Arbour-HRI Hospital

Patient Safety/De-Escalation Tool

Instructions: Request that each patient complete the Safety De-Escalation Tool, and then review it with them. Place a copy of this tool in the checks sheet binder in back of the patient's checks sheet. To be reviewed at team meeting.

When you're having a hard time, have any of these things been helpful to you?

___ having something to eat/drink

___voluntary time in quiet room

___ standing at the nurses' station

___ talking with another patient

___talking with staff

___ asking for a particular medication

___ reading a newspaper/book

___ lying down

___ warm/ cold face cloth

___ scented candles or scented spray

___ weighted blanket

___ stress ball

___ deep breathing exercises

___ cold packs

___ wrapping up in a blanket

___ drawing, crafts, etc.

___listening to music/ walkman

___ watching TV

___ calling a friend

___ calling your therapist

___ writing in a journal

___ pacing

___ sucking on hard candy

___ putting hands under cold water

___ other sensory items_____

___ other coping techniques not on this list_____

___ Staff observations (to be completed by staff)_____

How would staff observe your behavior before becoming upset?

_____

Are there triggers that you know cause you to escalate? What are they?

_____

What are some of the things that make it more difficult for you when you are already upset?

___ being touched

___ loud noise

___ being isolated

___ yelling

___ particular time of the day:
when?_____

___ particular time of the year:
when?_____

___ not having control/ input

Other: _____

Previous Hospitalization Restraint Questions:

- Have you ever been restrained in a hospital or other treatment setting? _____Yes _____No
- If you are escalating and are in danger of hurting yourself or others, we may need to use a restraint. If a restraint becomes necessary, do you have any specific preferences that we should know about?

  _____

  _____

  _____
- Do you have a preference regarding the gender assigned to you during/after restraint?

  _____
- Would you like us to notify someone if you are having a psychiatric crisis?____Yes____No

  If yes, whom?_____ Telephone Number: _____
- What else would be helpful to you during a restraint?

  _____

- **Patient Signature: _____Date:_____**
- **Staff Signature: _____Date: _____**

Family/caregiver input (when clinically indicated):

_____

_____

_____

Name of Caregiver: _____ Staff Signature: _____

Safety Plan Review:

_____

_____

Patient Signature: _____ Date: _____

Safety Plan Review:

_____

_____

Patient Signature: _____ Date: _____

Chart Contents

I. Beginning of Chart

A. Safety Tools
B. Intake Call Sheet and Safety Hand-off
C. Group Therapy Schedule
D. Patient Stickers

II. Admission Documents

A. Medicare Rights
B. Patient Admission Checklist
C. MHW Admission Checklist
D. Insurance Release
E. Patient Contact Organization Sheet
F. Release of Information Contact Sheet

III. Legal Documents

A. Conditional Voluntary
B. Notice of Rights Explaining CV
C. 12 B (Pink)
D. Notice of Rights Explaining 12B status
E. Patient Notice of 12B Rights
F. Private Practices Notice
G. Private Practices Receipt
H. Emergency Hearing Request
I. Medical Informed Consent Form

IV. Patient Check Sheets

A. All Check Sheets together
B. Any I&O Sheets together

V. Discharge Documents

A. Discharge Documents from HRI (MD,RN, then SW)
B. Copy of Patient Valuables Sheet

VI. Documents Coming From Other Hospitals

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO
Masspro

Telephone Number of QIO
(781) 890-0011

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call _____.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative	Date/Time

Steps To Appeal Your Discharge

- **Step 1**: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO:

    Name of QIO (in bold)
    Masspro

    Telephone Number of QIO
    (781) 890-0011
  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is :

Hospital Name	Provider ID Number
Arbour-HRI Hospital NPI #	**1518938174**

- **Step 2**: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **Step 3**: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **Step 4**: The QIO will review your medical records and other important information about your case.
- **Step 5**: The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

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Arbour-HRI Hospital NPI #	**1518938174**

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Arbour-HRI Hospital
Patient Admission Checklist

1. _____ I have received a Patient Booklet containing my rights as a patient.
2. _____ I have had the "Conditional Voluntary" explained to me including the legal implications of "signing in" and I have chosen to sign in.
3. _____ I have had the "Conditional Voluntary" explained to me and have declined to sign in and my rights as an involuntary patient have been explained to me.
4. _____ I am an involuntary patient and I believe a specific right has been violated qualifying me for an emergency hearing and I am requesting that the hospital assists me in the pursuit of this hearing. (Request for emergency hearing given to patient)
5. _____ A Health Care Proxy has been explained to me:
    - _____ Do not wish to pursue
    - _____ Would like assistance in preparing
    - _____ Will supply copy to the hospital
6. _____I have been asked to place my valuables in the safe and understand that the hospital cannot accept responsibility for personal property that is not kept in the safe.
7. _____The Mental Health Worker has orientated me by doing the following:
    - _____Introduced to roommates
    - _____Introduced to staff
    - _____Shown kitchen area, and was offered food and fluids
    - _____Explained the unit schedules; including smoke breaks, visiting hours and groups.
    - _____Explained valuable/belongings policy, and explained how to request and receive medications.
    - _____Given a unit tour, including showers, bathrooms, linen closest, laundry, group board, and team board.
    - _____Explained the use of Safety tool and communicating with staff.
8. _____I understand that Arbour-HRI will attempt to resuscitate all patients. In that Do Not Resuscitate is not policy.

