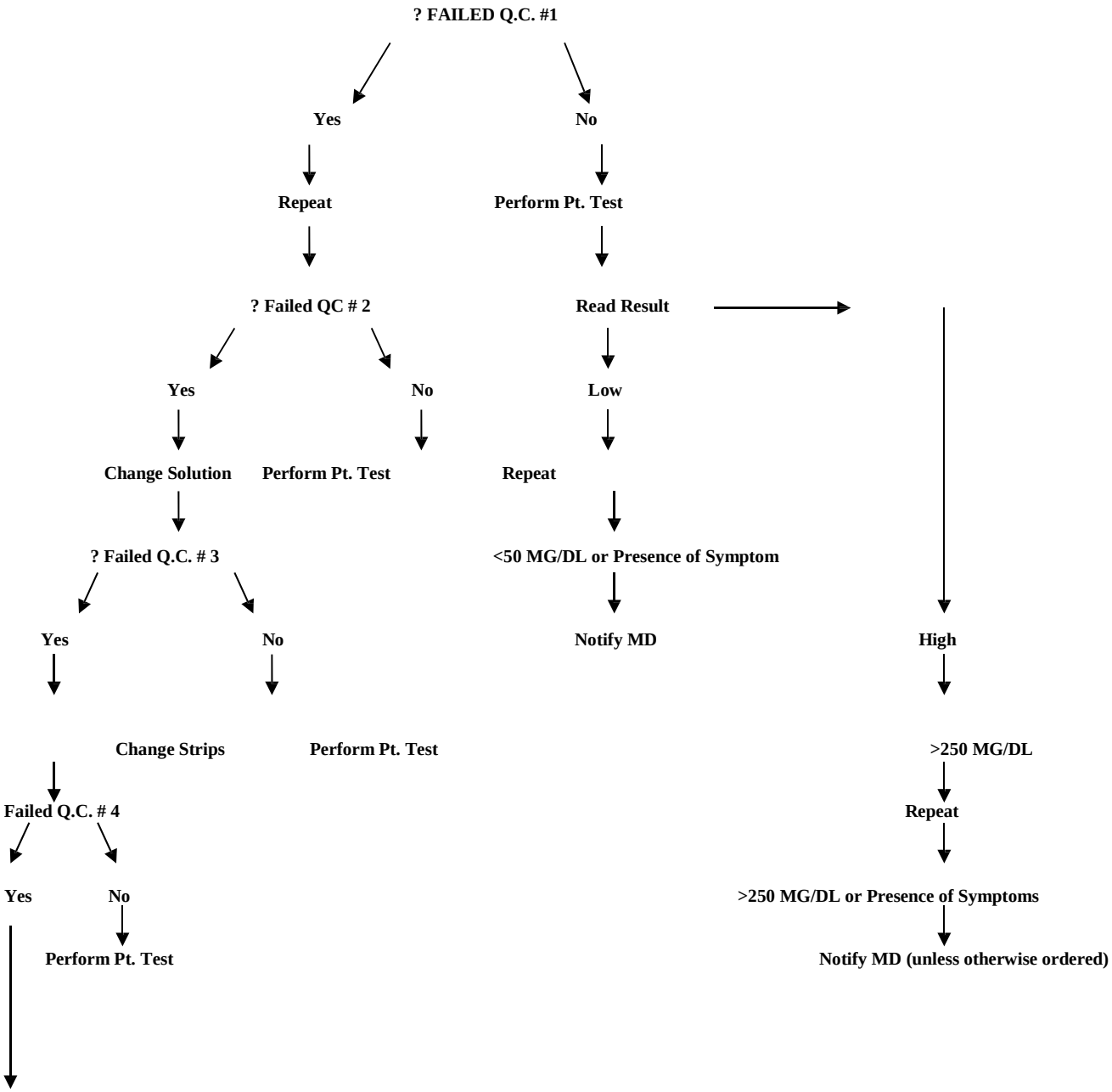
1. All quality control test results are documented on the Blood Glucose Monitoring Control Tests Record daily as performed.

2. Glucose readings are documented on the Diabetic Flow Sheet (Form#4-41-63 Rev. 1-5) and maintained in the medication room and filed under "Flow Sheets" section of the chart at the end of each month.

3. The serial number of the glucometer will be documented on the Blood Glucose Monitoring Control Tests Record monthly or at time machine is changed. The lot number and expiration date of the reagents will be documented on the Blood Glucose Monitoring Control Tests Record daily or at the time of change. (See Glucometer Quality Control Decision Tree.)

REFER TO CP85 Using the Glucometer & Values and procedure
REFER TO 1526 Care of the Diabetic Patient
REFER TO 1545 ADL/Hygiene for Nail care and foot/leg assessment)

GLUCOMETER QUALITY CONTROL DECISION TREE



Report to Pharmacy
Action Taken reported
Laboratory Director and Documented on
Blood Glucose Monitoring Control Tests Record.
(Fax copy of record to lab, ext. 6251)

CLSH/NPPM **POLICY NO. 1525.6**

GLUCOMETER QUALITY CONTROL LOG AND INFECTION CONTROL RECORD

Record daily the results of the High and Low quality control tests. Quality control tests are performed as indicated or by the night shift licensed staff on each unit. If a control test fails refer to the Glucometer Quality Control Decision Tree (Nursing Policy #1525 or Clinical Policy #85). After each use the monitor will be cleaned with hospital approved disinfectant or mild detergent and dried with a soft tissue.
NOTE: Glucose controls will remain stable until the Manufacturer's Expiration Date, or 6months after opening date, whichever comes first. Test strips will remain stable until manufacturer's expiration date.

Month/Year_____ Unit _____ Glucometer Serial _____
LOW Lot #_____ Exp. Date_____ # Date Opened:_____ Discard Date:_____
HIGH Lot#_____ Exp. Date_____ Date Opened: _____ Discard Date:_____

LOW Control Range _____ HIGH Control_ _____

You will find the acceptable range for both levels printed on the test strip container box

Date	Control Test Results	Tester Initials	Meter Cleanliness Check 7A-7P Initials	Meter Cleanliness Check 7P-7A Initials	Control Test F/U Documentation : Control Test Fail? Refer to Decision Tree and document follow up action below
	H- L-				
	H- L				
	H- L-				
	H- L-				
	H- L-				
	H- L-				
	H- L-				
	H- L-				
	H- L-				
	H- L-				
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	H- L-				
	H- L-				
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	H- L-				
	H- L-				
	H- L-				

SEND A COPY OF THIS FORM TO THE INFECTION CONTROL NURSE

CLSH/NPPM POLICY NO. 1525.7

Name: ___________CLSH #_______Age ___ Current Diet_______________

AC BREAKFAST				AC Lunch			AC Supper			Bed Time			Stat or Prn		
Date	Time/reading/initial			Time/reading/initial			Time/reading/initial			Time/reading/initial			Time/reading/initial		

Fasting Serum Glucose Normal Range =65-99 mg/dL (Per contract lab normal values)
Notify MD for glucose reading <50 or>250, unless otherwise ordered
Readings not recorded C=Patient refused; F=Patient absent from Dept.; H=See progress note

NURSING POLICY NO. 1539

SUBJECT: **NURSING RISK ASSESSMENT**

PURPOSE: To assure the assessment and evaluation of risk of dangerous/violent behavior, self-injury or potential for suicide/elopement and for the protection of patients, staff and the general public.

Adopted: May 2008
Reviewed: May 2009
Reviewed: May 2011
Reviewed: May 2013
Reviewed: June 2014
Revised: June 2016
Reviewed: June 2018

POLICY

It is the policy of the Nursing Department at CLSH that all incidents of risk (i.e. harm to self or others, elopement, any other dangerous/violent behavior, suicidal ideations or threats thereof) be assessed and evaluated by the RN on duty at the time of such incidents. This is a Nursing Risk Assessment and is separate from the LIP's risk assessment.

PROCEDURE

1. When any incident of risk is witnessed by or reported to any nursing staff member by any employee or visitor, the incident will be immediately reported to the unit RN on duty.

2. The unit RN will assess and evaluate the patient for injuries, risk for self-harm, elopement or any other dangerous behavior and initiate any protective measures needed to ensure safety of the patient, staff or visitors.

3. The RN will contact the treating LIP or OD LIP regarding the behavior.

4. The RN will document in the progress notes of the patient's medical record the assessment, evaluation, LIP notified, treatment given and protective measures instituted.

5. The RN on duty will report all of the above to the charge nurse/RN Supervisor and/or the OD nurse.

Refer to Clinical Policy Clinical Policy 91 for Physician's/LIP's Risk Assessment

NURSING POLICY NO. 2217

SUBJECT: **Prohibited Staff Activities**

Adopted: March 2013
Reviewed: May 2014
Revised: May 2015
Revised: June 2016
Revised: February 2017
Reviewed: April 2018
Revised: March 2019

Policy: It is a policy of CLSH Nursing Department to avoid activities and actions that distract from client observation, interfere with performance of duties, demonstrate inappropriate behavior in the presence of clients, jeopardize safety, threaten the welfare of others or interfere with teamwork.

PURPOSE: To maintain a culture of quality and safety and to promote a positive, respectful work environment.

Applicability: All Settings

Procedure:

A. The following activities interfere with client observation or distract from work assignment:
   1. Electronics: Employees are not allowed to utilize personal electronic devices (including, but not limited to: cellular telephones, pagers, CD players, MP3 players, iPods, laptop, hand held games, etc.) while in an on-duty status. An exception to this requirement is that employees may utilize personal electronic devices (listed above) during designated off unit breaks and official meal times when the employee is on off-duty status. Exceptions are pagers and cell phones issued by CLSH to authorized staff. The taking of photos of clients, transmission of hospital photos and/or posting of hospital information to social media sites (Face Book, Twitter, etc.) is prohibited. Accessing cell phone messages and games is unauthorized in the presence of clients.
   2. Computer Use: The use of the computer is limited to work-related duties. In accordance with State policy, "the misuse of computers is a violation of policy and can result in disciplinary action: "Sate resources are to be used only in conjunction with official business and as defined by the user's job description. Installing and using non-business related software, e.g., computer games, is strictly prohibited." This includes accessing websites.
   3. Personal Phone Calls: Personal phone calls are discouraged except in case of emergency when they should be as brief as possible.
   4. Watching TV: staff may watch TV as a client activity with the clients determining the program. After bedtime, the TV must be turned off or on low volume to prevent the sound from disturbing clients; the TV is NOT to interfere with the performance of duties, including attention to precautions and rounds.
   5. Sleeping on Duty: Sleeping on duty is prohibited and will not be tolerated. It jeopardizes the safety and welfare of the clients and staff on duty. This includes

no sleeping at desk, in day room, or in the sensory room. The break room/lounge should be used only when on break. Documentation of sleeping could result in disciplinary action.

6. Socializing with Co-Workers: staff are expected to maintain observation of clients:
   a. Engaging in personal conversation distracts from this task
   b. When observing group activities staff should be engaging the clients in the activity and not congregated together socializing
   c. Discussing one's personal life in the presence of clients
   d. Cannot play cards, watch movies, play pool unless a client is participating
7. Other Activities: the following personal activities distract from client care and are unauthorized in the presence of clients- reading books/magazines, crocheting/knitting, crossword puzzles, etc. These activities may be performed during designated off unit breaks and official meal times when the employee is on off-duty status.

B. ACTIVITIES INAPPROPRIATE WITH CLIENTS: The following activities and behaviors are inappropriate in the presence of clients:
   1. Eating in front of clients – do not eat food in front of clients; eating outside food that clients don't have access to is demeaning
   2. Smoking is prohibited on the grounds of CLSH
   3. Other - the following behaviors are inappropriate: joking, suggestive behavior, horse playing with staff, cursing or arguing in the presence of clients, showing cell phone photos
   4. Tips and or personal gifts shall not be accepted by Nursing Staff.

C. PERSONAL INVOLVEMENT WITH CLIENTS: staff are not to become personally involved with clients
   1. Transporting clients in private vehicles
   2. Having unnecessary physical contact with clients
   3. Giving to or receiving gifts from clients
   4. Purchasing personal items for, or from clients (e.g. good, cigarettes, candy, drinks, clothes, etc.)
   5. Paying undue attention to select clients unless it is part of the treatment plan
   6. Sharing detailed personal information about self or others with clients

D. CLIENT CONTACT: Staff are to avoid off duty contact with clients
   1. Having personal contact with clients while the client is on pass or following discharge from the hospital.
   2. Communicating with former clients in any form, verbal, written or electronic, unless under the provisions of the Discharge Plan for therapeutic reasons.

3. For client initiated communication by phone or intranet, the employee should acknowledge client, inform him/her that hospital policy prohibits contact, wish them well and terminate conversation. For contact by mail, the employee should return to sender. Continued contact should be reported to the Clients Rights Officer.

E. ABUSE/NEGLECT: staff must avoid acts of abuse/neglect which includes physical abuse, sexual abuse, emotional/mental abuse, exploitation, extortion or neglect. Neglect includes failure to provide adequate care (nutrition, clothing, health care, etc.). Any employee confirmed to have physically or sexually abused a client or failed to report physical/sexual abuse will be terminated.

F. CLIENT CONFIDENTIALITY: All information regarding client information, whether written, computerized, or verbal, is to be held in strict confidence. Any information about a client's condition, care or treatment must not be discussed with anyone, either at or away from the hospital, except with those persons who are directly responsible for the client's care and treatment.

G. CLIENT HAIR CARE: staff may not cut, color, perm (wave, curl, relax) or straighten client's hair.

H. BADGE/KEYS: Staff must wear their ID badge at all times. The badge is to be worn at or above the chest level and with photo and name visible. Lanyards are not to be worn. Keys are to remain secured at all times; never leave keys on desk or in door. Keys should not be visible to clients; do not dangle or jingle keys in front of clients. If a door is locked, be sure to lock it back.

I. VEHICLE CONTROL: You must obey traffic rules and driver requirements
   1. Register your car, complete driver safety, obtain decal in a timely manner
   2. Avoid speeding starting at entry to the grounds
   3. Obey parking rules – don NOT park in handicap, no parking, visitor, state vehicle locations or other designated parking areas; do not park on grass or in the street
   4. Refusal to allow a person or vehicle search may result in disciplinary action up to and including termination and shall result in the forfeiture of the right to drive your vehicle on grounds.

J. VISITING: Staff are not allowed to have visitors in the clinical areas. Staff are not allowed to visit other Units to socialize. Employees are not allowed on grounds when off duty.

K. INTERACTION WITH CO-WORKERS: all staff members are to remain cordial and pleasant with one another at all times. Failure to do so creates an adversarial work environment and affects teamwork. The following actions are prohibited:

1. Unwelcome name-calling, obscene language, and other abusive behavior; intimidation through direct or veiled verbal threats, physically touching another employee in an intimidating, malicious, or sexually harassing manner, including such acts as hitting, slapping, poking, kicking, pinching, grabbing, and pushing; and physically intimidating others through behaviors such as stalking, and including such acts as obscene gestures, "getting in your face", fist-shaking, throwing any object

2. Verbal outbursts, verbal threats, threatening behavior and physical threats, refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Reluctance or refusal to answer questions, return phone calls or pages, condescending language or voice intonation, and impatience with questions, profane or disrespectful language, demeaning or intimidating behavior, sexual comments or innuendo, inappropriate touching, racial or ethnic jokes, throwing objects, client assaults, inappropriately criticizing healthcare professionals in front of others, boundary violations, comments that undermine client's trust in others (e.g., criticizing co-worker in presence of clients), inappropriate chart notes (i.e., accusatory), unethical, dishonest behavior are considered inappropriate

3. Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitutes sexual harassment, repeated offensive sexual flirtations, advances or propositions, continued or repeated verbal abuse of a sexual nature; graphic or degrading verbal comments about an individual or their appearance, the display of sexually suggestive objects or pictures; or any offensive or abusive physical conduct can be considered sexual harassment

CONSEQUENCES

1. Staff may be sent home for inappropriate dress, on their own time
2. EPR will be written for minor offenses, repeat offenses may result in disciplinary action
3. Major offenses may result in immediate disciplinary action including termination
4. Confirmation of physical or sexual abuse or failure to report physical/sexual abuse may result in termination of employment.

STAFF ACKNOWLEDGEMENT

At the time of hire, all employees must sign acknowledgement of review of policy 2217 and Nursing Department policies which are inclusive of this policy and those referenced in this policy.

Refer to A 49 Code of Conduct in Dealing With Disruptive Behaviors

Refer to A 29 Firearms on Hospital Grounds

Central Louisiana State Hospital **Adaptive Behavior Service** **Patient Management System**

	General Description/Basic Characteristics	Privileges/Restrictions	Promotion Criteria (to Level II/YELLOW Level)	Demotion Criteria
I **R** **E** **D**	**A.) General Overview:** This is considered to be a level of maximum restriction, requiring closer supervision and intervention to assist the patient achieve treatment goals, and/or provide protection to the patient due to serious degree of behavioral/psychiatric dysfunction. **Patients admitted to this Service are automatically placed on this level for observational purposes.** Assignment to this level allows the patient to become familiar with the behavioral expectancies of the ABS, as well as afford the unit staff ample opportunity to observe the patient to assess their needs for supervision. **Patients who are already admitted to this service and are assigned to this level** have deteriorated to the extent that they require intensive staff supervision. Individuals remaining on this level for more than two consecutive weeks will need more individualized assistance to aide in their progression through this system. Patients may also be demoted to this level from Levels II (YELLOW), III (GREEN), or IV (BLUE) due to a demonstrated lack of self-initiative, and/or deterioration in behavioral or psychiatric status to the extent that would suggest the need for additional staff management to the degree required for patients on Level I/RED Level. Privileges are significantly limited at this level due to the patient's need for more intensified staff supervision. Some patients may be expected to remain at this level due to their inability to successfully function at a higher level of independence. **B.) Basic Characteristics (one or more):** 1.) Significant verbal aggression. 2.) Physical aggression. 3.) Constant refusal to maintain self or assist staff in maintaining self (within patient's individual capabilities). 4.) Significant non-compliance with participation in prescribed therapeutic program. 5.) Patient's behavior is judged by the treatment team to pose a danger to self or others. 6.) Patient is judged by the treatment team to be gravely disabled in caring for self to the extent that would warrant assignment to this level. 7.) Patient is prone to engage in self-injurious behavior. 8.) Patient is determined by a physician to be an elopement risk. 9.) Patient has threatened or attempted suicide. 10.) Patient has been placed on 1:1 precautions for non-medical reasons.	**A.) Unit:** 1.) Restricted to patient's unit, other than for therapies on the Service, which will require staff supervision. 2.) May access available personal funds only for personal necessities with treatment team approval. Any access to personal funds is subject to availability of funds. 3.) May not make any non-necessity purchases, even via other patients or staff. 4.) May participate in recreation activities which are confined to the patient's unit. **B.) Service:** 1.) May move about on the ABS with staff escort for therapy and meals only. 2.) Access to courtyard (with staff) on Unit 7 is by treatment team decision depending on patient's individual condition. **C.) Hospital Grounds:** 1.) No grounds privileges. 2) May not move about grounds except for sick-call or court. Must have staff escort. 3.) May not make any purchases from the canteen, even via staff or other patients. **D.) Off-Hospital Grounds:** 1.) No passes. 2.) No CLSH sponsored outings. 3) May leave CLSH grounds only for medical or legal reasons. 4.) May not make any non-necessity purchases from businesses off the CLSH grounds, even via staff or other patients.	**A.) General:** 1) Minimum of **one week** of successful functioning on Level I/Red Level. 2.) Approval by treatment team and corresponding physician's/psychiatrist's order. **B.) Psychiatric:** 1.) Patient has psychiatric symptoms under control to the extent that he/she is able to function off of his/her living unit with staff supervision, although not to the extent that he/she can move about the grounds on his/her own, or leave CLSH for non-essential purposes. **C.) Behavioral:** 1.) Does not require non-medical precautions. 2.) Completes ADL's with staff assistance and no more than minimal resistance by the patient. 3.) Attends therapies with staff assistance and no more than minimal resistance by the patient. 4.) Cooperates with unit rules with staff prompting assistance and no more than minimal resistance by the patient. 5.) Takes medication without "cheeking" or hiding it. 6.) Makes some effort to work with treatment team on discharge planning. **D.) Medical:** 1.) Within individual capability, the patient is able to assist staff in attending to his/her medical needs to the extent that patient can go off of the unit and ABS with staff supervision.	There are no demotion criteria due to this being the lowest level. **Patients are automatically demoted to Level I/RED Level as a result of any of the following:** 1.) Elopement, attempted elopement, or threatening to elope from CLSH. 2.) Physically attacking anyone. 3.) Self-injurious behavior. 4.) Attempting suicide or suicidal threat. 5.) Destroying CLSH property. 6.) Destroying the property of others. 7.) Flagrant abuse of current privileges. 8.) Any special restriction other than medical. 9.) Possession of contraband posing significant danger to others such as guns, knives, sharpen objects, or illicit substances. 10.) Smoking inside any hospital building.

Central Louisiana State Hospital **Adaptive Behavior Service** **Patient Management System**

Level	General Description/Basic Characteristics	Privileges/Restrictions	Promotion Criteria (to Level III/GREEN Level)	Demotion Criteria
II **Y** **E** **L** **L** **O** **W**	**A.) General Overview:** Patients assigned to this level are considered to be capable of some movement around the ABS and the CLSH grounds with staff supervision. Patients assigned to this level have been determined not to require as intense of staff supervision as evidenced by the absence of the following: (1) any individual restrictions; and (2) any behaviors which would pose significant physical danger to others or self. Patients assigned to this level are at least minimally cooperative in obeying unit rules, as well as attending their prescribed therapies. Patients on this level should be at least minimally compliant with maintaining himself/herself as well as his/her personal bed area, or cooperating with staff in such tasks (within patient's capabilities). Patients may also be demoted to this level from Levels III (GREEN) or IV (BLUE) due to a demonstrated lack of self-initiative, and/or deterioration in behavioral or psychiatric status to the extent that would suggest the need for additional staff management – although not to the degree required for patients on Level I (RED). Some patients may be expected to remain at this level due to their inability to successfully function at a higher level of independence. **B.) Basic Characteristics:** 1.) Does not require non-medical precautions. 2.) Completes ADL's with staff assistance and no more than minimal resistance by the patient. 3.) Attends therapies with staff assistance and no more than minimal resistance by the patient. 4.) Cooperates with unit rules with staff prompting assistance and no more than minimal resistance by the patient. 5.) Takes medication without "cheeking" or hiding it. 6.) Makes some effort to work with treatment team on discharge planning.	**A.) Unit:** 1.) May leave patient unit with staff supervision. 2.) May request maximum allowance of $6.00 per week for non-necessity needs. May access available personal funds for personal necessities with treatment team approval. Any access to personal funds is subject to availability of funds. 3.) May not personally make any non-necessity purchases other than vending machines on Unit 7. Use of vending machines must be according to unit schedule, individual patient diet, and under staff supervision. Non-necessity items may not be bought by staff or other patients. 4.) May participate in recreation or other therapeutic activities on the patient unit complex. **B.) Service:** 1.) May move about on the ABS for therapy, meals and courtyard with staff supervision. 2.) Use of vending machines according to unit schedule, individual patient diet, and under staff supervision. Non-necessity items may not be \ bought by staff or other patients. 3.) May participate in recreation or other therapeutic activities on the ABS with staff supervision. **C.) Hospital Grounds:** 1.) No grounds or canteen privileges. 2) May move about grounds for therapy, sick-call, other hospital activities or court with staff supervision. Movement must be via hospital transportation only (except for activity therapies that involve walking, accompanied by staff, and is part of the patient's individualized plan). **D.) Off-Hospital Grounds:** 1.) No passes, other than of an emergency nature with treatment team approval, provided no adverse legal issues are involved. 2.) No CLSH sponsored outings. 3) May leave CLSH grounds only for medical or legal reasons.	**A.) General:** 1.) Must have spent a minimum of **two weeks** on Level II/YELLOW Level with no significant problems. **B.) Psychiatric:** 1.) Patient has psychiatric symptoms under control to extent that he/she is able to function off of his/her living unit with limited staff supervision, although not to the extent that he/she can be discharged. **C.) Behavioral:** 1.) Active participation in therapies as judged by treatment team (using team members' observations and progress notes). 2.) Performs ADL's with staff prompting. 3.) Follows unit rules with minimal staff prompting. 4.) Takes medication or discusses desire to change medications with treatment team. If refusing medication, cooperates with administrative review process by discussing reasons calmly with team and considering rational alternatives. 5.) If there are barriers to discharge (such as legal or lack of community supports) is willing to cooperate with treatment team's efforts at finding solutions. **D.) Medical:** 1.) Within individual capability, the patient is able to assist staff in attending to his/her medical needs to the extent that patient can go off of the unit and ABS with staff supervision.	**Demotion From Level II/YELLOW Level to Level I/RED Level:** 1.) Refusal to follow patient unit sign-out/ sign-in rules. 2.) Possession of minor contraband repeatedly (more than once in a week period), or any possession of dangerous contraband. 3.) Leaving patient unit without permission. 4.) Being in off-limits areas on the Service. 5.) Flagrant repeated refusal to attend scheduled therapies. 6.) Having food in bed area (more than once in a week period). 7.) Minor, but consistent abuse of Level II/ YELLOW Level privileges. 8.) Excessive verbal abuse. 9.) Minor, but consistent disobeying of unit rules. 10.) Refusal to maintain self, or allow staff to assist. 11.) Refusal to maintain personal bed area. 12.) Stealing. **NOTE: Patients are automatically demoted to Level I/RED Level as a result of any of the following:** 1.) Elopement, attempted elopement, or threatening to elope from CLSH. 2.) Physically attacking anyone. 3.) Self-injurious behavior. 4.) Attempting suicide or suicidal threat. 5.) Destroying CLSH property. 6.) Destroying the property of others. 7.) Flagrant abuse of current privileges. 8.) Any special restriction or precaution other than medical. 9.) Possession of contraband posing significant danger to others such as guns, knives, sharpen objects, or illicit substances. 10.) Smoking inside any hospital building.