Patient Signature_____ Date_____

MHW Signature_____ Date_____

Arbour-HRI Hospital MHW Admission Checklist

Patient's Name: _____ Date: _____ Unit: _____

Staff Initials

1. Record Vital Signs and Height and Weight. _____

2. Obtain signature on "Release" form for family members and outpatient providers when possible.
   ☐ Yes ☐ No _____

3. Search all of the patient belongings for inappropriate and dangerous articles. Explain to the patient that items are put in the dryer or else they are stored in the basement. _____

4. Explain search procedures. Wand, then perform Johnny search. (two staff) _____/_____

5. If valuables cannot be sent home, list and place in a valuables envelope and send to the safe (wallets, cell phones, keys, etc.) For all currency, notify the nursing supervisor.

   - Valuables Envelope in Supervisor Office?
     ☐ Yes ☐ No _____

   - Belongings stored in basement?
     ☐ Yes, Number Bags_____ ☐ No

6. Provide tour of unit.

7. Explain: _____
   - Phone numbers
   - Use of phone
   - Meals
   - Visitor protocols
   - General unit guidelines
   - Laundry
   - Restricted items
   - Patient boundaries
   - Smoking policies

8. Patient admission checklist completed? _____
   ☐ Yes ☐ No

9. Safety Tool form completed and shown sensory items. _____

10. Pictures Taken? _____
    ☐ Yes ☐ No
    Loaded into Avenues?
    ☐ Yes ☐ No _____

11. Apply ID band for special diets when ordered.
    ☐ Yes ☐ No _____

MHW Signature: _____ MHW Name Printed Clearly: _____

ARBOUR- HRI HOSPITAL
Clothing List UNIT;_____

Clothing items	#	N/A	Comments
Pants			
Shirts			
Blouses			
Tee shirts-mens			
Women's tops-			
skirts			
Jeans			
Shorts			
underwear -Boxers			
Briefs			
Bras			
Underpants			
Socks			
shoes			
Sneakers			
Slippers			
Purse/pocketbook			
Backpack			

Kept on Unit

Clothing items	#	N/A	Comments
Pants			
Shirts			
Blouses			
Tee shirts-mens			
Women's tops-			
skirts			
Jeans			
Shorts			
Underwear -Boxers			
Briefs			
Bras			
Underpants			
Socks			
shoes			
Sneakers			
Slippers			

Completed by:_____

Arbour Hospital
Boston, MA

Arbour-HRI Hospital
Brookline, MA

Arbour-Fuller Hospital
Attleboro, MA

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF MEDICAL RECORD INFORMATION

I hereby authorize that payment under my health insurance program be made directly to the hospital indicated above for any and all services rendered to me during my period of hospitalization. I further authorize any holder of medical or other information pertaining to my treatment at Arbour Health System, to release said information to my insurance carrier and its intermediaries for utilization management, case management and quality review. I further authorize my health insurance carrier to release information about me to the Arbour Health System hospital indicated above, for the purpose of utilization review and case management, including past hospitalizations. I understand that the medical record may contain any of the following: psychiatric substance abuse, sexual/physical and HIV information. I permit a copy of my authorization to be used in place of the original.

REPRESENTATION ON A CLAIM

In the event this patient appears to have lost health insurance benefits, I hereby authorize the Hospital to represent me and guarantor in all eligible claims and legal action against the said employer and insurer, and to fully cooperate with the Hospital in said claims and legal action.

VERIFCATION OF EMPLOYMENT

I hereby authorize the Arbour Hospital indicated above to contact my employer to verify group insurance eligibility.

ADMISSION FINANCIAL RESPONSIBILITY

The undersigned jointly, severally, and unconditionally agree to pay the Arbour Health System hospital indicated above in full. Upon demand, all charges the hospital is entitled to receive which are not covered by health insurance for services rendered. I/we further understand that if said health insurance requires pre-certification or prior approval (such as Benefit Management Plan or Health Management Organizations), payments of benefits may be jeopardized if these are not obtained prior to admission and that I/we may be responsible for charges incurred.

SIGNATURE OF PERSON(S) RESPONSIBLE UNDER THIS AGREEMENT

_____
Signature of Hospital Representative Date

_____
Signature of Patient or Guarantor Date

Reason patient did not sign: ____ Refused ____ Unable
____ Other ____ Gave Verbal Permission

_____
Signature of Policy Holder (if different) Date

_____
Hospital Rep. Signature if Patient Will Not Sign & Reason

MEDICARE PATIENTS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.
I authorize any holder of medical or other information about me to release to the Social Security Administration intermediaries or carries any information needed for claims related to this admission. I request that payment authorized benefits be made on my behalf. I assign payment for any in-hospital physician charges for which the hospitals of the Arbour Health System are authorized to bill. I understand I am responsible for any insurance deductibles
and co-insurance.