Central Louisiana State Hospital **Adaptive Behavior Service** **Patient Management System**

Level	General Description/Basic Characteristics	Privileges/Restrictions	Promotion Criteria (to Level IV/BLUE Level)	Demotion Criteria
III **G** **R** **E** **E** **N**	**A.) General Overview:** This level is intended for those patients who have successfully attained a degree of behavioral control which reduces the level of required staff management to that of verbal assistance. Individuals promoted to this level should exhibit a higher than minimal degree of self-initiative for personal improvement as evidenced by consistently maintaining themselves and their personal bed areas at a level requiring verbal assistance, as well as attending and actively participating in their therapies (initiates participation) with little staff encouragement. Patients on this level will occasionally volunteer to help with the upkeep of their living unit. They are expected to exercise a reasonable degree of social judgement in responding to situations that they perceive as frustrating or unpleasant. Due to a decrease in the level of staff management required for individuals on this level, patients on this level are afforded a greater degree of independence compared to the lower levels. Patients may also be demoted to this level from Level IV (BLUE) due to a demonstrated lack of self-initiative, and/or deterioration in behavioral or psychiatric status to the extent that would suggest the need for additional staff management – although not to the degree required for patients on Levels II (YELLOW) or I (RED). Some patients may be expected to remain at this level due to their inability to successfully function at a higher level of independence. While patients on this level are occasionally considered for post-hospital placement, such placements are usually in structured environments such as group homes, or other facilities with a similar level of structure. **B.) Basic Characteristics:** 1.) Participates actively in therapies. 2.) Exhibits at least some prosocial behaviors such as initiating. conversation, greeting others, volunteering to help with unit upkeep. 3.) Reliable in being on time for meals, unit activities. 4.) Minimal staff prompting needed to keep up with unit schedule. 5.) Minimal or no staff prompting needed to keep bed area up. 6.) Minimal or no staff prompting needed to avoid arguments or fights. 7.) Minimal problems with accountability (seldom or never late in returning to unit. 8.) Readily accepts prompts to engage in prosocial behavior. 9.) Handles conflict without aggression.	**A.) Unit:** 1.) May leave patient unit with staff permission. Patient must observe rules for patient accountability. 2.) May request maximum allowance of $10.00 per week for non-necessity needs. May still access available personal funds for personal necessities with treatment team approval. Any access to personal funds is subject to availability of funds. 3.) May participate in recreation activities on the patient unit. **B.) Service:** 1.) May move about on the ABS for therapy and meals with staff supervision. Vending machine privileges consistent with service schedule and individual patient diet. 2.) May participate in recreation activities on the ABS with staff permission. 3.) ABS Courtyard privileges are allowed per ABS schedule and staff permission. Direct staff supervision is not necessary. **C.) Hospital Grounds:** 1.) May move about CLSH grounds for therapy, sick-call, other hospital activities or court **with direct staff supervision**. **D.) Off-Hospital Grounds:** 1.) No passes except with family. 2.) CLSH sponsored outings only if the Unit Physician and treatment team approve the patient going on a specific outing, and the Recreation staff are able to accommodate the supervision needs of the patient (in some cases unit staff may be required to accompany patient). Patient will require staff supervision. Prior approval by both parties by no later than the close of business for the working day prior to the activity. For this level, the ratio of Recreation/Unit staff to patients shall be no greater than 1:5. **NOTE: Being on this level is not an automatic guarantee that the patient can go on such outings.**	**A,) General:** 1.) Must have spent a minimum of **three weeks** on Level III (GREEN) with no significant problems. **B.) Psychiatric:** 1.) Patient has psychiatric symptoms under reasonable control and is able to demonstrate functional capacity to make safe decisions about everyday matters (personal safety and punctuality, for example). **C.) Behavioral:** 1.) Responsible behavior: maintain ADL's and bed area with no or very little prompting. 2.) Attend and actively participate in therapies willingly with no or very little prompting. 3.) Volunteers to help with unit upkeep. 4.) Initiates prosocial behaviors consistently handles conflict without aggression, and does not require staff prompts to do so. 5.) Actively participates in setting therapeutic goals and making discharge plans. 7.) If discharge is not an immediate option, patient actively participates with staff in planning active treatment as an inpatient. **D.) Medical:** 1.) Within individual capability, the patient is able to assist staff in attending to his/her medical needs to the extent that patient can go off of the unit, ABS, and CLSH with staff supervision.	**Demotion from Level III/GREEN Level to Level II/YELLOW Level:** 1.) Refusal to follow patient unit sign-out/ sign-in rules. 2.) Possession of minor contraband. 3.) Leaving patient unit without permission. 4.) Being in off-limits areas on the Service. 5.) Flagrant refusal to attend or participate in scheduled therapies. 6.) Having food in bed area. 7.) Minor, but consistent abuse of Level III/GREEN Level privileges. 8.) Excessive verbal abuse. 9.) Minor, but consistent disobeying of unit rules. 10.) Refusal to maintain self, or allow staff to assist. 11.) Refusal to maintain personal bed area. **Demotion Level III/GREEN Level to Level I/RED Level:** 1.) Stealing. 2.) Making false accusations towards other patients or staff. 3.) Inappropriate sexual behavior. 4.) Threatening others with violence or sexual acting out. **Patients are automatically demoted to Level I/RED Level as a result of any of the following:** 1.) Elopement from CLSH. 2.) Physically attacking anyone. 3.) Self-injurious behavior. 4.) Attempting suicide. 5.) Destroying CLSH property. 6.) Destroying the property of others. 7.) Flagrant abuse of current privileges. 8.) Any special restriction. 9.) Possession of contraband posing significant danger to others such as guns, knives, sharpen objects, or illicit substances. 10.) Smoking inside any hospital building.

Central Louisiana State Hospital **Adaptive Behavior Service** **Patient Management System**

Level	General Description/Basic Characteristics	Privileges/Restrictions	Promotion Criteria	Demotion Criteria
IV **B** **L** **U** **E**	**A.) General Overview:** Patients assigned to this level are expected to exhibit a considerable degree of responsible behavior. They maintain themselves and their personal bed areas with a minimum of verbal requests, little in the way of verbal prompting, and almost no physical assistance. Attendance and participation in prescribed therapies occurs with only a minimum of staff assistance and prompting. Patients on this level will consistently volunteer to help with the upkeep of their living unit. Social interaction with peers and staff is considered to be appropriate and consistent. Patients on this level are expected to exercise a reasonable degree of social judgement in responding to situations that they perceive as frustrating or unpleasant – with the resolution being practical and socially acceptable. Due to a significant decrease in the level of staff management required for individuals on this level, patients on this level are afforded a greater degree of independence. Patients on this level for four consecutive weeks should be considered for post-hospital placement . **B.) Basic Characteristics:** Active participation in treatment planning, setting goals, and working toward discharge (or if discharge not possible for legal or other reasons, is actively engaged in working with the treatment team on planning active inpatient treatment). 1.) Responsible behavior: maintain ADL's and bed area with no or very little prompting. 2.) Attend and actively participate in therapies willingly with no or very little prompting. 3.) Volunteers to help with unit upkeep. 4.) Initiates prosocial behaviors. 5.) Consistently handles conflict without aggression, and does not require staff prompts to do so. 6.) Actively participates in setting therapeutic goals and making discharge plans. 7.) If discharge is not an immediate option, patient actively participates with staff in planning active treatment as an inpatient.	**A.) Unit:** 1.) May leave patient unit with staff permission. Patient must observe rules for patient accountability. 2.) May request maximum allowance of $14.00 per week for non-necessity needs. May access available personal funds for personal necessities with treatment team approval. Any access to personal funds is subject to availability of funds. 3.) May participate in recreation activities on the patient unit. **B.) Service:** 1.) May move about on the ABS for therapy and meals with staff permission. 2.) Vending machine privileges consistent with service schedule, and individual patient diet. 3.) May participate in recreation activities on the ABS with staff supervision. 4.) ABS Courtyard privileges with staff permission. **C.) Hospital Grounds:** 1.) Grounds or canteen privileges are allowed per ABS schedule and staff permission. Patient must observe rules for patient accountability. 2.) May move about CLSH grounds for therapy, other hospital activities, sick-call, or court with staff permission. Patient must observe rules for patient accountability. **D.) Off-Hospital Grounds:** 1.) Passes with individuals approved by treatment team. 2.) CLSH sponsored outings only if the Unit Physician and treatment team approve the patient going on a specific outing, and the Recreation staff are able to accommodate the supervision needs of the patient (in some cases unit staff may be required to accompany patient). Patient will require staff supervision. Prior approval by both parties by no later than the close of business for the working day prior to the activity. For this level, the ratio of Recreation/Unit staff to patients shall be no greater than 1:5. **NOTE: Being on this level is not an automatic guarantee that the patient can go on such outings.**	There are no promotion criteria as this is the highest level in this system. The patient's treatment team should begin actively pursuing post-hospital placement if the patient has maintained this level for four consecutive weeks. If discharge is not a legal option or if medical criteria postpone discharge, the team is allowed to write special enhancements, with the patient's active participation, or plans that can motivate the patient to maintain therapeutic gains and foster active treatment. An example might be allowing special recreational activities chosen by the patient. This is not required but is an option for the patient and team to consider.	**Demotion from Level IV/BLUE Level to Level III/GREEN Level:** 1.) Refusal to follow patient unit sign-out/ sign-in rules. 2.) Possession of minor contraband. 3.) Leaving patient unit without permission. 4.) Being in off-limits areas on the Service. 5.) Flagrant refusal to attend or participate in scheduled therapies. 6.) Having food in bed area. 7.) Minor, but consistent abuse of Level IV/BLUE privileges. 8.) Excessive verbal abuse. 9.) Minor, but consistent disobeying of unit rules. 10.) Refusal to maintain self, or allow staff to assist. 11.) Refusal to maintain personal bed area. 12.) Persistent refusal to follow prescribed diet. **Demotion from Level IV/BLUE Level to Level II/YELLOW Level:** 1.) Stealing. 2.) Making false accusations towards other patients or staff. 3.) Inappropriate sexual behavior. 4.) Threatening others with violence or sexual acting out. **Demotion from Level IV/BLUE Level to Level I/RED Level (Patients are automatically demoted to Level I/RED Level as a result of any of the following):** 1.) Elopement from CLSH. 2.) Physically attacking anyone. 3.) Self-injurious behavior. 4.) Attempting suicide. 5.) Destroying CLSH property. 6.) Destroying the property of others. 7.) Flagrant abuse of current privileges. 8.) Any special restriction. 9.) Possession of contraband posing significant danger to others such as guns, knives, sharpen objects, or illicit substances. 10.) Smoking inside any hospital building.

OPERATIONAL GUIDELINES FOR ABS LEVELS SYSTEM:

1.) All promotions within the ABS Levels System will be approved by the treatment team and have a physician's order.

2.) All demotions within the ABS Levels System will be approved by the treatment team and have a physician's order.

3.) In instances requiring an instant demotion, a physician's order is required (Unit Physician, Service Program Director, Hospital Medical Director, or MOD.

4.) Individual patients having difficulty moving off of a particular level, such as Level I, may require an individualized behavior program from their treatment team to assist them in their therapeutic progress.

5.) Patients are allowed to go on off-campus CLSH outings only if the Unit Physician and treatment team approve that patient going on a specific outing (physician's order required), and the Recreation staff are able to accommodate the supervision needs of the patient. In some cases, unit staff may be required to accompany the patient. Patient will require staff supervision in all cases. Prior approval by both parties by no later than the close of business for the working day prior to the activity. The ratio of Recreation/Unit staff to patients shall be no greater than 1:5. **NOTE: Only patients on Levels III and IV are eligible for consideration to go on off-campus outings. However, being on these levels is not an automatic guarantee that the patient can go on such outings.**

6.) Patient levels will be identified by color coding their individual schedules, which they must have in their possession when they are off the unit; otherwise, they will be treated as a Level I patient and returned to the unit.

7.) Color coding will be as follows: Level I – Red; Level II – Yellow; Level III - Green; Level IV – Blue.

8.) A Physician may temporarily remove a patient from the ABS Levels System for significant medical reasons (Example: A patient returning from surgery and requiring staff supervision). There must be a physician's order removing the patient and indicating specific staff supervision required, as well as privileges granted during this period.

ADMINISTRATION OF MEDICATION

STEP 3 IN THE MEDICATION USE PROCESS

Administering the right medication to the right patient

Administering the medication when indicated

Informing the patient about the medication

Including the patient in administration

Policy

Only licensed personnel are authorized to administer medications or treatments, which involve the use of medication. Psychiatric aides may not administer medication.

Only licensed personnel may administer IM medications.

Only physicians and RN's with clinical practice privileges to do so may give IV medication or administer tube feedings.

Only licensed personnel will enter information on the medication sheet (drug, dosage, time, etc.) This duty cannot be delegated to unlicensed personnel.

Policy - Administration of Medication

It is the responsibility of the nurse giving medication to assure that all patients ordered medication have had their medication administered.

Procedure

Psychiatric aides may assist the licensed nurse by having patients come to the Medicine Room. However, if a patient is either unable or unwilling to do so, the licensed nurse must physically go to the patient and attempt to administer the medication at bedside or in any other location on the patient care unit. (September 1995)

POLICY

Accurate identification of the patient must be made prior to the administration of medication or performing any procedure including (but not limited to) laboratory procedures and dental procedures. A minimum of two patient identifiers must be used.

CLSH will utilize the following patient identifiers:

Current patient photograph attached to the MAR or the current photograph in the patient record.

Identification of the patient by Name by the Psychiatric Aide or another staff member who knows the patient.

PROCEDURE

Medication

The patient's photograph placed in the MAR should be checked as the patient identifies him/herself for medication administration. A psychiatric aide familiar with the patient should also identify the patient by name. If there is not an aide present who can identify the patient, medication will be held until a psychiatric aide or another staff member familiar with the patient can identify the patient.

Other Procedures

The patient's record containing a current photograph of the patient will accompany the patient at the time of procedure. The patient will be identified by name by a psychiatric aid familiar with the patient prior to the procedure. Additionally, the individual performing the venipuncture or procedure will ask the patient his/her name and verify that the stated name matches the patient's record and photograph.

Policy - Medication Administered by Licensed Personnel Preparing Dose

Medication is to be administered only by the licensed nursing person who prepared the medication.

- **To insure accurate results when preparing of giving medicines, concentrate undivided attention upon what you are doing. Do not permit conversation or other distractions to interfere with our preparation of doses for administration.**
- **The term "PO" medication refers to the route of administration. It is understood that medications are given in a solid dosage form (i.e.- tablet or capsule) unless the order specifies the medication is to be given liquid.**
- **Read each entry in the Medication Administration Record (MAR) carefully. Check to see that the MAR is accurate and legible.**
- **When calculating doses be sure that the calculation is correct. If in doubt, verify it by checking with the nursing supervisor, a physician or pharmacist.**
- **If a drug dose exceeds the maximum allowable dosage and there is no written justification by the physician as to the reason, check with the nursing supervisor or the responsible physician or O.D. physician.**
- **Always read the label on the bottle or until dose strip three times; before taking it from the patient bin, before preparing the medication and before returning it to the bin.**
- **Unmarked or Unlabeled medication is never to be used. Typed medication labels, unit dose prepackaging labels or manufacturer labels are to be on all medication until the time of administration. Only a pharmacist or authorized pharmacy personnel under the direction and supervision of a pharmacist may make labeling changes.**
- **Shake appropriately any bottle of liquid medication.**
- **When pouring liquid medication, hold the bottle with the label upward to avoid soiling it. Use a piece of tissue to wipe the, outside of the bottle before replacing the cap.**

- **Measure liquid quantities as ordered, using the proper disposable graduated medicine cup, the marked dropper, or by combining appropriate amounts of prepackaged unit dose liquids corresponding to the exact dosage ordered.**
- **When measuring fluids, hold the graduated cylinder or cup so that the line indicating the desired quantity is on level with the eye. The quantity is read when the lowest part of the concave surface of the fluid is on this line.**
- **Never put a medicine back into a bottle. If a liquid unit dose prepackaged seal is broken, do not administer the drug to the patient.**
- **Use the cap of the bottle or the unit dose-packaging strip to help get the tablet into the desired container for administration. Do not handle the tablets or capsules with the fingers. Wash hands before preparing medication.**
- **If medications change color or form a precipitate when mixed, do not give the medications together. Report this fact to a pharmacist. (Some medications are incompatible because of the chemical reaction which takes place)**
- **Always recap bottles immediately after pouring medication.**
- **Irritating and distasteful drugs may be diluted with an appropriate liquid unless otherwise ordered. Provide water with medications unless contraindicated.**
- **Medication should be poured immediately prior to administration to a single patient. Mass pre-pouring of medication should not be done as it allows for a greater margin of discrepancy in administering medication and deters positive identification of medication.**

<u>Unit Dose medications are never to be "stripped" out of the package until time of administration.</u>

- **Patients should be positively identified prior to administration of a dose of medication.**
- **Self-administration of medication by patients is permitted on a specific written order by the physician and in accordance with established hospital policy.**
- **If the patient refuses the oral form of a medication, an order from a physician is needed before the intramuscular route may administer the drug.**
- **Medication refused by a patient that is in the original unopened container should be returned to the Pharmacy.**

Under NO CIRCUMSTANCE should solid dose forms of medication be thrown into a trashcan! The ONLY method for proper disposition of solid oral dosage forms is for the nurse to discard the medication in the sharps container. The nurse may discard any medication refused, contaminated, adulterated, or otherwise rendered unfit for administration which is in a liquid, injectable or tablet form.

Procedure:

To dispose of oral liquid or injectable liquid medication (other than Controlled Substances) rendered unfit for administration, it shall be flushed in the Medicine Room with witness.

Ethics Policy

LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**AP-17**
Content	**Ethics**
Effective Date	April 20, 1994
Reviewed	4/95, 4/96, 4/97, 4/99, 1/00, 5/05, 08/19
Revised	5/02, 8/14, 11/15, 09/17
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Administration

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital that all employees adhere to the highest level of ethical standards of conduct in carrying out their duties and responsibilities. When ethical issues arise for which there is no clear standard, it is the policy that there be a mechanism by which those issues can be addressed and a standard developed which allows for the highest level of conduct, giving consideration to patient, family, employee, agency and public concerns.

Furthermore, it is the policy of this agency that patients, their representatives and employees be educated concerning these standards and on mechanisms for addressing ethical issues.

II. PURPOSE

To assure the highest level of care, treatment, and personal conduct.

III. APPLICABILITY

All hospital settings.

IV. EFFECTIVE DATE

The effective date is April 1994.

V. POLICY PROVISIONS/PROCEDURES

STANDARDS

All employees shall comply with the Code of Governmental Ethics for State Officials and Employees, a copy of which is kept in the Personnel Office and may be referred to as needed. When employees believe that they may be in conflict with any part of that code, they must notify the personnel officer for guidance. If it is determined that employees are in violation of the code, they will be ordered to alter their conduct in order to bring them back into compliance with the code.

All professional disciplines shall adhere to the ethical standards of conduct as developed and prescribed by the professional societies of which they are members. Each department head who supervises professional employees shall obtain a copy of the respective professional society's ethical standards of conduct and maintain a copy of those standards for reference by its employees/members.

ISSUES

It is recognized that ethics and the values by which they are determined are continually changing based on morals, life styles, social pressures, education, etc. and that there must be a mechanism for addressing those changes. When an ethical issue arises that has never been addressed, the following procedures shall be followed:

- Any person (patient, family member, advocate, employee, etc.) who believes that there is an issue involving ethics which needs to be addressed may discuss that issue with a treatment team member, department head, and/or a program director/manager.

- The treatment team member, department head, and/or program director/manager shall review all elements of the issue and make a decision regarding its merit. If a decision cannot be made, the issue shall be referred to the following:

  PATIENT CARE ISSUES - Matters not other wise addressed by a standing committee involving patient care shall be addressed by an adhoc committee appointed by the Appointing Authority. The Medical Executive Committee shall review all elements of the issue and make a decision regarding its merit.

  ADMINISTRATIVE & SUPPORT ISSUES - Matters involving the administrative and support functions of the hospital shall be brought to the Executive Management Team (EMT). EMT shall review all elements of the issue and make a decision regarding its merit.

  PERSONNEL ISSUES - Matters involving employee(s) conduct that do not affect one of the two above areas shall be brought to the Chief Executive Officer. The Chief Executive Officer shall review all elements of this issue and make a decision regarding its merit.

EDUCATION AND TRAINING

Patients & Patient Representatives – Ethical principles of care and treatment are made available to all patients and their representatives through the Patient/Family Handbook.

Employees - New Employees shall receive training regarding this policy during new employee orientation and annually.

ADHOC ETHICS COMMITTEE

The AdHoc committee referenced above shall be educational and advisory in nature. Its function will be to consider and assist in resolving unusual, complicated ethical problems involving issues that affect the care and treatment of patients within the hospital. Recommendations of the committee impose no obligation for acceptance on the part of any involved party. Recommendations will be referred to MEC for decision making purposes.

The committee shall be an ad hoc consultation team composed of at least 5 members including:

CEO

Med. Director (or designee)
DON
Clients Rights Officer
Mental Health Advocate

Other disciplines may be included as necessary.

References: American Medical Association Opinion 9.11- *Ethics Committees in Health Care Institutions*(1995)retrieved 4/14/2014 from http://www.ama-assn.org

MANAGEMENT DISCLOSURES

The Chief Executive Officer reserves the right to add, alter, change, or delete any and all prescribed policies and procedures of the agency as needs dictate without the necessity of giving prior notice and request for consent from employees or employee representatives. This includes the right to add, alter, change, or delete all work assignments, duties, requirements and responsibilities of Sections, Departments, Units, and individual employees. Violations of this policy may result in disciplinary action up to and including dismissal. All policies are available on the Central Louisiana State Hospital Intranet. Signed originals of each policy are available in the office of the Hospital Administrator.

Violence Prevention Program – Plan of Action	
LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**AP-28**
Content	Violence Prevention
Effective Date	08/97
Reviewed	04/99, 01/00, 05/02, 05/08, 09/12, 05/15, 04/17
Revised	02/05, 02/19
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Administration

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital to work toward a violence free workplace for state employees. CLSH complies with the Louisiana Department of Health (LDH) Workplace Violence Policy 85.1. Failure to comply with this policy could result in disciplinary action per LDH policy.

II. PURPOSE

The purposes of this plan are to:

1. Direct implementation of effective security measures and administrative work practices to minimize exposure to conditions that could result in harm to state workers;

2. Promote a positive, respectful and safe work environment that fosters employees' security, safety and health; and

3. Require ongoing analysis of the workforce and each work site for hazard prevention and control.

III. APPLICABILITY

All hospital settings. This policy applies to all CLSH employees, including contract and civil service staff.

IV. EFFECTIVE DATE

The effective date of this policy is August 1997.

V. POLICY PROVISIONS/PROCEDURES

Definitions:

1. **Assault** - Assault is an attempt to commit a battery or the intentional placing of another in reasonable apprehension of receiving a battery. (Example: I may have a stick raised and know

that I have no intention of striking you but, based on the circumstances, you have a reasonable apprehension that I plan to strike you.)

2. **Battery** - Battery is the intentional use of force or violence upon another or the intentional administration of a poison or other noxious liquid or substance to another.

3. **Credible Threat** - A credible threat is a statement or action that would cause a reasonable person to fear for the safety of him/herself or that of another person and does, in fact, cause such fear.

4. **Intentional** - Intentional refers to conduct when the circumstances indicate that the offender, in the ordinary course of human experience, must have considered the criminal consequences as reasonably certain to result from his act or failure to act.

5. **Violence** - Violence is the commission of an assault or battery or the making of a credible threat.

6. **Workplace** - The workplace is any site where an employee is placed for the purpose of completing job assignments.

7. **Workplace Violence** - Workplace violence is violence that takes place in the workplace.

Procedure:

Employees are the State's most valuable resource and their safety and security are essential to carrying out their responsibilities. Every employee has a reasonable expectation to perform his/her assigned duties in an atmosphere free of violence, including threats, harassment, and assaults.

Recognizing the increasing incidence of violence in the workplace, the Governor of the State of Louisiana issued an executive order committing the Governor and the State of Louisiana to work toward a violence free workplace for state employees.

The Louisiana Department of Health as well as Central Louisiana State Hospital fully supports this effort and is committed to a violence free workplace.

Management Responsibilities:

Central Louisiana State Hospital shall comply with federal and state statutes, rules, regulations and guidelines in making reasonable efforts to:

1 hire, train, supervise and discipline employees;

2 intervene in situations of harassment in the workplace where the employer is aware of the harassment;

3 ensure employees and/or independent contractors are fit for duty and do not pose unnecessary risks to others;

4 provide security precautions and other measures to minimize the risk of foreseeable criminal intrusion based upon prior experience or location in a dangerous area;

5 maintain an adequate level of security;

6 establish and implement a written policy and plan dealing with violence in the workplace;

7 provide employee training on the agency plan, warning signs of potential for violent behavior, and precautions which may enhance the personal safety of the employee at work;

8 warn an employee of a credible threat made by another to do harm to that employee;

9 support the application of sanctions and/or prosecution of offenders, as appropriate;

10 accommodate, after appropriate evaluation, employees who require special assistance following incident(s) of workplace violence;

11 cooperate with law enforcement agencies;

12 establish a uniform violence reporting system with regular review of submitted reports;

13 initiate procedures to protect from retaliation employees who report credible threats; and

14 keep up-to-date records to evaluate the effectiveness of administrative and work practice changes initiated to prevent workplace violence.

Management Commitment:

1. At Central Louisiana State Hospital, management commitment, including the endorsement and visible involvement of top levels of supervision, provides the motivation and resources to deal effectively with workplace violence and includes:

    a. organizational concern for employee emotional and physical safety and health;

    b. commitment to the safety and security of all persons at the workplace;

    c. assigned responsibility for the various aspects of the workplace violence prevention program to ensure that all supervisors and employees understand their roles and responsibilities; (**mandatory**)

    d. allocation of authority and resources to all responsible parties;

e. accountability for involved supervisors and employees;

f. debriefing/counseling for employees experiencing or witnessing assaults and other violent incidents;

g. support and implementation of appropriate recommendations from violence prevention committees; and

h. treatment of workplace violence, incidents, complaints and concerns with seriousness, keeping confidential all reports and the identification of parties, except to those who have a legitimate need to know and to the extent required by law. (**mandatory**)

Employee Responsibilities:

At Central Louisiana State Hospital:

1. Employees are required to report to the immediate supervisor all threats or incidents of violent behavior in the workplace which they observe or of which they are informed. Examples of inappropriate behavior which shall be reported include:

   a. unwelcome name-calling, obscene language, and other abusive behavior;

   b. intimidation through direct or veiled verbal threats; (To mask, hide, conceal, unrevealed implied threat.)

   c. physically touching another employee in an intimidating, malicious, or sexually harassing manner, including such acts as hitting, slapping, poking, kicking, pinching, grabbing, and pushing; and

   d. physically intimidating others including such acts as obscene gestures, "getting in your face," fist-shaking, throwing any object. Intentionally causing an employee to feel inadequate or afraid.

2. Employee involvement and feedback enable workers to develop and express their own commitment to safety and security and provide useful information to design, implement, and evaluate the program. At Central Louisiana State Hospital, employee involvement includes, but is not limited to:

   a. understanding and complying with the workplace violence prevention program and other safety and security measures;

   b. participating in employee complaint or suggestion procedures covering safety and security concerns;

c. providing prompt and accurate reporting of violent incidents;

d. cooperating with the safety and security committee that reviews violent incidents and security problems and makes security inspections; and

e. participating in continuing education covering techniques to recognize and abate escalating agitation, assaultive behavior or criminal intent.

Incidence Response and Evaluation:

1. Assistance for victimized employees and for employees who may be affected by witnessing a workplace violence incident will be provided. Whenever an incident takes place, injured employees will receive appropriate medical treatment and psychological evaluation as necessary, in accordance with existing statutes. At Central Louisiana State Hospital this assistance is provided through the Chief Executive Officer and the Environmental Health and Safety Committee.

2. An employee who has been threatened or assaulted by another at the workplace will immediately report the situation to his/her supervisor. The supervisor to whom the incident is reported will immediately notify the Chief Executive Officer, Safety Officer, Chairman of the Environmental Health and Safety Committee, Chief of Security, and the Human Resource Director.

3. Written statements shall be obtained from all involved, including those who witnessed the incident. A statement form which may be used is found in Attachment 3, "Violence Incident Statement." The form is designed to answer the WHO, WHAT, WHEN, WHERE, HOW, and WHY of the incident while the event is still fresh. Concurrent with obtaining the written statements or as soon as possible thereafter, the Safety Officer and the Chief of Security shall interview all parties to the incident, including victims, subjects and witnesses, and prepare written summaries of the interviews. The summaries shall be the bases on which to determine the facts of the event.

4. The following actions should be taken in accordance with the severity of the incident:

   a. The situation is not **dangerous:**

      i. separate employees involved and isolate until they are interviewed and their statements are taken;

      ii. separate witnesses until they are interviewed and their statements are taken; and

      iii. document all actions and statements.

   b. The situation is **dangerous:**

I. contact local police by dialing 911 Hospital Security and the Safety Officer by calling the Operator by dialing Zero;

ii. order all those presenting the danger to leave the facility immediately (unless this action must be taken by police/security);

iii. do not attempt to physically remove an individual (leave it to the police/security); and

iv. document all actions and statements.

5. Additional information concerning post incident response and evaluation can be found in Attachment 4, "Incident Response."

Records:

1. Records associated with violence in the workplace need to be kept in a permanent, secure, and confidential manner. The Safety Officer shall keep all records/documentation of violence in the work place. It shall be the responsibility of the Environmental Health and Safety Committee to help evaluate security, methods of hazard control, and identify training needs. The following records are important and shall be maintained in accordance with pertinent statutes as part of the violence prevention program:

   a. reports of work injury, including workers' compensation injuries, if necessary;

   b. report for each reported assault, incidents of abuse, verbal attack, or aggressive behavior occurring between persons in the workplace;

   c. police reports of incidents occurring in the workplace;

   d. minutes of safety meetings, records of hazards' analysis, and corrective actions recommended;

   e. violence in the workplace training, including subjects covered, attendees, and qualifications of trainers; and

   f. other appropriate reports.

Evaluation:

1. Regular evaluation of safety and security measures affecting the violence prevention program shall be conducted at least annually. At Central Louisiana State Hospital, this evaluation shall be the responsibility of the Environmental Health and Safety Committee.

2. The evaluation program consists of:

    a. reviewing reports and minutes from staff meetings on safety and security issues;

    b. analyzing trends in illness/injury or fatalities caused by violence;

    c. measuring improvement based on lowering the frequency and severity of workplace violence;

    d. surveying employees before and after making job or workplace changes or installing security measures or new systems to determine their effectiveness;

    e. requesting periodic outside review of the workplace for recommendations on improving employee safety; and

    f. interviewing employees who experience hostile situations about the medical treatment received (initially, several weeks later, and several months later).

Communication:

1. At Central Louisiana State Hospital, we recognize that to maintain a safe, healthy and secure workplace, we must have open communication among employees, including all levels of supervision, on these issues. The open communication process includes, but is not limited to:

    a. periodic review of this policy with all employees;

    b. discussions of violence in the workplace during scheduled safety meetings;

    c. posting or distributing information on violence in the workplace; and

    d. procedures to inform supervisors about violence in the workplace, hazards, or threats of violence.

2. The immediate supervisors shall provide an appropriate place for employees to discuss security concerns with assurance that necessary confidences will be maintained.

Training and Education:

1. At Central Louisiana State Hospital,

a. all employees, including all levels of supervisors shall have training and instruction on general, job-specific, and work site-specific safety and security practices; **(mandatory)**

b. training and instruction shall be provided within one year of policy implementation and regularly thereafter; and **(mandatory)**

c. training shall begin with orientation of new employees within three months of employment and regularly thereafter. **(mandatory)**

2. At Central Louisiana State Hospital, workplace violence training shall be the responsibility of Safety Officer in coordination with the Education and Training and Human Resource Department.

3. General violence in the workplace training and instruction address, but are not limited to, the following areas:

a. explanation of the violence in the workplace policy as established by Central Louisiana State Hospital;

b. measures for reporting any violent acts or threats of violence;

c. recognition of hazards including associated risk factors;

d. measures to prevent workplace violence, including procedures for reporting workplace hazards or threats to appropriate supervisor;

e. ways to defuse hostile or threatening situations;

f. measures to summon others for assistance;

g. routes of escape available to employees;

h. procedures for notification of law enforcement authorities when a criminal act may have occurred;

i. procedures for obtaining emergency medical care in the event of a violent act upon an employee; and

j. information on securing post-event trauma counseling for those employees desiring or needing such assistance.

Additional Information Concerning Workplace Violence:

1. Attachment 5, "Workplace Violence Checklist," may be used in identifying present or potential workplace violence problems.

2 Attachment 6, "Recognizing Inappropriate Behavior," may be helpful in identifying the types of behavior this policy forbids.

3. Attachment 7, "Personal Conduct to Minimize Violence," may be helpful to an individual in understanding what he/she might do to prevent violence.

Related Policies & Documents:

Attachments:

Administrative and Work Practice Controls
Violence Incident Report Form
Recognizing Inappropriate Behavior
Personal Conduct to Minimize Violence

MANAGEMENT DISCLOSURES

The Chief Executive Officer reserves the right to add, alter, change, or delete any and all prescribed policies and procedures of the agency as needs dictate without the necessity of giving prior notice and request for consent from employees or employee representatives. This includes the right to add, alter, change, or delete all work assignments, duties, requirements and responsibilities of Sections, Departments, Units, and individual employees. Violations of this policy may result in disciplinary action up to and including dismissal. All policies are available on the Central Louisiana State Hospital Intranet. Signed originals of each policy are available in the office of the Hospital Administrator.

ADMINISTRATIVE AND WORK PRACTICE CONTROLS

Administrative and work practice controls affect the way jobs or tasks are performed. The following examples illustrate how changes in work practices and administrative procedures can help prevent violent incidents.

State clearly to patients, clients, and employees that violence is not permitted or tolerated.

Establish liaisons with local police and state prosecutors. Report all incidents of violence. Provide police with physical layouts of facilities to expedite investigations.

Require employees to report all assaults or threats to a supervisor or manager (e.g., can be confidential interview).

Keep log books and reports of such incidents to help in determining any necessary actions to prevent further occurrences.

If needed, advise and assist employees of procedures for requesting police assistance or filing charges when assaulted.

Provide management support during emergencies. Respond promptly to all complaints.

Set up a trained response team to respond to emergencies.

Use properly trained security/police officers, when necessary, to deal with aggressive behavior, or dial 911 or 9-911, as appropriate. Follow written security procedures.

Ensure adequate and properly trained staff for restraining patients or clients.

Provide sensitive and timely information to persons waiting in line or in waiting rooms. Adopt measures to decrease waiting time.

Ensure adequate and qualified staff coverage at all times, taking into account the times of greatest risk at each facility.

Institute a sign-in procedure with passes for visitors. Enforce visitor hours and procedures.

Control access to facilities other than waiting rooms or other public access rooms.

Prohibit employees from working alone in areas of substantial risk, particularly at night or when assistance is unavailable.

Establish policies and procedures for secured areas and emergency evacuations.

Ascertain the behavioral history of new and transferred patients and clients to learn about any past violent or assaultive behaviors. Establish a system such as chart tags, log books, or verbal census reports to identify patients and clients with assaultive behavior problems, keeping in mind patient confidentiality and worker safety issues. Update as needed.

Treat and/or interview aggressive or agitated individuals in relatively open areas that still maintain privacy and confidentiality (e.g., rooms with removable partitions).

Use case management conferences with co-workers and supervisors to discuss ways to effectively treat potentially violent individuals.

Prepare contingency plans to deal with individuals who are "acting out" or making verbal or physical attacks or threats.

Transfer assaultive clients to "acute care units," "criminal units," or other more restrictive settings.

Periodically survey the facility to remove tools or possessions left by visitors or maintenance staff which could be used inappropriately.

Provide staff with identification badges, preferably without last names, to readily verify employment.

Provide staff members with security escorts to parking areas in evening or late hours. Parking areas should be highly visible, well-lighted, and safely accessible to the building.

Use the "buddy system," especially when personal safety may be threatened. Encourage employees to avoid threatening situations. Staff should exercise extra care in elevators, stairwells, and unfamiliar surroundings. Immediately leave premises if there is a hazardous situation and request security/police escort, if needed.

Develop policies and procedures covering how off-site visits will be conducted, the presence of others during the visits, and the refusal to provide services in a clearly hazardous situation.

Establish a daily work plan for field staff to keep a designated contact person informed about workers' whereabouts throughout the workday. If an employee does not report in, the contact person should follow up.

Conduct a comprehensive post-incident evaluation, including psychological as well as medical treatment, for employees who have been subjected to abusive behavior.

VIOLENCE INCIDENT STATEMENT

NOTE: The contents of this document shall be kept confidential with its contents released only to individuals with a legitimate need to know or unless it becomes public record by virtue of an appeal to a court or other adjudicative body.

Date of Incident:	**Place of Incident:**
Time Incident Began:	**Time ended:**
Name:	**Phone Number:**
Title:	**Work Location:**
Detailed description of incident. Answer all questions - WHO, WHAT, WHEN, WHERE, HOW and WHY. (If necessary, continue on plain paper and attached sheets.) Completed statement should be forwarded to appropriate personnel.	
Completed by:	**Date:**

RECOGNIZING INAPPROPRIATE BEHAVIOR

Inappropriate behavior is often a warning sign of potential hostility or violence. When left unchecked, it can escalate to higher levels. Employees who exhibit the following behaviors should be reported and disciplined in accordance with the organization's policies:

- Unwelcome name-calling, obscene language, and other abusive behavior.
- Intimidation through direct or veiled threats.
- Throwing objects in the workplace regardless of the size or type of object being thrown or whether a person is the target of a thrown object.
- Physically touching another employee in an intimidating, malicious, or sexually harassing manner. That includes such acts as hitting, slapping, poking, kicking, pinching, grabbing, and pushing.
- Physically intimidating others including such acts as obscene gestures, "getting in your face," and fist-shaking.

PERSONAL CONDUCT TO MINIMIZE VIOLENCE

Follow these suggestions in your daily interactions with people to defuse potentially violent situations. If at any time a person's behavior starts to escalate beyond your comfort zone, withdraw from the situation.

Do

- Project calmness: move and speak slowly, quietly, and confidently.
- Be a good listener: encourage the person to talk, and listen patiently.
- Focus your attention on the other person to demonstrate your interest in what he/she has to say.
- Maintain a relaxed yet attentive posture and position yourself at an angle rather than directly in front of the other person.
- Acknowledge the person's feelings by gestures such as nodding your head.
- Ask the person to move to a less public, quiet area, if appropriate.
- Establish ground rules if unreasonable behavior persists. Calmly describe the consequences of any violent behavior.
- Use delaying tactics which will give the person time to calm down. For example, offer a drink of water (in a disposable cup).
- Be reassuring and point out choices. Identify and deal with specific issues.
- Accept criticism in a professional manner.
- Ask for his/her recommendations. Repeat back to him/her what you feel he/she is requesting of you.
- Position yourself so that a visitor cannot block your access to an exit.

Do Not

- Make false statements or promises you cannot keep.

- Try to impart a lot of technical or complicated information when emotions are high.
- Take sides or agree with distortions.
- Invade the individual's personal space. Make sure there is a space of three to six feet between you and the person.
- Use styles of communication which generate hostility such as apathy, brush off, coldness, condescension, robotism, going strictly by the rules, or giving the run-around.
- Reject all of an individual's demands from the start.
- Pose in challenging stances such as standing directly opposite someone, hands on hips or crossing your arms. Avoid any physical contact, finger-pointing, or long periods of fixed eye contact.
- Make sudden movements which can be seen as threatening. Notice the tone, volume, and rate of your speech.
- Challenge, threaten, or dare the individual. Never belittle the person or make him/her feel foolish.
- Criticize or act impatiently toward the agitated individual.
- Attempt to bargain with a threatening individual.
- Try to make the situation seem less serious than it is.

Fire Arms on Hospital Grounds	
LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**AP-29**
Content	**Fire Arms on Hospital Grounds**
Effective Date	08/97
Reviewed	04/99, 05/02, 05/05, 05/08
Revised	01/00, 06/12, 04/15, 01/17, 11/18, 02/19
Approved By	CLSH-CEO, signature on file w/ policy coordinator
Inquiries to	Administration

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital to comply with Louisiana Law R.S. 14:402.1 (Introduction of Contraband onto State Owned Hospital Property). There shall be no firearms on the grounds except as authorized by this policy.

II. PURPOSE

To comply with Louisiana Law R.S. 14:402.1

AUTHORITY: Louisiana Law R.S. 14:402.1

III. APPLICABILITY

All hospital settings

IV. EFFECTIVE DATE

The effective date of this policy is August 1997.

V. POLICY PROVISIONS/PROCEDURES

Definitions:

Commissioned Peace Officer: Police Officer, Security Guard, Sheriff Deputy, Marshal, Corrections Officer, Constable and Probation and Parole Officer responsible for enforcement of Federal, State and/or local laws, and commissioned with arrest power, and authority to carry a firearm.

1. Only on-duty commissioned peace officers are allowed to carry firearms on the grounds while performing official duties in matters directly related to the hospital, employees, patients or visitors. All other peace officers or law enforcement personnel (i.e., those not on grounds in performance of their duties) are to lock their weapons in the trunk of their vehicle.

2. Prior to a peace officer entering a patient unit, courtyard, or admission building, the officer on official business will be escorted by CLSH Security. If at all possible, the law enforcement officer will be asked if the client or staff that he or she came to see can be brought with staff outside of the unit to be questioned.

3. If an employee or visitor has a weapon, the weapon will be checked in at the front gate and placed in a safe.

- The weapon must be unloaded by the owner before checking it in at the front gate.
- CLSH security personnel shall wear gloves when handling the weapon
- CLSH security must check that the safety is engaged prior to receiving the weapon
- The weapon will be logged in and locked in the gun safe
- The gun safe is locked at all times and only security personnel have a key to the safe
- When leaving CLSH grounds the visitor/employee will pick up their weapon and check out that they received their weapon.
- Weapons shall not be reloaded while on CLSH grounds
- Weapons shall be returned to the owner using the same safety procedure as detailed above

4. Any CLSH employee who is aware that a peace officer has entered or is about to enter a patient unit, courtyard, or admissions office with a weapon are to call CLSH security immediately for escort

5. Law enforcement officers on official duty are forbidden by their departments to take off their weapons.

5. The only exception is if a person in a patient unit, courtyard, or admissions building is armed with a dangerous weapon as defined by R.S. 14:2. Pineville Police and CLSH Security shall be called.

   Dangerous Weapons are defined as: any gas, liquid firearm, knife or other substance or instrumentality, which, in the manner used, is calculated or likely to produce death or great bodily harm.

   A peace officer may be called to assist Hospital Security to bring the situation under control. Any use of force by a peace officer shall be reviewed by the Chief Executive Officer, Chief of Security, Director of Nursing, Clients Rights Officer, and the appointing authority which the peace officer represents. A written report shall be submitted to the Executive Management Team.

Refer to LDH Policy 68.1 Weapons in the work place.

MANAGEMENT DISCLOSURES

The Chief Executive Officer reserves the right to add, alter, change, or delete any and all prescribed policies and procedures of the agency as needs dictate without the necessity of giving prior notice and request for consent from employees or employee representatives. This includes the right to add, alter, change, or delete all work assignments, duties, requirements and responsibilities of Sections, Departments, Units, and individual employees. Violations of this policy may result in disciplinary action up to and including dismissal. All policies are available on the Central Louisiana State Hospital Intranet. Signed originals of each policy are available in the office of the Hospital Administrator.

CENTRAL LOUISIANA STATE HOSPITAL POLICE DEPARTMENT

FRONT GATE WEAPONS STORAGE/RELEASE FORM

NAME OF REGISTERED OWNER: _____

CELL PHONE #: _____ Work PHONE #: _____

TYPE OF WEAPON: _____ **All Weapons Will Be Locked In Safe**

DATE/TIME CHECK IN	DATE/TIME CHECK OUT	OWNERS INITIALS	OFFICERS INITIALS

SECURITY SIGNATURE:_____

POSSESSOR SIGNATURE: _____

Central Louisiana State Hospital Is Not Responsible For Any Damage Done To Weapon.

Client Abuse and Neglect Policy and Procedure

LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**AP-44**
Content	Client Abuse and Neglect Policy and Procedure
Effective Date	08/2005
Reviewed	03/10, 08/17
Revised	03/07, 05/12, 08/13, 08/15
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Administration

Central Louisiana State Hospital (CLSH) is committed to preserving the right of each person receiving services to be free of abuse. All forms of abuse of clients by employees of CLSH and its affiliates are prohibited. To assure that client rights are protected, CLSH policies establish a uniform system for timely reporting and investigating alleged abuse / neglect of clients.

Authority: Adult Protective Services (APS) Abuse and Neglect Policy and Procedures for Louisiana Department of Health No. **76.1**

II. PURPOSE

To ensure a uniform system for reporting and investigating client abuse and neglect in accordance with APS Abuse and Neglect Policy and Procedures.

III. APPLICABILITY

This policy applies to all employees of CLSH and its affiliates and to all persons receiving services from CLSH and its affiliates.

IV. EFFECTIVE DATE

The effective date is August 2005.

V. POLICY PROVISIONS/PROCEDURES

Definitions:

A. Accused - The person that has been charged with abuse, neglect, exploitation or extortion of a client.

B. Administrator on Call (AOC) - The person designated by the CEO to be responsible for investigations and administrative functions during non-business hours. The AOC is designated as this person.

C. Affiliate - Any school, organization, or entity associated by interagency agreement in a working alliance with DHH programs and facilities providing direct client services. This includes organizations providing volunteer services, students or contract services.

D. Adult Protective Services (APS) - The APS is a Division in the Office of Aging and Adult Services responsible for developing and implementing a system of reporting,

investigating, reviewing and monitoring client related incidents, including assessment as follow-up, to safeguard the rights of the client.

E. Chief Executive Officer (CEO) - The individual responsible for the management of CLSH.

F. Client - Any person receiving services from CLSH or an affiliate of CLSH.

G. Client Rights Officer (CRO) - The designated staff person responsible for the protection of client rights.

H. Complainant/Reporter - Person reporting possibility of client abuse.

I. Corrective Action Plan - The preventative and/or corrective action steps to be taken to address deficiencies or problems that are identified during review or investigation of abuse/neglect incidents.

J. Criminal Act - Any act which violates the Louisiana Code (R.S.14). Examples include, but are not limited to, homicide, attempted homicide, rape, public lewdness, battery, criminal neglect, cruelty to the infirm, exploitation of the infirmed, and sexual battery of the infirm.

K. Designee - A staff member who is temporarily designated by the CEO to fulfill certain duties and responsibilities.

L. Facility/program – any organizational unit operated by DHH or its affiliates providing services to clients. Examples include but are not limited to hospitals, clinics development centers, health units, and direct service components of program offices and bureaus.

M. Investigative Review Committee (IRC) - A committee appointed by the CEO under whose auspices the investigative review process is conducted.

N. Investigator - A DHH staff person designated and approved to conduct investigation of client abuse.

O. Manager - The person responsible for the management of an individual DHH program or facility and its affiliates. For purposes of this policy, this may include but is not limited to CEO of 24-hour facilities, clinic managers, unit managers, program managers, and regional managers.

P. Not Substantiated - A determination based on the evidence that there is reasonable cause to believe that an alleged incident was not in violation of the abuse policy and/or not attributable to the accused.

Q. Online Incident Tracking System - an online database used for reporting of abuse, neglect, sensitive situations, or other mandatory reports.

R. Preponderance of Evidence - Greater weight of evidence that is more credible and convincing, that which best accords with reason and probability and more likely to be true.

S. Staff - Employees of DHH facilities and affiliates.

T. Substantiated - The Determination based on the evidence that there is reasonable cause to believe that conduct in violation of the abuse policy occurred and, where applicable, whether such conduct is attributable to the accused.

U. Unable to Verify - The determination that the available evidence does not support a final decision that there was reasonable cause to believe that abuse either did or did not occur.

Procedures:

STATUTORY DEFINITIONS OF ABUSE

Definitions of abuse, neglect, exploitation and extortion are found in the state and federal laws and regulations cited below. These definitions apply to different client populations and/or in different settings.

1. Louisiana Revised Statutes 15:1503. Adult Protective Services Law. These definitions apply to any person ages 18 through 59 (or an emancipated minor) who, due to a physical, mental or developmental disability is unable to manage his/her own resources, carryout the activities of daily living, or protect him/her from abuse, neglect, or exploitation. They apply in any setting.

2. Louisiana Revised Statutes 40:2009.20. These definitions apply to any person residing in a facility or receiving services from a provider licensed by Health Standards Section of the DHH Bureau of Health Services Financing. This includes, but is not limited to clients residing in a licensed hospital, and other licensed health facility as defined by this statute.

3. Code of Federal Regulations 45 CFR 1386.19 and 42 CFR 51.2. These definitions are contained in the Federal Regulations establishing protective and advocacy programs and apply to facilities serving the mentally ill.

4. Code of Federal Regulations 42 CFR 488.301. These definitions apply to long-term care facilities participating in the Medicaid and/or Medicare programs.

5. Louisiana Children's Code Article 603. These definitions apply to all persons under age 18 (except emancipated minors) regardless of setting.

ABUSE AND NEGLECT AS DEFINDED BY LOUISIANA R.S. 15:1503

Abuse- The infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or others things of value.

Neglect- The failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being.

EXAMPLES OF ABUSE

Listed below are examples of the type of conduct which constitutes abuse. This list of examples is not exhaustive and represents general categories of prohibited conduct. Conduct of a like or similar nature is also prohibited. Examples include, but are not limited to:

1. Physical Abuse - Physical contact such as hitting slapping, pinching, kicking, choking, scratching, pushing, twisting of head, arms or legs, tripping; the use of physical force which is unnecessary or excessive; and inappropriate or unauthorized use of restraint.

2. Verbal/Emotional/Psychological Abuse – Verbal conduct may be abusive because of either the manner of communication or the content to the communication. Examples include, yelling, cursing, ridiculing, harassment, coercion, threats, intimidation and other communication which is derogatory or disrespectful. Non-verbal communication, such as gestures, that have the same effect may be considered emotional or psychological abuse.

3. Sexual Abuse

    a. Any sexual activity between a client and an employee. Sexual activity includes but is not limited to kissing, hugging, stroking, or fondling with sexual intent;

    b. Failure to discourage sexual advances toward employees by clients:

    c. Permitting the sexual exploitation of clients or the use of client sexual activity for staff entertainment or other improper purpose;

    d. Any sexual activity where the client is forced, threatened, or otherwise coerced, by a person into sexual activity or contact.

    e. Any sexual situation where the client is involuntarily exposed to sexually explicit language or sexual activity or contact.

    f. Any sexual situation between a client and another person when the client lacks the capacity to consent and is engaged in sexual activity or contact by a person.

4. Exploitation - Includes using the client and/or the resources of the client for monetary or personal benefit, profit, gain or gratification. This includes forcing or encouraging a client to do anything illegal. Examples include taking money or other personal property from a client for one's own use, disposing of assets belonging to a client for personal gain, forcing a client to perform tasks that are not part of a treatment program.

5. Extortion – attempting to acquire or acquiring something of value from a client pr a client's family by physical force, intimidation, or abuse of official authority. Examples include coercing a client to give up something of value or soliciting payment from a client or family by threatening the client with harm.

6. Neglect – Acts or omissions by a person responsible for providing care or treatment which caused harm to a client, which placed a client at risk of harm, or which deprived a client of sufficient or appropriate services, treatment or basic care. Failure to provide appropriate services, treatment, or care by gross errors in judgment,

inattention, or ignoring may also be considered a form of neglect. Examples include, but are not limited to:

a. Failure to establish and carry out an appropriate program or treatment plan;
b. Failure to provide or withholding of adequate nutrition, clothing or health care;
c. Failure to provide a safe environment;
d. Failure to provide or obtain needed medical treatment;
e. Failure to supervise a client such that the client is placed in danger.

DUTY TO REPORT ABUSE

A. Louisiana law mandates reporting of abuse and provides that persons who report in good faith have immunity from liability unless they are themselves involved in the abuse. The following are violations of the law and subject to criminal penalties:

1. Failure to report
2. Making a false report
3. Retaliating against anyone making a report
4. Interfering with anyone making a report
5. Interfering with an investigation

B. Any employee of CLSH or an affiliate who has knowledge of possible abuse of a person or who receives a complaint of abuse from a client, shall report in accordance with the provisions of this policy, and applicable law. If the person is not an employee, e.g. a client, family member, visitor, etc. CLSH staff will assist the person in making a report, if necessary.

PROCEDURES FOR REPORTING

A. Any employee of CLSH or an affiliate who has knowledge of, or is a witness to client abuse, neglect, and exploitation will:

1. Immediately take measures to protect the safety and well being of the client(s) involved. This may include such actions as removing clients from danger, seeking medical attention, and notify appropriate supervisory personnel.

2. Immediately make a verbal report to the Client Rights Officer. In CRO's absence, to the Chief Executive Officer and in his absence to the Associate Hospital Administrator's office/designee.

   Note: After regular business hours, on weekends or holidays, make a verbal report to the AOC.

3. Complete the Client Incident, Injury and Data Reporting Form (BCRP/MH-03 1/02 Form 1), and Injury Review Form (BCRP/MH-03 1/02 Form 2).

4. Clinical staff that reports an incident/allegation of abuse/neglect will write a progress note regarding the incident. If non-clinical staff reports an incident/allegation of abuse/neglect, the nurse will write a progress note regarding the incident.

5. Within one (1) hour of the verbal report, take the original Client Incident, Injury and Data Reporting Form, and a copy of progress notes relative to the incident to the Client Rights Officers' office, in CRO's absence take to the CEO's office and in his absence take to the AOC's office.

   NOTE: After regular business hours, on weekends or holidays, give original form and copy of progress notes to the AOC and if that individual does not report to the unit, give original form and copy of progress notes to the investigator. Put a copy of the form and progress notes in the CRO's box in the administration building.

B. Supervisory personnel will take measures to:

1. Protect and ensure the safety and well being of the client(s).This may include the involved client(s) is removed from a hazard danger and receives appropriate care and/or medical treatment.

2. Protect and safeguard the evidence prior to the investigator's arrival.

3. Ensure staff (accused and witnesses) involved in the incident does not discuss/collaborate on the incident.

4. Ensure Client Incident, Injury and Data Reporting Form and Injury Review Form (MH03) and a copy of progress notes relative to the incident are appropriately completed and taken to the Client Rights Officer's office, CEO's office, or AOC s office within one (1) hour after verbal report.

   NOTE: After regular business hours, on weekends or holidays, ensure original forms and copy of progress notes are given to the AOC or the investigator.

5. Provide necessary support and input to the investigator as required and requested by the investigator, CRO, CEO, and IRC Chairperson.

6. Notify the treatment team physician of the incident/allegation. It is the responsibility of the treatment team physician to determine if the patient's treatment team needs to be convened to revise the treatment plan and to document both his knowledge of the incident and any revisions to the treatment plan.

7. Notify the OD physician of the incident/allegation.

C. The Client Right's Officer will:

1. After receiving the verbal report, consult with the Chief Executive Officer and in his absence the COO/designee to determine if an incident will be investigated under this policy in accordance with DHH policy no. 76.1.

   Receive reports of all incidents and allegations of abuse/neglect, exploitations that occur after regular business hours, on weekends and holidays the following regular work day.

2. Ensure that the safety and well-being of the patient has been provided and medical care if needed is being provided.

3. Inform the staff reporting the incident if it will be investigated or referred to the Treatment Team (if it is determined to be a Treatment Team issue).

4. When the allegation involves staff, contact the supervisor of the staff involved (DHH or affiliate) and assure initiation of administrative action to ensure the protection of the client(s). This may include, but is not limited to, removal of staff in accordance with Civil Service Rules or removal of clients. -

5. Make a verbal report to the Adult Protect Services.

6. Notify local law enforcement of all allegations of abuse/neglect that are investigated by Adult Protective Services the next business day, specifically, the Rapides Parish Sheriffs' Office and Pineville Police Department. Immediate notification may be necessary upon consultation with the CEO.

7. Notify the Child Protection Office on all allegations involving adolescents.

D. Administrator On Call (AOC) will:

1. After hours, the AOC will be in total charge of the initiation and sequence of all investigations.

2. Will receive all reports of abuse, neglect, exploitation and incidents after regular business hours, on weekends and holidays.

3. Assess information received and determine if it is an Abuse/Neglect issue or treatment team issue. Assess need to report to unit of the reported incident if determined to be an Abuse/Neglect issue.

4. Make a verbal assignment to the Adult Protective Services Investigative unit. NOTE: If decision is made to report to the unit, arrange to meet investigator on the unit.

5. Notify the local Child Protection Service Office (if applicable) of all incidents and/or allegations that are critical and require their immediate action. If not critical, notification will be the following workday by the Client Rights Officer.

6. Notify the parents/guardians/family, (person listed in client's record to be notified in case of emergency) of all incidents and/or allegations that are critical. If not critical, notification will be the following workday by the Social worker.

7. Make a verbal report to the CRO the following workday of all incidents/allegations. The CRO will notify the APS, IRC Chairperson, and Child Protection Office (if applicable).

FORMS FOR ABUSE, NEGLECT, EXPLOITATION/OTHER INCIDENTS

A. Completing and Distributing Forms

1. Client Incident, Injury and Data Reporting Form (BCRP/MH-03 FORM 1)

   (a) Must be completed by the individual to whom the report is first made and/or the individual who first became aware of the incident.
   (b) Must be completed within one (1) hour of the verbal report.
   (c) Original must be taken to CRO's office (in CRO's absence take to the CEO's office and in his absence to AOC with one (1) hour of the verbal report.

   NOTE: After regular business hours, on weekends or holidays, put form in the CRO's mail box that is in the Administration Building.

2. Injury Review Form (BCRP/MH –03 FORMS 2)

   (a) Must be completed by appropriate personnel if client was referred for injury review.
   (b) Must be completed within one (1) hour of the verbal report.
   (c) Must be attached to the Client Incident, Injury and Data Reporting Form (MH-03 FORM 1).
   (d) Must be taken to the CRO's office (in CRO's absence taken to the CEO's office and in his absence taken to the AOC within one hour of the verbal report.
   NOTE: After regular business hours, on weekends or holidays, put form in the CRO's mail box that is in the Administration building.

B. Distribution of Forms

1. Abuse/Neglect Allegations

    (a) Original to CRO
    (b) Copy to CEO
    (c) Copy to QM
    (d) Copy to Medical Director
    (e) Copy to Nursing Director
    (f) Copy to HR Director
    (g) QM sends a copy to Health Information Management (Medical Records)

PROHIBITION AGAINST RETALIATORY ACTION

No person who makes an allegation of abuse or neglect in good faith, or who gives information regarding such an allegation, shall be subject to retaliatory action. Any person who is subjected to retaliatory action upon making a report of client abuse or neglect shall immediately report the situation to any of the following:

1. Chief Executive Officer/designee, or
2. The Adult Protective Services (1800-898-4910); or
3. The Assistant Secretary of OBH/designee.

COOPERATION IN INVESTIGATIONS

All CLSH employees and affiliates are required to cooperate in any investigation of abuse. This includes, but not limited to, being available for interview, responding to the questions from the investigator.

CONFIDENTIALITY

All client information regarding allegations and/or investigations of abuse, neglect, exploitation or extortion is confidential. Such information may be shared as needed with hospital staff, supervisory and management personnel, as specified in this policy. All other discussions of incidents applicable to this policy are prohibited. Outside investigating agencies may obtain information as provided by law.

CONSEQUENCES OF ABUSE

A. Violation of this policy may be grounds for disciplinary action, up to and including termination. Violations include but are not limited to:

    1. Committing abuse, neglect, exploitation or extortion;
    2. Failing to report an alleged incident of abuse;
    3. Failing to report an alleged incident of abuse within specified time frames;

4. Refusing to cooperate in an investigation or giving untruthful information during an investigation; or interfering with an investigation.

B. Disciplinary action will be administered by the Chief Executive Officer in accordance with DHH Policy on Disciplinary Actions # 8111-80 and Civil Service Rules.

C. The expectation is that a staff member confirmed to have physically or sexually abused a client will be terminated from his/her employment. Any variance from the expectation requires a detailed justification by the CEO and approval by the OBS Assistant Secretary.

D. The expectation is that a staff member confirmed to have failed to report physical or sexual abuse of a client will be terminated from his/her employment. Any variance from this expectation requires a detailed justification by the CEO and approval by the OBH Assistant Secretary.

E. Abuse, neglect, exploitation or extortion may also constitute criminal offenses and be grounds for criminal prosecution.

F. Any employee of an affiliate found in violation of this policy may be excluded from the hospital.

STAFF TRAINING IN CLIENT ABUSE AND NEGLECT POLICY

A. At the time of hiring and annually, all employees and affiliates who have direct contact with clients will receive training in DHH/CLSH Abuse and Neglect Policy and procedures, namely, LDH 76.1/CLSH AP44. A training record, including the date of the training, the name and classification of the trainer, the course title, and the number of training hours, and acknowledgment of receiving this training shall be maintained in the Education Department records.

INVESTIGATIONS

All allegations of abuse and neglect are reported to APS that is housed at Pinecrest Supports and Services Center. They are responsible for and will investigate all allegations per this policy.

INVESTIGATIVE REVIEW PROCESS FOR 24-HOUR FACILITIES

A. Client Rights Officer

At all 24-hour facilities there shall be a designated Client Rights Officer (CRO). The person designated as CRO shall be trained in the duties of the job by the APS. The function of this job as it relates to this policy includes:

1. Assuring that clients (and where applicable, family or other responsible) are informed of the abuse/neglect policy and procedures;
2. Assessing all client related incidents and complaints for indications of abuse/neglect;
3. Advising the CEO of any client-related incident, occurrence, or complaint having indication that it should be reported as an abuse/neglect incident;
4. Assisting the client and/or, where applicable, family/client representative in hearings and appeals of findings in abuse/neglect cases;
5. Reviewing and assessing the Investigative Review Committee findings, and advising the CEO of any identified concerns;
6. Monitoring trends and patterns of reported incident, notifying the CEO of problem areas and need for attention to those areas; and
7. Monitoring for implementation of administrative and/or programmatic mandates to ensure the safety and well-being of clients.
8. Immediately notify the APS and the Health Standards Section of DHH.
9. Notify the IRC Chairperson.
10. Ensure the safety and well-being of the client(s).
11. Ensure every possible effort is made to notify parents/guardians/family (person listed in client's record who is be notified in case of an emergency). This notification must be made no later than 24 hours from the time of report of the incident.

B. Investigative Review Committee

1. The Investigative Review Committee (IRC) is the principal entity charged with receiving, assessing, and evaluating investigative data in abuse/neglect allegations, from which recommendations are made to the CEO. When applicable, this committee shall collect any additional data that is necessary to assist it in evaluating the incident.
2. The term of membership shall be one year. Members may be reappointed for more than one term, but there will be a rotation of members. Terms of members will be staggered so that some experienced members are on the committee at all times.
3. Each committee will ensure that:
    a. Incidents are processed within established time limits;
    b. A minimum of three members is present at every meeting, and at least one of the following are present, a: (1) client, (2) former client, (3) parent or client representative, or (4) a person not connected with the facility.
4. A committee member directly associated with the accused or the victim in an allegation shall recuse himself/herself from participating in the hearing.
5. Employees who have a direct responsibility to represent either the client or management will not serve as a voting member of the committee. Examples include, but are not limited to: facility administrator, clinical or program

director; unit directors where the incident occurred, human resource directors, client rights officers, or advocacy representatives.

6. When an allegation of abuse or neglect involves an employee of an affiliate, one member of the committee shall be a representative of that agency.
7. The chairperson is selected by the CEO.
8. The committee members shall be trained by APS in:

    a. The DHH and the facility Abuse/Neglect Policy;
    b. Collecting, reviewing and evaluating evidence; and,
    c. The responsibilities and requirements of a committee member.

9. The committee shall assess and evaluate all evidence and recommend to the CEO whether the allegation(s) of abuse or neglect should be substantiated, not substantiated, or is unable to be verified.
10. The committee shall make recommendations for corrective action(s).

C. Investigative reports by APS shall be faxed to the Region VI Attorney for review. The Regional Attorney will review it, and within 48 hours submit recommendations, if any, to IRC and APS. The submission of the written report to the Regional Attorney does not change or extend any deadline or time frame required by the DHH policy No 76.1 or other governing agency.

INVESTIGATIVE REVIEW COMMITTEE HEARING/RECOMMENDATION

1. The IRC chairperson is responsible for scheduling the committee hearing, notifying committee members and, when appropriate, notifying any witness of meeting arrangements. Meetings shall be scheduled in order to meet established time frames.
2. The committee will review and assess the information prepared and presented by the investigator.
3. The committee may call witnesses or request further investigation, if deemed necessary.
4. The committee will consider all evidence and will recommend whether, the allegation should be substantiated, should not be substantiated, or the allegation is unable to be verified. This recommendation shall be based on a preponderance of evidence. The committee will make a recommendation of whether or not an incident of abuse occurred even when the cause or/or accused cannot be determined.
5. The chairperson shall prepare a confidential report which includes:

    a. a statement of the allegation;
    b. a summary of the investigative methodology noting an analysis of the evidence;
    c. the committee's recommendation regarding substantiation, noting any additional concerns; and
    d. the committee's recommendations regarding corrective action to address the incident and/or any identified systemic deficiencies.

6. The IRC report will be submitted to the CEO within ten calendar days of the date the full investigative report is received by the committee. Committee members may disagree with the majority decision and may present such disagreement in writing for inclusion in the IRC report. A copy of the report will be forwarded to, the Client Rights Officer and the Adult Protective Services.
7. In cases where additional evidence must be gathered and additional time is needed, the CEO (with notice to the APS) may grant a single five-day extension. Any other extension must be granted by the Assistant Secretary for the Office of Behavioral Health with notifications to APS.
8. In cases involving allegations against the CEO of a facility, the Assistant Secretary will assume the role of the CEO and the DHH Deputy Secretary will assume the role of the Assistant Secretary.

FINAL ACTION BY THE CEO

1. The CEO shall receive and evaluate the findings of the committee. The CEO may accept the findings with or without comment. Should any part of the IRC findings and recommendations be rejected, written explanation for such rejection shall be supplied. When different from the recommendation of the IRC, the CEO's findings and/or proposed corrective action plan will be outlined and attached to the committee's report.
2. Within five days from the date the report is received by the CEO, his findings that differ from the IRC shall be routed back to the IRC chairperson with a written explanation. Copies shall be provided to, Clients Rights Officer, and APS.
3. The CEO shall assure that accused facility staff are notified of the findings and, where indicated, take prompt and appropriate disciplinary action when an allegation of abuse or neglect is confirmed.
4. Within 30 calendar days of the date the incident was reported, the CEO shall ensure that a copy of the complete investigative report has been placed in the mail to APS and to any other entity as mandated by law or DHH requirements. This report shall include the IRC's report; written witnesses' statements or tape transcriptions, the CEO's decision with written comments, if any, any documentary evidence such as portions of client records, diagrams of scene and medical treatment provided to the client or autopsy reports, the disciplinary action taken in cases of substantiated allegations of abuse and neglect, and a completed injury form when an injury is involved, and copies of external reports. If not available copies of external reports shall be submitted to APS as soon as they are received by the facility.
5. The CEO or designee shall be responsible for assuring the complainant and the client (if different), the family member or other party who was notified of the incident is informed of the case determination and appeal process.
6. The CEO or designee shall ensure that the corrective action plan is developed and forwarded to the facility employee who has responsibility for its implementation and monitoring.
7. The CEO or designee shall make appropriate reports of confirmed findings of abuse or neglect or ethical issues regarding licensed professional to the respective boards of examiners.

8. In cases involving allegations against the CEO, the Assistant Secretary will assume the role of the CEO.

TIME FRAMES FOR REPORTING, INVESTIGATING AND REVIEW OF ABUSE/NEGLECT

1. Immediately make a verbal report to the Client Rights Officer, Chief Executive Officer or AOC as applicable.
2. Within one (1) hour of the verbal report, the Injury & Data Reporting Form should be completed and taken to the Client Rights Officer, CEO or AOC.
3. Within two (2) hours of the reporting, the Client Rights Officer will contact the Adult Protective Services.
4. Within three (3) hours the investigation is initiated by APS.
5. Within 24 hours the social worker will notify the family.
6. Notify local law enforcement of all allegations of abuse/neglect that are investigated by Adult Protective Services the next business day, specifically, the Rapides Parish Sheriffs' Office and Pineville Police Department. Immediate` notification may be necessary upon consultation with the CEO.
7. Within ten (10) working days from the date of receipt of the report, the APS Investigator will send investigation report to the CEO, IRC, HRS, CRO, and the APS.
8. Within ten (10) working days from the date of receipt of the investigation report the IRC will send its' report to the CEO.
9. If not satisfied, the CEO has five days to re-route the recommendation back to the IRC. Otherwise, the CEO has 30 days from the date the incident was reported to report to APS.

RECORD-KEEPING AND DOCUMENTATION OF ABUSE, NEGLECT, EXPLOITATION INVESTIGATIONS

All original documents, evidence and investigative reports will be maintained in a secure place by the Chief Executive Officer for a period of three (3) years from date of the client's discharge. Tapes of witness's statements that have been transcribed and signed by the witness may be erased. Tapes of the investigative review hearing will be maintained for a period of three (3) years from date of the client's discharge. Cases in litigation or where charges are pending shall be maintained in accordance with legal mandates in the particular situation involved.

REVIEW AND CLOSURE BY APS

A. APS shall review and assess all investigative reports in order to monitor for:

   1. Clear and thorough documentation of findings;
   2. Conclusions based on a preponderance of the creditable evidence; and

   3. Implementation of recommended corrective actions to resolve identified problems.

B. APS may request:

1. Any missing documentation required by DHH Policy and Procedures;
2. Clarification of facts and findings where necessary;
3. Additional information be gathered and submitted; and
4. Review of the decision should the facility fail to provide sufficient evidence, documentation or clarification of findings.

C. APS shall consider the investigation completed and closed when the criteria is met.

D. APS will systematically collect data, analyze for trends and patterns, and supply periodic reports and recommendations to address identified problems to the facilities, program office, and Assistant Secretaries.

APPEAL OF FINDINGS

A. Any individual making an allegation of client abuse or neglect, or any victim or legally responsible representative who is not satisfied with the findings may appeal to APS. The appeal may be verbal or in writing and must be made within fifteen (15) calendar days from the date of notification of the findings or from date of postmark when findings are placed in the mail.

B. APS shall review the investigative findings, conduct any additional investigation that may be warranted and respond to the complainant within fifteen (15) calendar days. A copy of APS's findings shall be supplied to the CEO and Assistant Secretary.

C. If the complainant/client does not accept the findings of APS, the appeal may be made within fifteen (15) calendar days to the Secretary/ designee. The Secretary shall render his/her findings to the client/complainant within fifteen (15) calendar days of receipt of the appeal with copies to the CEO, Assistant Secretary, and APS. The Secretary's decision shall be the final step in the appeal process.

D. In cases involving allegations against the CEO, the Assistant Secretary, or the Deputy Secretary, will assume the role of the CEO.

OTHER INCIDENTS/SENSITIVE INCIDENTS

Any other incident which the CEO deems sensitive in nature to warrant reporting will be reported to DHH State Office as per the DHH State Facilities *Operational Instruction A-1: EMERGENCY & CRITICAL INCIDENT NOTIFICATION TO DHH*. Examples include client arrests, elopements that constitute a danger to client(s) or to other individuals, environmental conditions which constitute a danger to clients (flooding, gas leaks, bomb threats, fires, etc.), serious incidents of client exploitation, etc.

This internal policy and procedure is written in accordance with the Louisiana Department of Health APS Policy Number 76.1. Should you have questions regarding this policy and procedure, contact the Client Rights Officer, Monday through Friday, 8:00 a.m. to 4:30 p.m., at (318) 484-6207.

Related Policies & Documents:

Adult Protective Services *ABUSE AND NEGLECT POLICY AND PROCEDURES FOR LDH* POLICY NUMBER **76.1**
Client Incident, Injury and Data (CID) Reporting form (MH-03 FORM 1)
Injury Review form (MH-03 FORM 2)
The DHH State Facilities *Operational Instruction #A-1: EMERGENCY & CRITICAL INCIDENT NOTIFICATION TO DHH,* dated February 17, 2014

MANAGEMENT DISCLOSURES

The Chief Executive Officer reserves the right to add, alter, change, or delete any and all prescribed policies and procedures of the agency as needs dictate without the necessity of giving prior notice and request for consent from employees or employee representatives. This includes the right to add, alter, change, or delete all work assignments, duties, requirements and responsibilities of Sections, Departments, Units, and individual employees. Violations of this policy may result in disciplinary action up to and including dismissal. All policies are available on the Central Louisiana State Hospital Intranet. Signed originals of each policy are available in the office of the Hospital Administrator.

Code of Conduct and Dealing with Disruptive Behaviors

LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**AP-49**
Content	Code of Conduct and Dealing with Disruptive Behaviors
Effective Date	01/09
Reviewed	04/17, 12/18
Revised	04/13, 5/15, 6/16
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Administration

I. POLICY STATEMENT

It shall be the policy of Central Louisiana State Hospital to be committed to maintaining a high level of professional and ethical standards in the conduct of its business. The hospital places a high importance upon its reputation for honesty, integrity and high ethical standards.

II. PURPOSE

To formalize the expected conduct of CLSH employees through its Code of Ethics and to provide a safer environment through defined methods of dealing with disruptive behavior.

III. APPLICABILITY

This policy applies to all CLSH employees, contract staff, and volunteers. This policy does not negate the provisions contained in policies that apply to client abuse/neglect, sexual harassment or workplace violence.

IV. EFFECTIVE DATE

The effective date of this policy is January 2009.

V. POLICY PROVISIONS/PROCEDURES

1. **Ethical Practice Standards**

   A. A high level of ethical standards can only be achieved through the actions and conduct of all Central Louisiana State Hospital Staff. Each and every employee, including Medical Staff, and Management Staff, is obligated to conduct himself/herself in a manner to ensure compliance with these standards. Such actions and conduct will be important factors in evaluating an employee's judgment and competence during the annual PES Process. Employees who ignore or disregard the principles of this policy will be subject to appropriate disciplinary actions available.

   B. All Central Louisiana State Hospital employees are required to participate in the ongoing educational programs developed by this organization. Questions regarding these

requirements shall be directed to the appropriate Department Head, Senior Leadership of the hospital, or Department of Health and Hospitals Legal Counsel.

C. Employees of Central Louisiana State Hospital will be educated on all applicable federal and state laws and regulations that apply to and impact upon the hospital's documentation, coding, billing, and treatment practices. Each employee who is directly involved in any of the hospital's documentation, coding, billing, or treatment practices has an obligation to familiarize himself/herself with all such applicable laws and regulations and to adhere at all times to the requirements thereof.

2. Admission, Transfer, Discharge

All decisions to admit, transfer and discharge patients will be based solely on the best interests of the patient and his/her medical and needs requirements and to ensure access to an appropriate level of care in the most suitable setting that meets the treatment needs of the patient.

3. Contracting, Disclosure

A. Central Louisiana State Hospital and its employees will deal fairly and honestly with clients, customers, vendors, payers and all stakeholders.

C. Financial and operational reports shall be accurate, fair and truthful.

D. Patients and Legal Guardians will be informed of any relationships that exist with regard to contracted services and how they were selected.

4. Conflict of Interest

Any staff having an investment, financial interest, or compensation relationship, direct or indirect, with any vendor of Central Louisiana State Hospital, shall make full disclosure when entered into and annually thereafter.

5. Billing Compliance

A. Standards and policies that guide personnel and others involved in the billing process have been developed to ensure the accuracy and documentation of professional fee billing and services.

B. Coordinated training is provided to clinical and billing personnel concerning applicable billing requirements and other relevant Central Louisianan State Hospital policies.

C. Periodic medical record reviews and billing audits are conducted to ensure compliance and to identify areas of weakness, or areas that require clarification, correction, or additional training for staff.

6. Employee Conduct

A. To assure quality patient care and to promote a culture of safety, Central Louisiana State Hospital is committed to addressing problematic staff behaviors that threaten the performance of the health care team. Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction, and also lead to preventable adverse patient outcomes.

B. Intimidating and disruptive behaviors include overt actions such as verbal outbursts, and physical threats. (See Central Louisiana State Hospital Administrative Policy No. 28, "Violence Prevention Program.") Intimidating and Disruptive Behavior also includes passive activities such as refusing to perform assigned tasks, or quietly exhibiting uncooperative attitudes during routine activities.

C. Behaviors that undermine a Culture of Safety:

Verbal outbursts/Verbal threat of violence
Outbursts of rage or violence
Physical threats or threatening behavior
Refusing to perform assigned tasks
Exhibiting uncooperative behaviors during routine activities
Reluctance or refusal to answer questions
Repeated lack of response to calls or pages
Condescending language or voice intonation
Impatience with questions
Profane or disrespectful language
Demeaning or intimidation behavior
Sexual comments or innuendo
Inappropriate touching
Racial or ethnic jokes
Throwing objects
Inappropriately criticizing healthcare professionals in front of others
Boundary violations
Comments that undermine client's trust in others (e.g., criticizing co-worker in presence of clients)
Inappropriate chart notes (i.e., accusatory)
Unethical, dishonest behavior

D. All intimidating and disruptive behaviors are unprofessional and will not be tolerated while employed at Central Louisiana State Hospital. The zero tolerance policy is incorporated into the medical staff bylaws, and all employment agreements.

E. Each and every employee, including Medical Staff and Management Staff, receive during orientation, and annually thereafter, in-service education on appropriate behavior and behavior that is defined as intimidating and disruptive.

F. All staff members of Central Louisiana State Hospital are held accountable for modeling desirable behaviors. Acceptable employee conduct is enforced equitably among all staff regardless of seniority or position held.

G. All employees are responsible to report or cooperate in the investigation of intimidating, disruptive, or other unprofessional behavior. No employee shall be subject to retaliation for reporting, or cooperating in the investigation of intimidating, disruptive, or other unprofessional behavior. Intimidating, disruptive, or unprofessional behavior can be reported either to the direct supervisor, the patient advocate, or anonymously through submitting an Incident Statement to the patient advocate.

H. All leaders and managers of Central Louisiana State Hospital are provided skill-based training and coaching in relationship building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.

I. Disciplinary action such as suspension, termination, loss of clinical privileges, and reports to professional licensure bodies will follow Civil Service Policies and be reviewed/approved by Department of Health and Hospitals Legal counsel.

7. Employee Orientation

This policy and the accompanying CENTRAL LOUISIANA STATE HOSPITAL RULES OF CONDUCT shall be mandatory inclusion New Employee Orientation and in the CLSH Annual Training Fair.

Related Policies & Documents:

Administrative Policy 28, Violence Prevention Program

MANAGEMENT DISCLOSURES

The Chief Executive Officer reserves the right to add, alter, change, or delete any and all prescribed policies and procedures of the agency as needs dictate without the necessity of giving prior notice and request for consent from employees or employee representatives. This includes the right to add, alter, change, or delete all work assignments, duties, requirements and responsibilities of Sections, Departments, Units, and individual employees. Violations of this policy may result in disciplinary action up to and including dismissal. All policies are available on the Central Louisiana State Hospital Intranet. Signed originals of each policy are available in the office of the Hospital Administrator.

CENTRAL LOUISIANA STATE HOSPITAL
RULES OF CONDUCT

(Attachment to CLSH Policy No AP_49)

The following rules govern the conduct of all employees of Central Louisiana State Hospital. Failure to comply with these rules may result in dismissal.

1. Never strike or otherwise physically abuse a patient. Louisiana Law provides under Act No. 87 Cruelty to the Infirmed, that any person who mistreats or neglects a patient of a facility for the mentally ill shall be fined not more than ten thousand dollars, or imprisoned for not more than ten years, or both.
2. Never fail to report an incident where patient abuse is suspected. Failure to do so shall make you a party to the incident.
3. Never incite a patient or other person to strike or abuse a patient.
4. Never curse, tease, or verbally abuse a patient. Never use profane or vulgar language in the presence of a patient.
5. Never encourage sexual behaviors between patients. Engaging in sexual behavior with a patient is considered sexual abuse.
6. Do not curse or taunt fellow employees.
7. Never leave your assigned place of duty without authorized permission from your supervisor and authorized relief of another employee.
8. Never be under the influence of intoxicants, narcotics, or hallucinogenic substances while on duty.
9. Never bring to the hospital grounds any intoxicant, narcotics or hallucinogenic substance, or any firearm or other instrument customarily considered a dangerous weapon.
10. Never refuse to carry out a directive and/or assignment from your supervisor not in conflict with the rules and regulations of Central Louisiana State Hospital, the Office of Behavioral Health, or the Louisiana Department of Health.
11. Never sleep while on duty.
12. Never divulge any information concerning a patient to any unauthorized person, which includes a patient's name or showing of a patient's photograph.
13. Never restrain or place a patient in seclusion without using proper Central Louisiana State Hospital procedures.
14. Never bring to your post of duty overnight bags or other large containers.
15. Never bring to your post of duty groceries not to be consumed at work. Do not store personal items in Central's refrigeration facilities that are not to be consumed while on duty status.
16. Never remove from the grounds any property of a patient, another employee, or of the hospital without proper authorization.
17. Never accept money, gifts, personal items or buy, sell or trade items with patients or former patients still receiving mental health care.
18. Never falsify documents such as patient records, leave slips, doctor's statements, work orders, injury reports, insurance claims or purchase orders.
19. All employees are expected to comply with and follow rules governing fire and safety.
20. Taking pictures/recordings of patients or patient related materials are prohibited.

I hereby certify that I have received a copy of LDH Policy 86.1- LDH Guidelines for Employee Conduct. CLSH Policy AP49-Code of Conduct, and CLSH form - CENTRAL LOUISIANA STATE HOSPITAL RULES OF CONDUCT. I also certify that I have read, understand, support and shall conduct myself in accordance with the guidelines, codes and rules presented in these materials in connection with my employment at Central.

Employee Signature	**DATE**	**Witness (CLSH-HR or Training Dept. staff)**	**DATE**

- Signed original to HR/employee file
- Signed copy (or duplicate original) to employee

CLSH Form- **RULES OF CONDUCT. Revised June 2016**

Identification Code Numbers for Patients

LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**AP-53**
Content	Identification Code Numbers for Patients
Effective Date	11/09
Reviewed	04/12, 03/15, 08/16, 08/18
Revised	
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Administration

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital that in order to ensure that confidentiality is maintained at all times, the patient is assigned a code number at the time of admission. The code number is assigned so that the patient can provide it to only those family, friends, etc. with whom they wish to maintain contact during their hospitalization. The correct code number must be given to the staff member answering the telephone before they can acknowledge that the patient is in the facility.

II. PURPOSE

To provide a mechanism to ensure confidentiality for all patients.

III. APPLICABILITY

All hospital settings

IV. EFFECTIVE DATE

The effective date of this policy is November 2009.

V. POLICY PROVISIONS/PROCEDURES

Upon admission, the patient is issued a code number which will be the last four (4) digits of their social security number. This code number will be given to the patient or parent/legal guardian, in the case of a minor.

The ID Code Number will be printed on the Addressograph Card.

After the initial release of the code number by admission staff as noted above, only the patient or parent/legal guardian may disclose the patient code number to anyone.

The Admission staff will send an e-mail to the switchboard operator indicating patient's name and code number immediately following the admission process.

Anyone requesting to speak or visit with the patient must have a code number. Staff must check for the appropriate code number as listed on the patient's Addressograph card which is located inside the chart.

Anytime an inquiry is made about a patient by someone without an appropriate code number, staff should answer in the following manner. "I cannot confirm or deny that a person by that name is hospitalized in this facility, you may leave your name and number if you wish".

The staff member should then tell the patient the name of the person trying to contact them and have them call the person back and give them the code number if they so choose.

Any time there is a need to change the patient's code number, the last four (4) digits of the patient's medical record number will be utilized.

Admission staff will make a new Addressograph card for the chart and immediately notify the switchboard operator of the change in the patient's code number.

MANAGEMENT DISCLOSURES

The Chief Executive Officer reserves the right to add, alter, change, or delete any and all prescribed policies and procedures of the agency as needs dictate without the necessity of giving prior notice and request for consent from employees or employee representatives. This includes the right to add, alter, change, or delete all work assignments, duties, requirements and responsibilities of Sections, Departments, Units, and individual employees. Violations of this policy may result in disciplinary action up to and including dismissal. All policies are available on the Central Louisiana State Hospital Intranet. Signed originals of each policy are available in the office of the Hospital Administrator.

CLSH Tobacco Free Campus Policy

LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**AP-71**
Content	**CLSH Tobacco Free Campus Policy**
Effective Date	March 30, 2013
Reviewed	05/15, 03/17
Revised	11/18, 07/19
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Administration

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital to maintain a tobacco-free environment in all areas of the campus. This will be effective by March 30, 2013.

II. PURPOSE

The purpose of this policy is to provide guidelines that create and maintain a healthier environment for the CLSH campus, and all individuals who are treated, work or visit there.
We believe this collective effort will:

a. Create a healthier environment for everyone who visits our campuses by eliminating second-hand smoke.
b. Demonstrate our commitment to improve the health of our patients and employees.

III. APPLICABILITY

a. All facilities, buildings, and grounds which are directly operated by CLSH
b. Adjoining sidewalks
c. Parking lots and driveways that are used by CLSH
d. Vehicles owned, leased or the property of CLSH

IV. EFFECTIVE DATE

The effective date of this policy is March 30, 2013.

V. POLICY PROVISIONS/PROCEDURES

A. Patients - Residents

1. Patients and Residents will be given information about the Tobacco Free Policy at the time of admission or as soon as possible thereafter. Tobacco Free Campus signage will be posted throughout patient care areas.

2. Patients will not be permitted to use tobacco products on grounds, under any circumstances.

3. Tobacco use assessment and referral for smoking/tobacco use cessation assistance will be documented in the medical record.

B. Employees

1. All employees are required to observe and promote compliance with the Tobacco Free Policy.

2. Employees will not be permitted to use tobacco products on grounds, under any circumstances.

3. Employees who leave CLSH property for non-work related matters must clock or sign-out. Unauthorized breaks may be subject to disciplinary action.

4. Employees who violate this policy may be subject to disciplinary action up to and including termination. Previous disciplinary actions will be taken into consideration when determining type of disciplinary action for violation of this policy.

C. Visitors

1. Visitors will be provided information on the tobacco free status of the CLSH campus at the switchboard and other locations as needed.

2. Employees observing visitors using tobacco products will remind visitors of the policy.

3. Visitors who refuse to comply with the policy should be reported to Security for immediate assistance.

D. Contractors/Vendors

1. All Contractors and vendors will be informed of CLSH Tobacco Free Policy at the time a contract is agreed upon.

2. This policy will be available for contractors and vendors at the switchboard.

3. Employees observing contractors or vendors using tobacco products will remind contractors or vendors of the policy.

4. Contractors or vendors who refuse to comply with the policy should be reported to Security for immediate assistance.

E. Environmental

1. Signs will be posted which clearly state that CLSH is a tobacco free environment.

2. Staff members will be informed at the time of hire and during general orientation of this policy.

3. Education and options for tobacco cessation activities will also be provided as appropriate to patients as part of their medical care.

4. This policy will be available at switchboard and on the units.

F. Use of Electronic Cigarettes (e-Cigarettes)

1. The electronic cigarette is an unapproved nicotine delivery device, unregulated by the FDA.

2. The FDA has concluded that E-cigarettes pose acute health risks and contain detectable levels of carcinogens and toxic chemicals. They are not a proven safe alternative to smoking and no scientific evidence at this time has shown that they help smokers quit.

3. The use of e-Cigarettes is prohibited on the campus of CLSH, as defined in this policy.

Definitions:

A. **Employees** – a person on any Central Louisiana State Hospital (CLSH) grounds directly associated with CLSH, whether on or off duty compensated or not which includes all hospital staff, physicians, volunteers, contractors, and students.
B. **Campus** – refers to the specific acreage, buildings, structures, grounds, courtyards and Streets and parking lots which constitute the facility.
C. **Tobacco Free** – prohibits all tobacco use, including smoking, chewing, or snuffing tobacco products.
D. **Tobacco Products** – include cigarettes, pipes, pipe tobacco, tobacco substitutes, chewing tobacco and cigars.
E. **Nicotine Replacement Products** – includes gum, patches, lozenges, and inhalers.
F. **Workforce** – includes employees, independent practitioners, contractors, students, interns and volunteers.
G. **Visitors** – includes representatives from other state agencies, community agencies (public and private) contractors performing work on grounds, family members of clients and workforce individuals and delivery personnel from outside vendors.

MANAGEMENT DISCLOSURES

The Chief Executive Officer reserves the right to add, alter, change, or delete any and all prescribed policies and procedures of the agency as needs dictate without the necessity of giving prior notice and request for consent from employees or employee representatives. This includes the right to add, alter, change, or delete all work assignments, duties, requirements and responsibilities of Sections, Departments, Units, and individual employees. Violations of this policy may result in disciplinary action up to and including

dismissal. All policies are available on the Central Louisiana State Hospital Intranet. Signed originals of each policy are available in the office of the Hospital Administrator.

NURSING POLICY NO. 2209

SUBJECT: **DRESS CODE**

Adopted:
Revised: March 2007
Reviewed: September 2007
Revised: January 2008
Reviewed: January 2010
Revised: October 2011
Revised: January 2012
Revised: June 2012
Revised: March 2013
Revised: September 2013
Revised: April 2015
Revised: May 2015
Revised: October 2015
Revised: May 2016
Revised: July 2016
Revised: February 2017
Revised: September 2018
Revised: January 2019
Revised: July 2019

POLICY

It is the responsibility of CLSH employees, as representatives of the hospital serving the community and state, to provide a neat, clean, attractive appearance while on duty. Employees must set an example for patients, clients or students by adhering to the following guidelines.

1. Clothing should be clean, in good repair, wrinkle-free, properly hemmed, well-fitted, with proper undergarments.
2. Body should be clean and free from body odor.
3. Hair should be clean and attractively arranged. Hair that is shoulder length or longer must be secured. It should not interfere with job duties or pose a safety hazard.
4. Beards should be neatly trimmed.
5. Shoes should be clean, in good repair. Tennis shoes are recommended. **No** shoes are permitted that could be hazardous while on duty (no heels higher than one (1) inch, no thongs, no slides, etc.) Sandals that have a secure back maybe worn. Shoes may be worn with or without hosiery.
6. Identification badges will be worn at all times. Identification badge must be worn on clothing at or above chest level and facing forward. No stickers, smiling faces, etc., are allowed to cover any identifying information.
7. All direct care nursing staff are required to wear a watch with a second hand.

NURSING SERVICE GUIDELINES

1. Scrubs will be worn by nursing staff (including unit ACs) in direct patient care areas. PA staff will wear Navy scrubs. Nurses will wear Gray scrubs. Lab coats are optional. Fridays will be deemed CLSH spirit day. Jeans that are below the knee and without holes/rips and CLSH t-shirts may be worn on Fridays and Holidays. Scrub tops must be visible inside the building. Cold weather attire worn must be open in the front or worn under scrubs.
2. Administrative nurses (RNSB and above) may wear business attire, but are required to have white lab coats while rounding on the patient care units.
3. No head coverings, caps, hats, hoods, or sunglasses are to be worn inside the building. Prescription sunglasses are acceptable inside the building **if** the need for them is validated by a physician. No stereo headphones are to be worn.
4. Nails should be short enough to allow the individuals to thoroughly clean underneath them and not long enough to cause glove tears.
    a. NAILS must be short and well-manicured. (Avoid ragged edges.)
    b. Polish that starts to chip must be removed.

c.. Recommended ¼" or 0.5 cm over the end of the finger. (Piano playing or sport length).

d. Use of artificial nails or any overlay material is prohibited in direct patient care

e. Nail jewelry is prohibited in clinical area.

f. Do not avoid handwashing to preserve your manicure.

g. Alcohol gels (ex. hand sanitizer) may be slightly more effective than soap and water at removing harmful bacteria from the nail bed.

CDC Guidelines for Hand Hygiene in Healthcare settings. 2002. Refer to clinical Policy # 77 – Hand Hygiene.

7. Jewelry should be kept to a minimum and should not present a safety hazard.

   a. Ear rings that are acceptable for direct patient care staff include studs and small hoops (no more than 2 in each ear).

   b. Absolutely NO visible body jewelry is allowed. For example - nose, tongue, lip or eyebrow rings. Clear retainers may be worn if needed.

   c. Rings should be limited to 1 on each hand while on duty, except wedding sets with two pieces.

   d. Personal pagers are acceptable and are to be used for emergencies only. Pagers must be in the vibrate mode. **CELL PHONES, LAPTOPS, SMART WATCHES, ELECTRONIC DEVICES, ETC. TABLETS, IN DIRECT CARE AREAS/IN THE PRESENCE OF PATIENTS ARE PROHIBTED.** Verbal counseling will be conducted for the first infraction with progressive discipline to follow if repeated. An exception to cell phone use by staff: Nursing Administration will utilize cell phones to communicate with each other and others when making rounds on the units and as needed for hospital business.

*** If violated, employee will be sent home.**

CP-11 Patient's Rights (Adults)	
LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**CP-11**
Content	Patient's Rights (Adults)
Effective Date	04/1994
Reviewed	04-96, 04/97, 04/99, 04/00, 07/02, 03/06
Revised	03/03, 03/09, 05/12, 05/15, 10/16, 06/18
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Medical Director

I. POLICY STATEMENT

In accordance with the Mental Health Laws of the State of Louisiana Revised Statutes amended, it is the policy of Central Louisiana State Hospital to promote and protect the rights of every patient. Please note that if any conflict exists between local, state, or federal laws and the guidelines presented in this policy, then the applicable law will prevail and supersede that policy statement.

II. PURPOSE

To insure that all employees are aware of the rights of patients in accordance with the law and those rights are respected.

AUTHORITY: Louisiana Revised Statutes, Title 28, Mental Health Laws, June 1995
Joint Commission

III. APPLICABILITY

All hospital settings

IV. EFFECTIVE DATE

The effective date of this policy is April 1994.

V. POLICY PROVISIONS/PROCEDURES

Definitions:

A. **Restraint** means the partial or total immobilization of any or all of the extremities or the torso by mechanical means for psychiatric indications. Restraint does not include the use of mechanisms usually and customarily used during medical or surgical procedures, including but not limited to, body immobilization during surgery and arm immobilization during intravenous administration. Restraint does not include orthopedic appliances used to posturally support the patient, such as posies.

B. **Seclusion** means the involuntary confinement of a patient alone in a room where the patient is physically prevented from leaving for any period of time, except that seclusion does not include the placement of a patient alone in a room or other area for no more than thirty

minutes at a time and no more than three hours in any twenty-four hour period pursuant to behavior-shaping techniques, such as "time-out."

C. **Substance Abuse** means the condition of a person who uses narcotic, stimulant, depressant, soporific, tranquilizing, or hallucinogenic drugs or alcohol to the extent that it renders the person dangerous to himself or others or renders the person gravely disabled.

D. **Treatment** means an active effort to accomplish an improvement in the mental condition or behavior of a patient or to prevent deterioration in his condition or behavior. Treatment includes, but is not limited to, hospitalization, outpatient services, examination, diagnosis, training, the use of pharmaceutical and other services provided for patients by a treatment facility.

E. **Treatment Facility** means any public or private hospital, retreat, institution, mental health center, or facility licensed by the state in which any mentally ill person or person suffering from substance abuse is received or detained as a patient. The term includes Veterans Administration and public health hospitals and forensic facilities.

Rights of Persons Suffering from Mental Illness and Substance abuse (LA.R.S. Title 28:171)

171. Enumeration of rights guaranteed

A. No patient in a treatment facility pursuant to this Chapter shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Louisiana, or the Constitution of the United States solely because of his status as a patient in a treatment facility.

These rights, benefits and privileges include, but are not limited to, civil service status; the right to vote; the right to privacy; rights relating to the granting, renewal, forfeiture, or denial of a license or permit for which the patient is otherwise eligible; and the right to enter contractual relationships and to manage property.

B. No patient in a treatment facility shall be presumed incompetent, nor shall such person be held incompetent except as determined by a court of competent jurisdiction. This determination shall be separate from the judicial determination of whether the person is a proper subject for involuntary commitment.

C. (1) The patient in a treatment facility shall be permitted unimpeded, private and uncensored communication with persons of his choice by mail, telephone, and visitation. These rights may be restricted by the director of the treatment facility if sufficient cause exists and is so documented in the patient's medical records. The patient's legal counsel, as well as his next of kin or responsible party must be notified in writing of any such restrictions and the reasons therefore. When the cause for any

restriction ceases to exist, the patient's full rights shall be reinstated. A patient shall have the right to communicate in any manner in private with his attorney at all times.

(2) The director of a treatment facility shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available. Writing materials, postage, and telephone usage funds shall be provided in reasonable amounts to recipients who are unable to procure such items.

(3) Reasonable times and places for the use of telephones and for visits may be established in writing by the director of any treatment facility. However, the time and places established by the director must allow patients, at a minimum, reasonable daily communication by telephone and visitation. These rights may be restricted by the director of the treatment facility if sufficient cause exists and is so documented in the patient's medical records. The patient's legal counsel, as well as his next of kin or responsible party must be notified in writing of any such restrictions and the reasons therefore. When the cause for any restriction ceases to exist, the patient's full rights shall be reinstated.

(4) The director of any substance abuse treatment facility may restrict the visitation rights of a patient who is voluntarily admitted to such treatment facility under the provisions of R.S. 28:52, 52.1, 52.2, 52.3, and 52.4 for the initial phase of treatment but no longer than seven (7) days unless good cause exists to extend the restriction and is so documented in the patient's record. This restriction shall not apply to visitation by the patient's attorney or, if he is not represented by counsel, the mental health advocate, or the patient's minister. This restriction shall also not apply to a parent or legal guardian of a patient who is a minor unless the director determines that good cause exists that such restriction shall be in the best interest of the patient and is so documented in the patient's record. When the facility director determines the need to restrict visitation of new patients, he shall post notice of such restriction in places prominent to all new admissions, and shall inform each new patient of the restriction prior to the admission of the patient, and the length and duration thereof, and further, that such restriction may be extended on an individual basis as determined to be in the patient's interest by the treatment staff with the concurrence of the medical director.

Nothing herein shall be construed to further restrict other forms of patient communication as permitted in this Section, nor shall this restriction apply to mental health treatment facilities.

D. Seclusion or restraint shall only be used to prevent a patient from physically injuring himself or others. Seclusion or restraint may not be used to punish or discipline a patient or used as a convenience to the staff of the treatment facility. Seclusion or restraint shall be used only in accordance with the following standards:

(1) Seclusion or restraint shall only be used when verbal intervention or less restrictive measures fail. Use of seclusion or restraint shall require documentation in the

patient's record of the clinical justification for such use as well as the inadequacy of less restrictive intervention techniques.

(2) Seclusion or restraint shall only be used in an emergency. An emergency occurs when there is either substantial risk of self-destructive behavior, as evidenced by clinically significant threats or attempts to commit suicide or to inflict serious harm to self , or a substantial risk or serious physical assault on another person, as evidenced by dangerous actions or clinically significant threats that the patient has the apparent ability to carry out.

(3) A written order from a physician or a psychologist acting within the scope of his institutional privileges shall be required for any use of seclusion and restraint. If, however, no physician or psychologist is immediately available, a registered nurse who has been trained in management of disturbed behavior may utilize seclusion or restraint. The nurse or the nursing supervisor shall then immediately notify a physician or a psychologist with institutional authority to order seclusion or restraint and provide him with sufficient information to determine whether seclusion is necessary and whether less restrictive interventions have been tried or considered. The physician or psychologist may then issue a telephone order for seclusion or restraint if such order is indicated.

(4) Written orders for the use of seclusion or restraints shall be time limited and not more than twelve hours in duration. The written order shall include the date and time of the actual examination of the patient, the date and time the patient was placed in seclusion or restraint, and the date and time the order was signed.

(5) A renewal order for up to twelve hours of seclusion or restraint may be issued by a physician or a psychologist with institutional authority to order seclusion or restraint after determining that there is no less restrictive means of preventing injury to the patient or others. If any patient is held in seclusion or restraint for twenty-four hours, the physician or psychologist with institutional authority shall conduct an actual examination of the patient and document the reason why the use of seclusion or restraint beyond twenty-four hours is necessary. The next of kin or responsible party shall be notified by the twenty-sixth hour.

(6) Staff who implement written orders for seclusion or restraint shall have documented training in the proper use of the procedure for which the order was written.

(7) Periodic monitoring and care of the patient shall be provided by responsible staff. A patient in seclusion or restraint shall be evaluated every fifteen minutes, especially in regard to regular meals, water, and snacks, bathing and the need for motion and exercise, and use of the bathroom. Documentation of these evaluations shall be entered in the patient's record.

(8) Patients shall be released from seclusion or restraint as soon as the reasons justifying the use of seclusion or restraint subside. If at any time during the period of seclusion

or restraint a registered nurse determines that the emergency which justified the seclusion or restraint has subsided and a physician or psychologist with institutional authority to order seclusion or restraint is not immediately available, the patient shall be released. At the end of the period of seclusion or restraint ordered by the physician or psychologist the patient shall be released unless a renewal order is issued.

(9) Mechanical restraints shall be designed and used so as not to cause physical injury to the patient and so as to cause the least possible discomfort.

(10) Facilities using seclusion or restraint shall have written policies concerning their use in place before they can be used. These policies shall include standards and procedures for placing a patient in seclusion or restraint, for informing him of the reason he was put in seclusion or restraint, and the means of terminating such seclusion or restraint.

(11) Nothing in this Section shall be construed to expand the scope of practice of psychology as defined in R.S. 37:2351 et seq. to authorize the ordering, administering, or dispensing of medications, or to authorize any practice not permitted under the privileges granted by the institution.

(12) The department shall adopt rules and regulations in accordance with the Administrative Procedure Act to govern the use of seclusion and restraint. Such rules and regulations shall respect the patient's individual rights, protect the patient's health, safety, and welfare, and be the least restrictive of the patient's liberty. The department shall adopt rules and regulations to provide for enforcement procedures and penalties applicable to a person who violates the requirements of this Section.

E. No patient confined by emergency certificate, judicial commitment, or non-contested status shall receive major surgical procedures or electroshock therapy without the written consent of a court of competent jurisdiction after a hearing.

If the director of the treatment facility, in consultation with two physicians, determines that the condition of such a patient is of such a critical nature that it may be life threatening unless major surgical procedures or electroshock therapy are administered, such emergency measures may be performed without the consent otherwise provided for in this section. No physician shall be liable for a good faith determination that a medical emergency exists.

F. Every patient shall have the right to wear his own clothes, to keep and use his personal possessions, including toilet articles, unless determined by a physician that these are medically inappropriate and the reasons therefore are documented in his medical record. The patient shall also be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases when clinically appropriate, and to have access to individual storage spaces for his private use. If the patient is financially unable to provide these articles for himself, the treatment facility shall provide a reasonable supply of clothing and toiletries.

G. Every patient shall have the right to be employed at a useful occupation depending upon his condition and available facilities.

H. Every patient shall have the right to sell the products of his personal skill and labor at the discretion of the director of the treatment facility and to keep or spend the proceeds thereof or to send them to his family.

I. Every patient shall have the right to be discharged from a treatment facility when his condition has changed or improved to the extent that confinement and treatment at the treatment facility are no longer required. The director of the treatment facility shall have the authority to discharge a patient admitted by judicial commitment without the approval of the court which committed him to the treatment facility. The court shall be advised of any such discharge. The director shall not be legally responsible to any person for the subsequent acts or behavior of a patient discharged by him in good faith.

J. Every patient shall have the right to engage a private attorney. If a patient is indigent, he shall be provided an attorney by the mental health advocacy service, if he so requests. The attorney provided by the mental health service or appointed by a court shall be interested and qualified by training and/or experience in the field of mental health statutes and jurisprudence.

K. Every patient shall have the right to request an informal court hearing to be held at the discretion of the court within five days of the receipt of the request by the court. If the court determines that a hearing is appropriate and if the patient is not represented by an attorney of his own or from the mental health advocacy service, the court shall appoint an attorney to represent the patient. The purpose of the hearing shall be to determine whether or not the patient should be discharged from the treatment facility or transferred to a less restrictive and medically suitable treatment facility.

L. No provision hereof shall abridge or diminish the right of any patient to avail himself of the right of habeas corpus at any time.

M. Every patient shall have the right to be visited and examined at his own expense by a physician designated by him, a member of his family, or an interested party. The physician may consult and confer with the medical staff of the treatment facility and have the benefit of all information contained in the patient's medical record.

N. Prefrontal lobotomy shall be prohibited as a treatment solely for mental or emotional illness.

O. No medication may be administered to a patient except upon the order of a physician. The physician is responsible for all medications which he has ordered and which are administered to a patient. A record of medications administered to each patient shall be kept in his medical record. Medication shall not be used for nonmedical reasons such as punishment or for convenience of the staff.

P. A person admitted to a treatment facility has the right to an individualized treatment plan and periodic review to determine his progress. The appropriate staff of the facility shall review the person's progress at least at intervals of thirty, ninety, one hundred eighty days, and every

one hundred eighty days thereafter. The staff shall enter into the person's medical records his response to medical treatment, his current mental status, and specific reasons why continued treatment is necessary in the current setting or whether a treatment facility is available which is medically suitable and less restrictive of the patient's liberty.

Q. A person admitted to a treatment facility has the right to have available such treatment as is medically appropriate to his condition. Should the treatment facility be unable to provide an active and appropriate medical treatment program, the patient shall be discharged.

Rights of Patients in Accordance with the Joint Commission

A. The hospital provides the patient or surrogate decision maker with the information about the outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions. RI. 01.02.01 #20

B. The hospital informs the patient or surrogate decision-maker about unanticipated outcomes of care, treatment, and services that related to sentinel events considered reviewable by The Joint Commission. RI. 01.02. 01 #21.

C. The hospital respects the patient's right to pain management. RI.01.01.01. #8

Discharge Procedures

Definitions:

Formal Voluntary Admission means the admission of a person suffering from mental illness or substance abuse desiring admission to a treatment facility for diagnosis and/or treatment of such condition who may be formally admitted upon his written request. Such persons may be detained following a request for discharge pursuant to R.S.28:52.2.

A patient admitted under the provisions of this Section shall not be detained in the treatment facility for longer than seventy-two hours after making a valid written request for discharge to the director unless an emergency certificate is executed pursuant to R.S. 28:53, or unless judicial commitment is instituted pursuant to R.S. 28:54, after making a valid written request for discharge to the director of the treatment facility.

Judicial Commitment means the admission of a person, after a court hearing, who is determined to be dangerous to self or others or is gravely disabled as a result of mental illness or substance abuse, and the court renders a judgment for his commitment.

A. The director may discharge any patient that in his opinion discharge is appropriate. The director shall not be legally responsible to any person for the subsequent acts or behavior of a patient discharged in good faith.

B. A person who is judicially committed shall be allowed to appeal devolutively from the order to the court of appeal. If the lower court finds the individual indigent, it shall allow the appeal to

be taken in forma pauperis. Upon perfection of an appeal, it shall be heard in a summary manner, taking preference over all other cases except similar matters.

C. Upon affirmation of the order of commitment, the individual may apply for appropriate writs from the Supreme Court which shall be heard in a summary manner.

D. Nothing in this Title shall deny the right of habeas corpus, including an application based upon a change of circumstances.

Staff Education

During the hospital new employee orientation and annual training thereafter, all employees receive training on this policy. All employees are responsible for abiding by this policy.

Inquiries

Questions concerning this Policy should be directed to Client's Rights Officer, telephone (318) 484- 6207.

Related Policies & Documents:

CP01 Admission Criteria
CP02 Discharge Planning and Process
CP16 Client/Consumer Complaint Policy and Procedure
CP32 Restriction of Patient's Rights
CP59 Seclusion/Restraint
CP52 Pain Management
CP73 Patient, and When Appropriate, Their Families, Right to Be Informed About the Outcomes of Care and Unanticipated Outcomes.
AP20 Visiting Policy

MANAGEMENT DISCLOSURES

The Chief Executive Officer reserves the right to add, alter, change, or delete any and all prescribed policies and procedures of the agency as needs dictate without the necessity of giving prior notice and request for consent from employees or employee representatives. This includes the right to add, alter, change, or delete all work assignments, duties, requirements and responsibilities of Sections, Departments, Units, and individual employees. Violations of this policy may result in disciplinary action up to and including dismissal. All policies are available on the Central Louisiana State Hospital Intranet. Signed originals of each policy are available in the office of the Hospital Administrator.

Patient Confidentiality

LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**CP-23**
Content	**Patient Confidentiality**
Effective Date	04/94
Reviewed	04/95, 04/96, 04/97, 04/99, 07/02, 12/02, 02/05, 07/08, 06/16
Revised	04/00, 07/11, 03/15, 04/18, 06/18
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Medical Director

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital that the identity of individuals as patients of this hospital and all information concerning current patients and former patients remain confidential except as: 1) disclosed by the patient; 2) disclosed by the treatment team with a signed release by the patient or guardian with a Power of Attorney; 3) directed by the court; and 4) dictated by an emergency situation.

II. PURPOSE

To ensure the identity of individuals as patients of the hospital and information concerning current and discharged patients are confidential.

III. APPLICABILITY

All hospital settings

IV. EFFECTIVE DATE

The effective date of this policy is April 1994.

V. POLICY PROVISIONS/PROCEDURES

1. Staff **will not** acknowledge to a telephone caller from outside the hospital that a person is/is not a patient, or was a former patient of this hospital. Refer caller to immediate supervisor. NOTE: After regular business hours, weekends and holidays, refer caller to the Administrative On Duty person.

2. Staff **will not** verbally disclose patient information to a telephone caller from outside the hospital about a current patient or a former patient. For persons authorized to receive information, the patient ID code must be provided and there must be a signed release on record first. If the request is in regards to a former patient, refer caller to the Health Information Director (Medical Records).

3. Staff **will not** disclose patient information to visitors unless there is a signed release by the patient to disclose information to that person.

4. Staff **will not** discuss patient information within the hearing range of other patients and visitors.

5. Staff **will not** discuss patient information with other patients and visitors.

INQUIRIES

Questions concerning this policy and procedure should be directed the Clients Rights Officer.

Related Policies & Documents:

AP-53 Identification Code Numbers for Patients

MANAGEMENT DISCLOSURES

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Labeling of Charts for Allergies and Medication Contraindications

LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**CP-24**
Content	Labeling of Charts for Allergies and Medication Contraindications
Effective Date	04/94
Reviewed	04/95, 04/96, 04/97, 07/02, 03/05, 03/08, 06/16
Revised	05/99, 07/11, 3/15, 4/18
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Medical Director

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital that medications or other allergens to which a patient has a known hypersensitive state acquired through exposure shall be indicated on a sticker affixed to the front of the patient's medical record.

Medications specifically contraindicated for administration to the patient based on clinical judgment and/or drug protocols approved by the Medical Staff may be listed as do not give (DNG).

Allergies and DNG medications will be listed as separate problems on the patient's active problem list. If a DNG is activated due to a drug protocol, the discontinuation of the drug protocol is justification for closure of the active problem.

Allergies and do not give medications will be entered in the following areas of the patient's clinical documentation:

- Label on front of chart
- Header of the MAR
- Header of the physician's order sheet
- Treatment Plan
- Active Problem List

II. PURPOSE

To establish a policy to identify allergies and contraindicated medications affecting the safety of CLSH patients

III. APPLICABILITY

All inpatient settings

IV. EFFECTIVE DATE

The effective date of this policy is April 1994.

V. POLICY PROVISIONS/PROCEDURES

At the time of admission, the nurse shall make inquiry into patient allergies. She will communicate that information to the LIP who will address the patient's allergies in his initial assessment. Upon determination of the patient's allergies, in coordination with the LIP, the nurse will affix an "Alert" sticker to the front of the patient's medical record. If the allergy is known at the time of admission, the date of admission will be entered in parentheses after the name(s) of the medications or other allergen(s) to which the patient is allergic.

At any time should the "Alert" sticker become illegible, a new sticker including the required information should be affixed to the front of the patient's record by the assigned RN.

"Alert" stickers may be obtained from Nursing Administration.

If the allergy is identified during the patient's hospitalization, the medication or other allergen will be entered on the sticker with the date allergy was identified. Subsequently, the nurse will add the name of the medication or other allergen, as authorized, for entry onto the "Alert" sticker by the treating physician who will write an order to include identified allergy and indicate the occurrence in his progress notes. The date of the physician's order will be entered after the drug or allergen name in parentheses.

Specific drug contraindications pertinent to the patient's care may be entered onto the patient's medical record in the form of a DNG order. If the physician has written an order restricting the administration of medication(s), the physician will document his rationale in the progress notes. The nurse will affix an "Alert" sticker to the front of the patient's record and indicate the date of the physician's order.

Related Policies & Documents:

Pharmacy Policies and Procedures – Clozaril Atypical Protocol and DNG

Disposition of Opened Multi-dose Medication Vials	
LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**CP-41**
Content	**Disposition of Opened Multi-dose Medication Vials**
Effective Date	04/94
Reviewed	04/95, 04/96, 04/97, 04/99, 07/02, 03/12, 10/16
Revised	03/00, 10/04, 08/07, 02/08, 02/09, 02/17, 10/18
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Medical Director

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital to assure sterility/stability of parenteral medication packaged in multi-dose vials a procedure for dating and return of such medication within the manufacturer's guidelines after the initial puncture of the sterility membrane is established.

II. PURPOSE

Allow vials to remain on the nursing unit within the manufacturer's guidelines after puncture of the protective vial diaphragm.

III. APPLICABILITY

All hospital settings

IV. EFFECTIVE DATE

The effective date of this policy is April 1994.

V. POLICY PROVISIONS/PROCEDURES

Multi-dose Parenteral Medical Vials:

Parenteral medications commonly are dispensed in multi-dose parenteral medication (MDVs) that may be used for prolonged periods for one or more patients. According to the Centers for Disease Control the overall risk of extrinsic contamination of MDVs appears to be small, an estimated 0.5 per 1000 vials through contamination of MDVs due to breaks in aseptic technique have resulted in nosocomial outbreaks.

CDC reports that in a study of preservative-containing multi-dose injectables, bacteria remained viable significantly longer in refrigerated vials than in vials stored at room temperature, suggesting that multi-dose vials can be stored safely at room temperature unless manufacturers' recommendations or drug stability dictate otherwise.

a) Once the sterility membrane on a parenteral multi-dose vial has been compromised (punctured), the nurse withdrawing that initial dose of medication will record the date of puncture and the 28 day expiration date on the container. The multi-dose parenteral

medication should be stored safely according to the manufacturer's recommendations. When injectables are supplied to the individual patient, they should be stored in the patient's medication bin. Multi-dose vials remain useable once punctured, according to the manufacturer's guidelines up to 28 days maximum. All multi-dose vials must be returned to the pharmacy 28 days after initial puncture. This excludes Influenza vaccine, which will be utilized according to the manufacturer's guidelines alone.

A replacement vial may be obtained from the Pharmacy through the usual requisitioning procedure.

VI. Monitoring:

Medical Director

Related Policies & Documents:

Refer to pharmacy guidelines for details.

CLIENT MEDICATION EDUCATION

LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**CP-42**
Content	CLIENT MEDICATION EDUCATION
Effective Date	April 20, 1994
Reviewed	04/95, 04/96, 04/97, 04/99, 04/00, 03/02, 08/07, 09/17
Revised	06/97, 02/04, 03/04, 08/10, 11/13, 08/15
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Medical Director

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital to provide medication education and counseling which includes written/printed material provided at discharge.

II. PURPOSE

To update current procedures.

III. APPLICABILITY

All hospital settings.

IV. EFFECTIVE DATE

The effective date is April 20, 1994.

V. POLICY PROVISIONS/PROCEDURES

Patient Medication Education Form #4-41-53 (rev) is used to document client medication education done on the unit by nursing staff.

Information to be given the client or other caregivers should include, but is not limited to, the following:

1. Name, description and use of the medication
2. Dosage and instructions for taking the medication (including the duration) and what to do if a dose is missed)
3. Any special instructions with regard to medication use or use of medical equipment for dosage delivery or monitoring
4. What to do if the client experiences side effects or adverse effects
5. Other considerations of therapy with regard to diet and other drugs or alcohol
6. Proper storage of medication and how to obtain refills.

Medication information sheets are available for each nursing unit to use when instructing clients/families. Additional information can be found in the following resources available in each client care area:

- USP-DI, current edition
- Educational materials are available for families on psychopharmacology
- Counseling materials for clients with special needs (Grade 3 reading level, language, physical impairments) can be obtained through the Pharmacy Department.

Prior to discharge, the client and/or family will receive education about the medications being sent with the client. The nurse will provide such education. When the nurse provides the education (when medication for discharge is picked up on the unit), it will be documented on the Patient Medication Education Sheet. In addition to verbal counseling, printed Medication Information Sheets are included with the prescriptions that are dispensed at time of discharge.

MANAGEMENT DISCLOSURES

The Chief Executive Officer reserves the right to add, alter, change, or delete any and all prescribed policies and procedures of the agency as needs dictate without the necessity of giving prior notice and request for consent from employees or employee representatives. This includes the right to add, alter, change, or delete all work assignments, duties, requirements and responsibilities of Sections, Departments, Units, and individual employees. Violations of this policy may result in disciplinary action up to and including dismissal. All policies are available on the Central Louisiana State Hospital Intranet. Signed originals of each policy are available in the office of the Hospital Administrator.

Medical Emergency and Early Recognition Policy	
LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**CP-57**
Content	**Medical Emergency and Early Recognition Policy**
Effective Date	02/1995
Reviewed	04/95, 04/96, 04/97, 04/04, 10/04
Revised	10/97, 04/99, 12/02, 04/08, 08/08, 01/09, 07/11, 11/11, 09/14, 01/16, 10/17
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Medical Director

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital that No employee will be subject to negative administrative action for activating this emergency response protocol in good faith and without malice.

A. Physician emergency coverage is available through a Medical On-Duty schedule published on a monthly basis.

B. All hospital direct care staff are CPR certified and recertified every two years, and meet all legal requirements.

C. First-aid training is available and is provided every two years to appropriate staff.

II. PURPOSE

To assure that there is an appropriate mechanism in place to handle any and all medical emergencies so that patients, employees, and visitors will be treated and referred in the best possible manner. Early recognition of clinical deterioration will be supported and encouraged in an attempt to reduce or eliminate acute emergencies.

III. APPLICABILITY

All hospital clients, settings, and clinical staff.

IV. EFFECTIVE DATE

The effective date is February 1995.

V. POLICY PROVISIONS/PROCEDURES

Definitions:

A medical emergency is defined as an incident/illness, which constitutes a danger to life or limb or at least is identified as such through assessment or requires further assessment. This applies to patients, staff, and visitors.

Early recognition of clinical deterioration is valuable in reducing the number and intensity of medical emergencies. The response to such early recognition is outlined below.

EMERGENCY SERVICES

I. GENERAL PROCEDURES

Any emergency, or suspected emergency, involving patients, staff or visitors shall be evaluated by either an M.D. or Nurse. However, if not available, any staff member shall initiate first aid or assess for CPR. Unless the condition is immediately resolved, the following steps will be implemented.

A. If an employee suspects there is significant medical deterioration in the condition of a patient, staff, or visitor, the first step is to assure that the affected person does not need immediate emergency care such as CPR.

- Next, the unit physician is notified to evaluate the person
- If unavailable promptly, another staff physician, the on-call physician, the Medical Clinic Physician or the Medical Director is to be notified to evaluate
- In the unlikely event that none of the above is available promptly, the employee shall proceed with the "Medical Emergency Procedures" outlined below without delay by calling the Medical Emergency Hot Line "6911".

B. Circumstances that might trigger concern that a significant deterioration is occurring, included but are not limited to:

- Acute changes in heart rate, blood pressure, respiratory rate or level of consciousness
- Significant concern that the patient does not look well or stable
- Signs or symptoms suggestive of an acute coronary syndrome
- Signs or symptoms of stroke

II. MEDICAL EMERGENCY PROCEDURES

A. Medical personnel (i.e., physician, nurse or staff member) in the immediate vicinity will, based upon the initial assessment, attempt to stabilize the individual.

- If medical personnel are unavailable, the hospital operator shall be contacted by calling the Medical Emergency Hot Line "6911". The caller should give their name and unit number and identify the nature of the medical emergency.

B. Based upon the emergency situation, the operator shall also notify appropriate services such as:

- Acadian Ambulance Service advising them of the type of emergency

- Security Department to meet the ambulance at the front gate and escort the emergency vehicle to the unit
- Chief Executive Officer/Designee
- City Police, if appropriate
- Fire Department, when appropriate
- If staff member emergency, notify Personnel Department for notification of appropriate family member, etc.
- If visitor, based upon visitor request, make appropriate notification.

C. Medical Emergencies (Leased Units)

- Call 911.
- Give your name and unit number.
- Inform the 911 operator of the type of medical emergency.
- Call the CLSH switchboard operator (O) and advise her that you have a medical emergency.
- The operator will notify security.
- The Security Department will meet the emergency vehicles at the front gate and escort them to the location of the medical emergency.

III. PATIENT EMERGENCY

A. The following information shall accompany the patient:

- Green Consult Sheet
- Face Sheet
- Intake Data Sheet
- List of Current Meds.

B. The Unit Nurse or House Manager shall have the following records sent with the patient or as soon as possible thereafter. The Unit Physician or Unit Nurse will notify the Emergency Room of the transfer. A hospital staff member will always accompany the patient.

- Consult Sheet properly filled out with pertinent medical information
- Procedure for emergency release of medical records shall be followed
- Completed Injury Review form

C. If the incident is assessed as non-life-threatening, the patient shall be assessed for further care by a physician, who shall write a progress note based on the findings. The patient will be referred to the 7A Medical Clinic for follow-up care.

IV. EMPLOYEE EMERGENCY

A. If an emergency situation is determined, a physician, nurse, or staff assess the staff member and administer first aid or initiate CPR.

B. If potentially life threatening, notify EMS for assessment/transport.

C. If not life threatening, the employee may be referred to a physician of their choice.

V. VISITOR EMERGENCY

If an emergency situation is determined, EMS shall be notified and appropriate care (i.e. first aid or initiate CPR) shall be implemented.

VI. STAFF EDUCATION

All staff will receive education regarding this policy as well as signs of and procedure for early recognition of clinical deterioration at initial orientation and annually thereafter. This education will be conducted by the Education and Training Department.

VII. EMERGENCY PHONE NUMBERS

CLSH Switchboard 0
CLSH Medical Emergency Hot Line 6911
CLSH Fire 6911
Pineville Police Department 442-6603
Pineville Fire Department 442-4452
Ambulance 448-3596
Rapides General Hospital 473-3000
St. Frances Cabrini Hospital 487-1122
Rapides Parish Communication Center 911
Acadian Ambulance 311

VIII. NON-EMERGENCY TRANSPORTATION (CLSH)

Non-emergency transportation shall be defined as non-life threatening transporting of a patient/client of CLSH who needs to be transported.

- Call the Operator by dialing "0".
- Give your name and unit number.
- Inform the operator of the nature of your request for non-emergency transportation.
- The operator will notify the Security Department.

Related Policies & Documents:
CLSH Security Manuel

MANAGEMENT DISCLOSURES

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Contraband Search Policy	
LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**CP-58**
Content	Contraband Search Policy
Effective Date	06/95
Reviewed	04/96, 04/97, 04/99, 04/00, 07/02, 10/07, 11/11, 10/15
Revised	02/04, 07/08, 8/14, 05/16, 09/17
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Medical Director

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital that no person will have in his/her possession or under his/her custody any item that is potentially hazardous to clients/staff/visitors. Therefore, all individuals and individual's belongings will be searched for contraband at identified times.

It is also the policy of Central Louisiana State Hospital to respect the dignity and rights of all individuals during the search procedure.

II. PURPOSE

Searches for contraband will be instituted solely for the protection of patients, staff, and visitors.

III. APPLICABILITY

All hospital settings

IV. EFFECTIVE DATE

The effective date is June 1995.

V. POLICY PROVISIONS/PROCEDURES

Definitions:

Contraband shall be defined as any item or instrument that may be used to cause harm to any patient, staff member or visitor or any substance or drug that may be harmful or illegal

Note: No shoelaces or strings are allowed.

Procedure:

A. ADMISSIONS OFFICE SEARCH:

1. From 8:00 a.m. to 4:30 p.m., Monday through Friday, Admission staff will notify Security staff that an individual is being processed for admission and is ready for the "contraband search."

2. From 4:31 p.m. to 7:59 a.m., Monday through Friday, and on weekends and holidays, the telephone operator or the O.D. nurse will notify Security staff that an individual is being processed for admission and is ready for the "contraband search."

3. Prior to the search, staff members conducting the search will explain the search procedure to the individual.

4. Individuals will be asked to empty out pockets of the clothing they are wearing and remove all metal objects from their person and clothing.

5. This search will be conducted by staff from Security and Nursing services and will employ the use of a metal detector, which will be moved along close to the individual's body and over all of the individual's clothing.

6. If the search indicates something suspicious, which cannot be identified or verified, the patient will be asked to remove their clothing in stages for a visual body search. Two staff members, preferably of the same sex as the patient, will conduct this search.

7. Large amounts of cash, credit cards, jewelry or other valuables will be placed in the hospital safe in the Patients' Accounts Department.

8. Contraband will be returned to the individual at the time of discharge or, if indicated, turned over to proper authorities.

9. Admission personnel will list all items on Inventory of Patients' Personal Items Form #4-41-39, sign the form indicating the search was completed, and file the form in the medical record.

10. All pertinent facts relating to the search will be documented by Nursing staff in the Nurses' Progress Note section of the medical record of the individual.

11. If contraband is found, a Client Incident, Injury and Data Reporting Form will be completed by Nursing staff and signed by Security staff indicating the confiscation of questionable item(s).

B. <u>BODY/BELONGINGS VISUAL SEARCHES:</u>

Contraband search and visual inspection of patient's body/belongings will be conducted:

- When a patient is admitted to the unit.
- Upon initiation of precaution
- As specified by the physician on the Precautions Order Sheet
- When a patient returns from off-grounds passes such as home or town passes.

- When a patient returns from elopement.
- After a patient has had a visitor
- When there is suspicion that a client may be in possession of a dangerous substance or object that may be of harm to self/others.
- When a patient returns from a trip off campus (medical appointments, shopping, etc.)

1. This procedure is routinely conducted by Nursing staff members. However, if contraband is suspected or if the patient is presenting behavior(s) deemed dangerous to self or others, the Unit nurse will assess the situation and determine if Security officers should be present to assist nursing members during the search for safety purposes. Procedures as described in nursing and unit policies shall be followed in this regard.

2. A verbal consent should be obtained from the patient prior to conducting the body/belongings visual search. Explain the rationale for the procedure, how it will be completed, and encourage the patient to participate. If the patient refuses to allow the procedure, notify the physician for an order and proceed with the search.

3. Carefully search all personal items including luggage, purses, billfolds, packages, etc., that the patient brings to the unit. Use metal detector as part of this body/belongings visual search procedure, as outlined in nursing procedure manual.

4. Ask the patient to empty pockets in their clothing. Check contents.

5. The body search/assessment is accomplished by visual inspection. If assessed that a more detailed body cavity search is needed, then a physician's order must be obtained prior to the search and justification clearly documented in the patient's medical record.

6. The body search/assessment must be conducted by two staff members.

7. Any contraband found will be properly stored or disposed of by Nursing or Security staff, depending upon the object(s) or substance found. For example, a lighter might be stored in the patient's personal effect cabinet, whereas, illegal drugs would be confiscated by Security.

8. Staff members who conduct the body/belongings search will properly dispose of articles. Clothing/safe items will be given to the patient. Items deemed unsafe to keep out on the unit will be properly stored.

9. If contraband is found during any search procedure, the Unit nurse will be notified. The Unit nurse will assess the situation and notify other persons, as appropriate, which may include direct supervisor, Unit physician, treatment team members and, if after hours, the AOD.

10. Each department will complete appropriate reports. Nursing staff will document in the Nursing Progress Notes the event itself, the rationale for the search, the findings and/or disposition of items. If contraband is found, Nursing staff will fill out a Client Incident, Injury and Data Reporting Form and the assisting Security officer will sign it, if applicable, indicating the confiscation of any item(s).

C. UNIT SEARCHES FOR CONTRABAND:

1. If there is reason to suspect that contraband materials are present on a unit, a search may be initiated by Unit staff members. Security officers may be called to assist. The Unit nurse will assess the situation and notify other persons, as appropriate, which may include direct supervisor, Unit physician, treatment team members and, if after hours, the AOD.

2. Nursing staff will inform patients that there is going to be a unit search and the reason for the search. Patients may be asked to open their lockers during the search.

3. Any contraband found will be properly stored or disposed of by Nursing or Security staff, depending upon the object(s) or substance found. For example, a lighter might be stored in the patient's personal effect cabinet, whereas, illegal drugs would be confiscated by Security.

4. Record events of this search on appropriate departmental forms. If contraband is found, complete a Client Incident, Injury and Data Reporting Form. Security will note on the Incident Form any seized items. Enter all pertinent information in the medical record of any patient found with contraband.

Contraband Protocol

I. When contraband protocol is ordered by LIP, the following will be adhered to **unless otherwise specified by LIP** on the contraband protocol order:

1. The patient will wear elastic scrub bottoms. No clothing with drawstrings, pockets, tags, buttons, snaps, or zippers allowed.
2. The patient must use alternate eating utensils.
3. The patient is not allowed to have any item in his/her possession, including but not limited to pens, pencils, colored pencils, money (coins or paper), magazines, books, games, unless specified by the LIP on the contraband protocol order.

II. A contraband search will be performed at the frequency ordered by the LIP and documented on the therapeutic surveillance flow sheet. The contraband search will include the following:

1. The patient's shirt, pants, shoes (including under soles), and socks will be searched for contraband.
2. When the patient is in the day area, the corners of the room, the air conditioner cage (if applicable), the patients chair and table will be searched for contraband.
3. When the patient is in his/her bed area, the blankets, pillow cases, sheets, under mattress, and air conditioner cage (if applicable) will be searched.
4. Search of patient's body/clothing will include use of the metal detector by staff.
   In addition to the metal detector being utilized during contraband search, staff will employ use of the metal detector:
   a) After patient uses bathroom
   b) After return from outside activity
   c) After return from any appointments on grounds or off grounds.
   d) When changing from one staff to another (including shift change)

III. Magnetic Sweeper:

1. In addition to the designated contraband search, the magnetic sweeper will be utilized throughout the entire patient care unit within the first hour of each shift.
2. Use of the magnetic sweeper will be assigned to nursing staff responsible for the suicide risk reduction rounds and included on the psychiatric aide assignment sheet.
3. The assigned psychiatric aide will document on the suicide rounds form upon completion of unit sweep.

MANAGEMENT DISCLOSURES

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Incident Reporting

LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**CP-76**
Content	Incident Reporting
Effective Date	11/2003
Reviewed	
Revised	02/04, 06/04, 05/05, 04/06, 03/09, 4/12, 8/12, 05/15, 01/17, 03/17, 06/17, 11/17
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Medical Director

I. POLICY STATEMENT

Central Louisiana State Hospital will assure that patient and staff safety is protected and that hospital functions are carried out appropriately. This policy establishes a system for timely reporting and review of patient incidents.

In cases of suspected client abuse, neglect or exploitation please refer to AP 44.

II. PURPOSE

To promote patient and staff safety by documenting, analyzing, and responding to incidents of threat or potential threat to patients.

III. APPLICABILITY

This policy applies to all employees of the LDH and its affiliates and to all persons receiving services from LDH and its affiliates.

IV. EFFECTIVE DATE

The effective date of this policy is November 2003.

V. POLICY PROVISIONS/PROCEDURES

Definitions:

An **incident** (for which a client incident, injury and data reporting form must be prepared) is an occurrence in which a patient sustains an injury or is potentially placed in a dangerous situation, or is allegedly the victim of abuse, neglect or exploitation.

Examples include death, medication discrepancies, attempted or completed self-harm or self-injury, attempted or completed elopement, altercation, sexual activity, property destruction, aggressive behavior, falls, slips, threats of violence or other accidents with potential for injury.

Illness is included if the event is a new onset of a potentially serious problem or involves injury. Episodes of ongoing illness not involving injury, especially if the illness is recognized and under treatment, are not included.

Minor accidental superficial scrapes or bumps not requiring intervention beyond hygiene are not included. Any injury requiring medical evaluation is included. Any injury or attempted injury involving contraband is included.

Procedures:

Any employee, agent of the facility, or an affiliate agency who has knowledge of, or is a witness to an incident will:

1. Immediately take measures to protect the safety and well being of the client(s) or staff involved and notify appropriate supervisory personnel.

2. Complete form OBH-03 (9/14) Form 1 (Client Incident, Injury and Data Reporting form) and the STATE OF LOUSIANA DEPARTMENT OF HEALTH – 24 HOUR FACILITIES SUPPLEMENTAL DA-3000 QUESTIONS FORM. This form must be completed by the individual to whom the report is first made and/or the individual who first became aware of the incident. This report must be completed by the end of the employee's shift or as soon thereafter as possible

3. The Injury Review Form OBH-03 (9/14) Form 2 must be completed by appropriate personnel if client was referred for injury review.

Distribution

All incidents other than abuse or neglect:

a. Original to Nursing Director's Office

b. Copy to CRO (Client Rights Officer)

c. Copy to Medical Director

d. Copy to CEO

e. Copy to COO

f. Copy to HR Director

g. Copy to the Safety Officer

h. Nursing Director/Designee will review for completeness, initial, make a copy for nursing files and send the original to Quality Management Department

i. A Quality Management Department representative will sign receipt for the original incident report, enter into the computer, and collect data for monitoring purposes; QM will forward the original to the Health Information Director to be filed in the client's folder.

j. If the incident is an alleged abuse, exploitation or neglect the only change in distribution is that the CRO will get the original and a copy of the report will be sent to the Nursing Director for the same distribution.

Criteria for Review

The following criteria will be utilized for intensive review.

a. Any injury requiring off campus medical evaluation or care.

b. Self-injury with contraband or patient found with dangerous contraband.

c. Elopement not directly observed by staff responsible for accountability.

d. Any attempted elopement or other incident in which a question of inappropriate supervision/accountability is identified/raised.

e. Any incident judged by the monitoring team as a serious deviation from usual care, functioning or procedures for patient monitoring or accountability.

f. All incidents involving restraint.

g. Falls sustained by identified fall risk patients.

h. Medical emergency events such as cardiac arrest, respiratory arrest, or airway obstruction.

i. Medication administration errors.

Procedure

1. 100% of the incident reports are reviewed by the DON/Designee. Incident reports meeting the above criteria are reviewed by the Intensive Review team Monday through Friday. Incident reports that occur on the weekend and meet the above criteria will be reviewed by the Intensive Review Team on Monday morning.

2. The Intensive Review team shall consist of the DON and/or the ADON, the Unit R.N. Manager/Designee, the Quality Management Director and/or designee, Client Rights

Officer, the Safety Officer, when appropriate, and the Medical Director, when able to attend.

Action to be Taken When Incidents Meet the Intensive Review Criteria

1. The Intensive Review team will review the incidents(s) and answer the question: Why did this occur? The team will determine if corrective action is required and designate the responsible party. Incidents meeting intensive review criteria but involving allegations of abuse or neglect will be reviewed in the context of CLSH systems and procedures, but will not address the validity of the allegation.

2. Quality Management shall maintain a log of incidents and corrective actions taken until resolution. Follow-up on other incidents not requiring intensive review will also be noted on the log.

3. When appropriate, Safety Alerts will be emailed to all staff by the Quality Management Director. This alert is a hospital wide notification of problem areas uncovered in the hospital through the incident report review. All Department heads and unit managers shall review alerts with their staff at their respective meetings and nursing shall review it at each shift change until all nursing shifts are aware of the alert.

Related Policies & Documents:

AP44

MANAGEMENT DISCLOSURES

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CP-93 Physician Verbal and Phone Orders

LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**CP-93**
Content	**Physician Verbal and Phone Orders**
Effective Date	05/09
Reviewed	03/16, 03/18
Revised	04/11, 01/15
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Medical Director

I. POLICY STATEMENT

It is the policy of Central Louisiana State Hospital that routine verbal orders are not allowed at Central Hospital except in dire emergencies. All instances of verbal orders given by physicians and received by nursing staff will be reviewed after the fact by the Medical Director and the Director of Nursing.

II. PURPOSE

To eliminate verbal orders and to ensure phone orders are signed, dated, and timed within applicable regulatory guidelines

III. APPLICABILITY

All inpatient settings.

IV. EFFECTIVE DATE

The effective date of this policy is May 2009.

V. POLICY PROVISIONS/PROCEDURES

Verbal Orders: Orders given by a physician to a nurse verbally, but not telephonically, when both are within normal hearing range of each other.

Phone Orders: Specific type of verbal order delivered by a physician to a nurse via telephone when the physician is not on-site.

Phone orders will be given, received, and recorded in the usual fashion, consistent with current nursing and clinical policies, rules, and regulations. Nursing staff will record patient name, date and time the order was received on the unit conference room board and assure a physician signature is obtained by the next morning, but no later than 72 hours. Each morning, Saturday and Sunday, nursing will notify On-Call physician if there are phone orders to be signed.

MANAGEMENT DISCLOSURES

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Diversity in the Workplace

(Taken from HSTN: EDA 280-0244)

Cultural diversity awareness and sensitivity is a top priority in healthcare facilities today and the new standard of the future. In the United States alone, projections for the next 50 years show a continued growth in all the major minority groups. Approximately 25% of the U.S. population now belongs to ethnic or racial minority groups. In healthcare, approximately 10%, or about 250, 000 of 2,550,000 RNs in the United States are from a racial or ethnic minority. Because such a large percentage of patients and staff are from different cultures, the ability to communicate across cultures is a top priority in healthcare organizations. Diversity awareness and cultural sensitivity training can help achieve this goal.

TARGET AUDIENCE

The target audience for this activity includes all ancillary staff.

LEARNING OBJECTIVES

After completing this activity, the participant should be able to:

1. Explain the importance of being sensitive to cultural differences at work.
2. Identify six attitudes that affect how people communicate across cultures.
3. Discuss issues in caring for patients from different cultures.
4. List common things people do that can help or hinder communication.
5. Examine case studies related to cultural diversity.

DIVERSITY IN THE WORKPLACE

Workers who are skilled in dealing with different cultures are in high demand in healthcare today. In the United States, the next 50 years are expected to show steady growth in all minority groups. About 25% of the U.S. population belongs to ethnic or racial minority groups. 12% are African American, 9% are Hispanic, 4% are Asian and 2% belong to other groups. In fact, 10% of all RNs in the United States are from a racial or ethnic group.

Patients and staff are now more diverse culturally than ever before. An employee who can work well with other cultures is a real asset in a healthcare facility. Learn to work with diverse cultures. The more you know about any given culture, the more sensitive you are to each group's needs.

CULTURAL SENSITIVITY DEFINED

Let's define *cultural sensitivity*. Cultural Sensitivity is defined as having knowledge of the values and norms of other cultures. It is an important part of giving good care to all patients. It begins with thinking about your own personal feelings, values and beliefs. Look at your own feelings toward people who are different from you. This is the first step in learning how to work in a diverse team. When you know how you feel about people who are different than you, you can begin to work better with other cultures.

Make the effort to learn about the differences between cultures and ethnic groups. Accepting the differences of others will help bring your team closer together. Take a moment to complete the cultural sensitivity worksheet included. This worksheet asks questions about your personal values and feelings toward other cultures. Use it to gain insight into possible problems you may have when dealing with other cultures.

After you have a better idea of your own values and beliefs, you are ready to take the next step, which is to think about how a person from another culture may think of you. The way 2 people from different cultures relate to each other is influenced by each person's *attitude*. Attitudes are the feelings and thoughts you have

about another person. Sometimes you may not even know you have a negative attitude towards others. If you are not careful these attitudes can create a self-fulfilling prophecy; in other words, because you have negative attitudes toward people of other cultures, you will behave negatively toward them.

BARRIERS TO WORKING WITH OTHER CULTURES

In fact, your attitude can control whether you view working with diverse coworkers and patients as a good thing or a bad thing. When talking with a person from a different culture, pay attention to the following six attitudes. These attitudes can cause problems when dealing with different cultures:

1. Assumed similarity.
2. Comfort with the familiar.
3. Anxiety and tension.
4. Ethnocentrism.
5. Stereotyping.
6. Prejudice.

ASSUMED SIMILARITY

The first attitude to watch out for is *assumed similarity*. When you assume similarity, you tend to think that everyone else sees the world the same way you do. For example, a nurse assumes that a patient can read a brochure because the nurse can read it and in the nurse's experience other patients have been able to read it. In reality though, not all people learn the same way. A patient may be able to understand spoken English but not be able to read it. In this situation, the nurse's belief could lead to errors in treatment. The patient may learn by seeing, doing or a combination of the two. The best solution is to use more than one approach. In addition to offering a brochure, offer treatment options out loud and show the procedure if possible. This is the best way to make sure that the patient understands the nurse's instructions.

COMFORT WITH THE FAMILIAR

The second attitude to look for is *comfort with the familiar*. This means that we are often drawn to others who look, act or think the way we do. For example, an employee in a long-term care facility probably tends to eat lunch with coworkers from the same unit or department because they are familiar to the coworker. A new person however may feel more comfortable eating lunch with a coworker from another department if the two went through orientation together.

ANXIETY AND TENSION

The third attitude to be aware of is *anxiety and tension*. Anxiety and tension can happen when you feel uncomfortable around people who are different from you. The key here is how you handle the problem. In the case of the new employee who eats with another department, coworkers in the employee's department can invite him or her to eat lunch with them. On the other hand, the coworkers could also snub the new person for being different. How the coworkers treat the new member affects everyone. It will either add to or cut down on the anxiety and tension of all the members of the group, especially for the new person.

ETHNOCENTRISM

The fourth attitude to watch out for is *ethnocentrism*. This is the belief that one's own culture or ethnic group is better than anyone else's. Differences are often viewed as inferior. If a new staff member thinks of boldness as a good thing, he or she may feel free to ask questions and debate issues with the supervisor. However, if the supervisor is from a culture that values harmony over boldness, he or she may think the new person is bossy or rude. Before taking offense, put yourself in the other person's place. Think about his or her cultural norms before making an assumption.

STEREOTYPING

The fifth attitude to look out for is *stereotyping*. A stereotype is an exaggerated belief about a person based on his or her background. Thinking that all nurses from other countries have poor training is an example

of a stereotype. Judge a person based on what he or she actually does. Do not judge on what you think that person will do.

'REJUDICE

The sixth and final attitude is *prejudice*. Prejudice is a hostile attitude towards people who do not fit in with your group. Treating a coworker from another country or culture as if he or she is not smart is an example of prejudice. Language can often be a big problem for the staff members another country. The medical terms are different. Medications have different names. A coworker with low English skills is often translating in his or her head at work.

To help the coworker, allow him or her to record information to listen to later if possible. This can be especially helpful in a pre-screening situation in which a nurse must complete assignments before starting work. He or she might find it easier to read in a second language than to listen to it. That person may also need more time to take tests than usual.

CARING FOR PATIENTS

Now that have learned about some of the attitudes that can cause problems, take a moment to think about some of the issues that can come up when caring for patients from diverse cultures. It is, of course, important for you to be able to talk with the patient regardless of his or her culture. It is impossible to know the social customs and values of every culture. It is possible, however, to tailor you speaking style to the needs of the patient. The more you know about a patient's culture and values, the more likely you are to get your point across.

ASK QUESTIONS

For example, ask questions. Asking the patient about his or her culture is as important as asking the patient about his or her health. It is a lot like completing a patient health assessment. In addition to asking if the patient if he or she has a family history of heart disease or high blood pressure, ask about the patient's culture as 't relates to treatment.

Answers to these questions can help you take any special precautions and provide the patient with the best acre possible. A Jewish or Hindu patient may have special dietary needs, for example. Explain to the patient what he or she can expect in the way of treatment. Also explain how the treatment may differ from what the patient is used to. Asking questions about a patient's culture adds to your ability to see issues from his or her point of view.

WATCH FOR CLUES

In addition to asking the patient about his or her cultural values, pay attention to how the patient answers questions. Watch what a person does when he or she is speaking. Knowing what to look for can help you avoid misunderstandings. Take eye contact, for example. A person who does not value boldness may think its rude. Take your cues from the other person.

Other things to watch for are how close a person stands to you, the gestures he or she uses, and his or her tone of voice. Each one of these things can mean something different, depending on the culture. In some cultures, standing close to a person when speaking is a sign of respect. In other cultures, standing to close to a person can make him or her uncomfortable. Spotting these differences is speaking styles can help you better understand the other person. It can also help you recover if you make a mistake. If you accidentally offend a coworker or patient, apologize at once.

Even though a person from another culture may speak differently than you do, some basic principles still apply. For instance, smile, speak in a friendly tone of voice, and treat others fairly and respectfully. Make allowances for differences in customs and social background.

SUMMARY

As we grow more culturally diverse, the need for cultural sensitivity and skilled communication increases. Check with your human resource department for more information on how to deal with diverse cultures in the workplace. All patients and coworkers have a basic right to respect, equal treatment and good care, and providing these rights should be part of the goals of any healthcare organization.

DISCUSSION QUESTIONS

1. What assumptions do healthcare workers make about patients or colleagues from different cultures?
2. What are some misconceptions you have discovered when dealing with a patient from a different culture or ethnic group?
3. Why is understanding cultural diversity important to you in your position in the facility?
4. Of the interpersonal attitudes discussed in the syllabus, which attitude have you had difficulty with and how can you learn more to avoid future misconceptions?

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Laroche, L. (2002). *Managing cultural diversity in the technical professions*. New York: Elsvier Science & Techology Books.

Thomas, R.R. & Woodruff, M.I. (1999). Building a house for diversity: A fable about a giraffe and an elephant offers new strategies for today's workforce. New York: Amacom.

Enumeration of Stages

The stages are:

1. **Denial and isolation – The "No, not me" stage.**: *"This is not happening to me."*
2. **Anger – The "Why me?" stage.:** *"How dare you do this to me?!"* (either referring to a God, the late person, or themselves)
3. **Bargaining – The "If I do this, you'll do that" stage**: *Just let me live to see my son graduate."*
4. **Depression – The "It's really happened" stage:** *"I can't bear to face going through this, putting my family through this."*
5. **Acceptance – The "This is going to happen" stage:** *I'm ready, I don't want to struggle anymore."*

Kubler-Ross originally applied these stages to any form of catastrophic personal loss, such as the death of a loved one, or even divorce. She also claimed these steps do not necessarily come in order, nor are they all experienced by all patients, though she stated a person will always experience at least two.

Others have noticed that any significant personal change can follow these stages. For example, experienced criminal defense attorneys are aware that defendants who are facing stiff sentences, yet have no defenses or mitigating factors to lessen their sentences, often experience the stages. Accordingly, they must get to the acceptance stage before they are prepared to plead guilty.

Grief

In popular culture these stages are almost exclusively applied only to news of one's own impending death. The notion that to resolve grief they must all be followed, in order, is also common.

Although, in 1974, "*The Handbook of Psychiatry*" defined grief as "...the normal response to the loss of a loved one by death," and other kinds of losses were labeled "Pathological Depressive Reactions," this has become the predominant way for counselors and professionals to approach grief, loss, tragedy and traumatic experiences.

Symptoms of Behavior of Unresolved Grief

- *Overactivity without a sense of loss.*
- *Acquisition of symptoms belonging to the last illness of the deceased.*
- *Development of psychosomatic illness.*
- *Alteration in relationships with friends and relatives.*
- *Furious hostility against specific persons somehow connected with the death.*

- *Wooden and formal conduct masking hostile feelings.*
- *Lasting loss of patterns of social interaction.*
- *Actions detrimental to one's social and economic well-being; for example, giving away belongings.*
- *Agitated depression with tension, agitation, insomnia, feelings of worthlessness, bitter self-accusation, obvious need for punishment, and even suicidal tendencies.*
- *History of delayed or prolonged grief.*
- *A feeling the death occurred yesterday, even though the loss took place months or years ago.*
- *Unwillingness to move the possessions of the deceased after a reasonable amount of time.*
- *Inability to discuss the deceased without crying, particularly over a year after the loss.*
- *A relatively minor event triggering major grief reactions.*
- *False euphoria subsequent to the death.*
- *Overidentification with the deceased.*
- *Phobias about illness or death.*

DEFINITIONS – Patients who are dying

People are considered to be dying when they are sick with a progressive condition that is expected to end in death and for which there is no treatment that can substantially alter the outcome. Thus, people are dying when they have illnesses such as advanced dementia or severe congestive heart failure, in addition to illnesses more routinely recognized as terminal, such as advanced cancer. Care of dying patients also encompasses patients who have elected to forgo available treatments that might forestall death, such as dialysis for end stage renal disease.

Palliative Care

Palliative care refers to care directed toward the quality of life of patients who are dying, including the relief of pain and other symptoms, attention to the psychological, emotional, social and spiritual needs of the patient, and the provision of support for the dying patient and the patient's family.

Patient Care Issues

Statement I

The care of the dying patient, like all medical care, should be guided by the values and preferences of the individual patient. Independence and dignity are central issues for many dying patients, particularly in the elderly. Maintaining control and not being a burden can also be relevant concerns.

Rationale

Optimal medical care of all patients, not just those who are dying, rests on frank and sensitive communication between patients and physicians. For dying patients, this ordinarily entails recognition and discussion of the facts surrounding prognosis and the likely course with a palliative plan of care. The conversations throughout must continue to elicit and respond to the patient's needs. Physicians sometimes face the challenge of being asked to respect patients' choices, which may maximize the quality of life and independence at the expense of optimal safety. This tension requires particular thoughtfulness and sensitivity to each patient's needs and values. When the patient loses decision-making capacity, care should be guided by previous conversations as well as by written advance directives, if available. Decisions made by surrogates should be guided by the patient's known and previously expressed wishes.

Statement II

Palliative care of dying patients is an interdisciplinary undertaking that attends to the needs of both patient and family.

Rationale

In caring for dying patients, physicians must themselves develop a broad array of knowledge and skills and attentiveness to comprehensive care. In addition, whether or not the patient is enrolled in a formal hospice program, physicians most often should function as members of a team. The team may include nurses, social workers, home health aides, physical therapists, personal caregivers, chaplains, volunteers, and the patient's family. Each team member contributes the special knowledge and skills of his or her discipline to help meet the needs of dying patients. Together, team members provide care for the patient and assist the family in coping with the patient's dying and death. Family members (with "family" defined by the individual patient) usually play a critical role in both providing care for dying patients and in making decisions for dying patients who have lost decision-making capacity. Providing support for the patient's family, including a period after the patient dies, is an important aspect of the care of dying patients.

Statement III

Care for dying patients should focus on the relief of symptoms, not limited to pain, and should use both pharmacologic and non-pharmacologic means.

Rationale

Pain, anxiety, depression, dyspnea, constipation, and other symptoms can all be significantly ameliorated, if not eliminated, in the vast majority of dying patients. Symptoms should be treated as vigorously as is appropriate to the patient's situation and preferences to maximize comfort, even if the unintended effect of these efforts is, on rare occasions, the hastening of death.

Dying patients should be guaranteed palliative care as part of any health care coverage, without care being conditioned on the financial status of the patient. Reimbursement and administrative arrangements should encourage continuity across sites and time, so that commitments to patients can be honored regardless of point of care.

EDUCATION ISSUES

Statement IV

Physicians and other health care professionals, at all levels of training should receive in-depth, insightful, and culturally sensitive instruction in the optimal care of dying patients.

Rationale

More attention has been paid in recent years to improving education in the care of dying patients. This instruction can still be expanded and targeted to reach a broader audience. Health care professionals in training and in practice need adequate knowledge of symptom management (especially pain control and adequate use of opioid analgesics), ethical issues relevant for end-of-life care, and use of multi-disciplinary teams. They ought to have adequate training in communication skills necessary for delivering bad news, discussing advance directives, and exploring patient wishes and goals. They should know their own attitudes towards and reactions to death and care of the dying, and have a personal process for grief over the loss of patients cared for. Instruction in the physician's role during the dying process and in guiding the family through bereavement are necessary. The importance of knowledge about the care of dying patients should be reinforced by evaluating it on board exams and other specialty certification exams.

Statement V

The public, including our patients/family and our colleagues, needs to be educated regarding the availability of palliative care as an important and desirable option for dying patients. The AGS should be active in this education.

Rationale

It is the position of AGS that this kind of educational effort would benefit many by dispelling the notion that the only options available to dying patients are continued futile therapy in a medical setting or turning to assisted suicide or euthanasia (see related position paper).

Statement VI

Adequate funding for research on the optimal care of dying patients is essential to improving end of life care.

Rationale

Much of the information base needed to inform patients and physicians regarding optimal care of dying patients does not yet exist. Studies documenting the outcomes of various models of care delivery, medications, and treatment settings, focused on the experience of the dying patient and significant others should take place. Although traditional biomedical research on symptom relief is needed, much of what is already known about symptom relief is not implemented effectively because of professional ethical concerns about aggressive symptom management and institutional barriers to the provision of palliative care. Research to identify these barriers and to evaluate educational approaches and interventions to promote palliative care is needed.

ADVANCE DIRECTIVES

It is the policy of Central Louisiana State Hospital to inform all adult patients, legal guardians of patients, and/or family, of their right to make advance directives and/or to designate another person to make medical decisions if the individual loses decision-making capacity. If a patient requires acute or critical medical care as determined by the treating physician, Central Louisiana State Hospital will continue life sustaining procedures and transport the patient with his/her advance directives to an acute/critical medical care facility. Patients will be informed annually of their right to formulate an Advance Directive and given the opportunity to do so.

It is also the policy of Central Louisiana State Hospital to acknowledge patients' wishes concerning organ donations.

STANDARDS FOR NUTRITIONAL SUPPORT

Overview: Guidelines For End Of Life Issues

The American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) is a scientific society whose members are health care professionals --- physicians, dietitians, nurses, pharmacists, other allied health professionals, and researchers---dedicated to assuring that every patient receives optimal nutrition care.

The following terms, which are used in these standards. Definitions of Terms Used in A.S.P.E.N. Guidelines and Standards" or by the JCAHO.

Drug-drug interaction. An event that occurs when a drug's activity, availability, or effect is altered by another drug.

Drug-nutrient interaction. An event that occurs when nutrient availability is altered by a medication, or when a drug effect is altered or an adverse reaction caused by the intake of nutrients.

Malnutrition. Any disorder of nutrition status including disorders resulting from a deficiency of nutrient intake, impaired nutrient metabolism, or over nutrition.

Nutrition assessment. A comprehensive evaluation to define nutrition status, including medical history, dietary history, physical examination, anthropometric measurements, and laboratory data.

Nutritionally-at-risk. Adults are considered at nutritional risk if they have any one of the following:

- Actual or potential developing malnutrition (involuntary loss or gain of >10% of usual body weight within 6 months, or >5% of usual body weight in 1 month, a weight of 20% over or under ideal body weight) presence of chronic disease, or increased metabolic requirements.
- Altered diets or diet schedules (receiving total parenteral or enteral nutrition, recent surgery, illness, or trauma).
- Inadequate nutrition intake including not receiving food or nutrition products (impaired ability to ingest or absorb food adequately) for greater than 7 days.

Gradually Hope Comes Through

Excerpt:

Rabbi Joshua Liebman in his book, *"Peace of Mind"* has an excellent chapter on "Grief's Slow Wisdom", which speaks most effectively to this temptation not to return to usual activities again, says Liebman. The melody that the loved one played upon the piano of your life will never be played quite that way again but we must not close the keyboard and allow the instrument to gather dust. We must seek out other artists of the spirit, new friends who gradually will help us to find the road to life again, who will walk that road with us."

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6. Kubler-Ross Model (1973). On Death and Dying.

7. Westberg, Granger E. 1997. Good Grief Excerpt p.60 Liebman, Joshua Loth, *Peace of Mind*, Copyright 1946. By permission of Simon and Schuster, Inc.

CLSH Mission – Vision – Values – Philosophy Statement	
LOUISIANA DEPARTMENT OF HEALTH	**Central Louisiana State Hospital (CLSH)**
Policy Number	**HRP_818**
Content	**Mission, Vision, Values, Philosophy**
Effective Date	12/2014
Reviewed	06/16
Revised	12/17, 12/19
Approved By	CLSH-CEO, signature on file w/policy coordinator
Inquiries to	Human Resources

I. POLICY STATEMENT

STATEMENT OF MISSION – VISION – VALUES – GUIDING PRINCIPLES

CLSH MISSION:

Strive to provide quality, person-centered care with focus on recovery and resiliency in a safe and secure environment.

CLSH VISION:

Strive to be the best public psychiatric hospital we can be.

CLSH VALUES: "I C.A.R.E."

- **Integrity -** *Fair, honest, open, and patient-focused in all relationships and activities*.
- **Compassion -** *Sensitive to the whole person.*
- **Accountability -** *Take personal responsibility for our own actions.*
- **Respect -** *Have regard for the worth and dignity of all people.*
- **Excellence -** *Strive to be the best that we can be in all things.*

GUIDING PRINCIPLES

CLSH believes that all persons are resilient, capable of recovery and growth. We are therefore committed to a consumer focused system of person centered care that aims for the following outcomes for all persons (patients and employees).

- Aim for the **highest quality and accountability** of care possible.
- Aim to **provide maximum opportunity for all people to achieve the highest quality of life they can**.
- Aim to **serve our patients in ways that allow them to return to the community as soon as possible**, and **fosters individual employee growth and the CLSH team/servant cultural values**.

II. PURPOSE

The purpose of the CLSH mission, vision, values, guiding principles and annual business goals is to define how the hospital will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. Central's common purpose is most likely achieved when it is understood by all who work in or are served by the hospital.

The CLSH MISSION statement, VISION statement, VALUES statement, and GUIDING PRINCIPLES - has its own distinct function in the strategic planning process and the daily operations of the hospital. The mission statement explains why we exist and what we do. The mission statement supports the vision and serves to communicate purpose and direction to employees, customers, vendors and other stakeholders. The vision statement describes the organization as it appears when success is being achieved. Our core values and philosophy describe what we believe in and how we behave. They are the moral/ethical compass that guides decision-making and establishes a standard that actions can be assessed against. Values and guiding principles shape the content of Central's character, conduct and culture.

III. APPLICABILITY

This policy is applicable to all CLSH employees.

IV. EFFECTIVE DATE

The effective date of this policy is December 2014.

V. POLICY PROVISIONS/PROCEDURES

A. "The mission, vision, values and guiding principles of CLSH shall support the safety and quality of care, treatment, and services; leaders shall communicate the CLSH mission, vision, values and guiding principles to staff and the population(s) the hospital serves."

B. All employees shall be formally trained in the theory and practice of the CLSH mission, vision, values and guiding principles.

C. All employees shall at all times conduct themselves in accordance with the theory and practice of the CLSH mission, vision, values and guiding principles.

References:

TJC Leadership Chapter.

TJC HR Chapter.

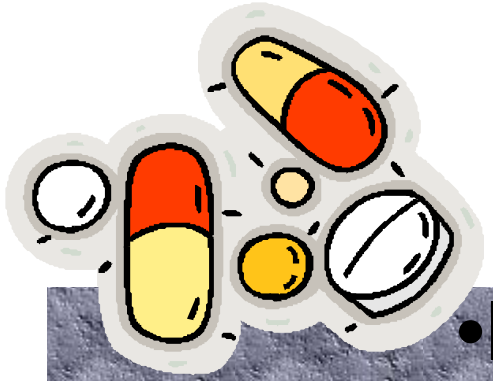
LDH Mission, 5-Year Strategic Plan and Behavioral Health Philosophy of Resiliency and Recovery

MANAGEMENT DISCLOSURES

The Chief Executive Officer reserves the right to add, alter, change, or delete any and all prescribed policies and procedures of the agency as needs dictate without the necessity of giving prior notice and request for consent from employees or employee representatives. This includes the right to add, alter, change, or delete all work assignments, duties, requirements and responsibilities of Sections, Departments, Units, and individual employees. Violations of this policy may result in disciplinary action up to and including dismissal. All policies are available on the Central Louisiana State Hospital Intranet. Signed originals of each policy are available in the office of the Hospital Administrator.

Nursing Pharmacology

Nursing Pharmacology



Medications

- **Instruct all clients on:**

- **Medications should never be discontinued without talking to the doctor about it.**

- **Medications should be taken as ordered.**

- **Medication side effects should be reported to the doctor or nurse.**

Antipsychotics

- *Haloperidol* -- Haldol
- *Fluphenazine* – Prolixin
- *Chlorpromazine* – Thorazine
- *Thiothixene* – Navane
- *Clozapine* – Clozaril
- *Olanzapine* – Zyprexa
- *Quetiapine* – Seroquel
- *Ziprasidone* – Geodon
- *Risperidone* – Risperdol
- *Aripiprazole* -- Abilify

Antipsychotic Side Effects

Weight Gain Dry Mouth Sedation	Orthostatic Hypotension – change in B/P with postural changes	Akethesia– A form of EPS with internal feeling of nervousness	**Neurolyptic Malignant Syndrome**
Tardive Dyskinesia	May predispose patients to diabetes		**Cogwheeling** Stiffening of the joints

Extrapyramidal Side Effects

- Tardive Dyskinesia
- Dystonia
- Dyskinesia
- Akathesia
- Neuroleptic Malignant Syndrome

Drugs used to counter act EPS are:

1. ***Cogentin***
2. ***Benadryl***
3. ***Artane***

Clozaril

Atypical Antipsychotic

- Used for management of psychotic symptoms in schizophrenic clients when other antipsychotics have failed

- Agranulocytosis—
(loss of white blood cells)

- Blood tests

Clients taking antipsychotic medications should tell their doctor about:

- <u>All medications they are taking</u>:
  - Prescription drugs
  - Vitamins, minerals, herbal supplements
  - Over the counter medications

Antipsychotic Medications

May interfere with:

- ✓ Antihypertensive medications
- ✓ Anticonvulsants
- ✓ Antiparkinson medications

- **Seroquel** is an atypical antipsychotic that can cause urinary retention.

- Should be taken by women who are pregnant only after they discuss the effects with their doctor

- Atypical antipsychotics have a decreased incidence of Tardive Dyskinesia compared to major tranquilizers.

Antidepressants – used to treat major depressive disorders

- **SSRIs** – Celexa, Prozac, Luvox, Paxil, Zoloft, Lexapro – *Third generation antidepressants, less likely to be lethal*

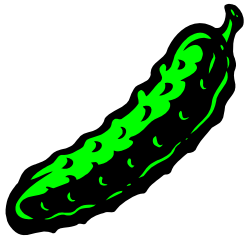
  Wellbutrin—lowers the seizure threshhold

- **MAOIs** – Parnate, Marplan, Nardil, Eldepryl

- **Tricyclic** – Elavil, Anafranil, Asendin, Tofranil, Pamelor, Norpramin

Antidepressant Concerns

- MAO inhibitors: Avoid decongestants and foods high in tyramine: Aged cheese, red wine, pickles



- Tricyclics: Effective but more side effects than newer antidepressants—most affect neurotransmitters, norepinephrine and serotonin

- SSRIs: Newest antidepressants; sometimes sexual side effects

Antidepressants

- **Antidepressants have a time lag of 10-30 days before they may reach therapeutic effectiveness**
- **Daytime drowsiness-- usually passes soon, may give the medication at bedtime**
- **Use all antidepressants with caution with suicidal patients**

Antianxiety

Benzodiazepines

Alprazolam – Xanax
Chlordiazepoxide – Librax, Librium
Clonazepam -- Klonopin
Diazepam – Valium
Lorazepam – Ativan

- Buspar – Needs a blood level to be effective
- Usually 2 weeks

Antianxiety Side Effects

- Always consult your doctor before stopping a benzodiazepine to avoid potentially severe withdrawal reactions.
- Patients can develop a tolerance to benzodiazepines
- Med can be used for overdose.

Bipolar Disorder

- An antipsychotic medication and lithium can often successfully treat acute mania
- Anticonvulsants are often used when clients do not benefit from Lithium.
- Client may take more than one med:
  - Mood stabilizer
  - Antidepressant
  - Anti-anxiety
  - Hypnotic

Mood Stabilizers / Anticonvulsants

- Neurontin (Gabepentin): Anticonvulsant with mood stabilizing properties
- Lithium: Used for Bipolar patients—Pregnant women should consult their doctor to determine if they should discontinue use during their first trimester
- Depakote: Anticonvulsant used for acute control of mania—usually the main alternative medication for lithium

Lithium

Therapeutic range — 0.4 to 1.2 mEq/L

Must observe for dehydration which increases the risk of lithium toxicity

Requires blood work for therapeutic levels

S & S of possible toxicity

Vomiting

Diarrhea

Loss of coordination

First Dose Medication Monitoring Protocol

- "New Medication" applies to **all** meds, not just psychotropic medications

- An RN or LPN must physically observe and assess a patient within 60 minutes after administering a new medication and during the next shift after the new medication

Blood levels must be drawn on patients taking these medications

- Lithium – Therapeutic range
- Depakote – Liver function studies
- Clozaril – WBC for agranulocytosis

High Alert / High Risk Medications

- Trailing zeros are not allowed
- Look-alike, sound alike meds are labeled
- Special alerts placed on labels
- Some meds have mandatory stop dates
- Some meds require scheduled lab followup

Drug Protocols

Medication specific protocols can be

found under Medication Use Guidelines located in each medication room.

"The Red Book"

Neurolyptic Malignant Syndrome

Rare but can have fatal complications

Atypical antipsychotics may cause NMS

- Hyperthermia (High Fever)
- Hypertonicity of skeletal muscles (Muscle Rigidity)
- Mental changes
- Autonomic instability

ALLERGIES

ALWAYS Noted in red ink

Changes in a client's allergy status should be noted by a doctor's order

Should be on the front of a client's chart on the Alert Sticker.

Medication Non-compliance

Depot Medications
– Deep IM injections
Prolixin D—2 wks
Haldol D—4 wks
Check for cheeking

Do Not Use Abbreviations

- IU, u or U
- Trailing zeros
- Lack of leading zero
- QD, QID, QOD
- MS, MSO4

ADHD

Most commonly prescribed medications for ADHD are called stimulants.

- **Ritalin**
- **Adderall**
- **Concerta**
- **Dexedrine**
- **Cylert**

Medication Administration

- Use at least two identifiers when administering medications to clients
- Take the time to correctly identify medications and dosages
- Check clients to see that medications are actually taken