_____
Signature of Patient Date

TO BE COMPLETED BY PERENTS OR GUARDIAN ON ADMISSION

FAMILY AND AGENCIES INVOLVED

MOTHER:

NAME: _____

ADDRESS: _____

_____

PHONE# HM _____ WK _____

FATHER:

NAME: _____

ADDRESS: _____

_____

PHONE# HM _____ WK _____

WHOM TO NOTIFY IN CASE OF EMERGENCY:
(If different than above)

NAME: _____

ADDRESS: _____

_____

PHONE# HM _____ WK _____

STEP PARENTS/GUARDIAN:

NAME: _____

ADDRESS: _____

_____

PHONE# HM _____ WK _____
*Please indicate if Release of Info signed ☐

DSS WORKER:

NAME: _____

ADDRESS: _____

WK NIGHTS
PHONE# DAYS WKNDS
*Please indicate if Release of Info signed ☐

PROBATION OFFICER:

NAME: _____

ADDRESS: _____

_____

WK NIGHTS
PHONE# DAYS WKNDS
*Please indicate if Release of Info signed ☐

OUTPATIENT THERAPIST:

NAME: _____

ADDRESS: _____

_____

WK NIGHTS
PHONE# DAYS WKNDS
*Please indicate if Release of Info signed ☐

APPROPRIATE SCHOOL PERSONNEL:

NAME: _____

ADDRESS: _____

_____

WK NIGHTS
PHONE# DAYS WKNDS
*Please indicate if Release of Info signed ☐

OTHER INVOLVED AGENCY PERSONNEL OR RELATIVES:
NAME: _____

ADDRESS: _____

_____

WK NIGHTS
PHONE# DAYS WKNDS
*Please indicate if Release of Info signed ☐

SUPERVISOR OF DSS WORKER:

NAME: _____

ADDRESS: _____

WK NIGHTS
PHONE# DAYS WKNDS
*Please indicate if Release of Info signed ☐

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Application For Care And Treatment On A Conditional Voluntary Basis
M.G.L. Chapter 123, Sections 10 & 11

Name of Patient (please print)_____

Address:_____City/Town_____State_____

Social Security Number: _____Date of Birth: _____Sex M ☐ F ☐

To the Superintendent (or other head) of _____
Name of Facility

1. I am 16 years of age or older and hereby apply to be a patient at the above facility.

2. I realize that when I want to leave the facility, I must give written notice to the Superintendent of the facility, who may delay my departure for up to three days (excluding Saturday, Sunday and holidays).

3. Once I give notice of my intention to leave the facility, I realize that if the Superintendent thinks I might be a danger to myself or other people because of my mental illness, he or she may petition the District Court within the three-day period seeking to have me committed to (ordered to stay at) the facility for up to six months. The Court will schedule a hearing. I have a right to be represented by an attorney at the hearing. If I cannot afford an attorney, the Court will appoint one for me. After the filing of the petition, the Court has five (5) business days to begin a hearing on my commitment. During this time, I must remain at the facility. At the hearing, the judge will decide whether or not I can leave the facility.

4. I realize that if the Superintendent thinks I need to have a legal guardian with special authority to consent to my staying at the facility, he or she may petition the Probate Court to hold a hearing. However, he or she may not delay my departure unless an order allowing such a delay is issued by a Probate Court judge before the end of the third day (excluding Saturday, Sunday and holidays) after I give notice.

5. I agree to receive treatment at this facility for my mental illness. I understand that this agreement does not limit my right to refuse at any time specific treatment interventions such as antipsychotic medication, electroconvulsive therapy or psychosurgery.

6. I have been given a copy of my Notice of Rights (Form CV-301).

7. I have been offered the opportunity to consult with a lawyer or paralegal concerning the effect of a conditional voluntary admission.

8. I understand that the facility will accept or reject this application in accordance with the applicable clinical and legal standards.

_____ _____
Signature of Patient Date

_____ _____
Witness Date

ACCEPTANCE/REJECTION BY THE FACILITY

The following questions shall be answered, and the application shall be accepted or rejected, by a designated physician* of the facility.

	Yes	No
1. This patient		
A. has been diagnosed with mental illness, as defined in 104 CMR 27.05 (1),	☐	☐
B. is in need of care and treatment for this mental illness,	☐	☐
C. is in need of hospitalization (i) for such care and treatment or (ii) to prevent serious harm due to the absence of a more appropriate placement alternative.	☐	☐
2. This facility is suitable for such care and treatment.	☐	☐
3. I have determined that this patient understands that he/she		
A. is agreeing to stay and receive treatment at this facility,	☐	☐
B. must sign a three-day notice of his/her intention to leave,	☐	☐
C. may or may not be allowed to leave without a court hearing.	☐	☐

****

**

If every box is checked "Yes", then the application shall be accepted unless the patient has not yet been admitted, in which case the application may be accepted only if the facility's criteria for admission have been met. If any box is checked "No", the application shall be rejected, unless only boxes "1.A", "1.B.", or "2" are checked "No" and the patient's continued voluntary hospitalization is necessary to prevent serious harm due to the absence of a more appropriate placement alternative.

****

**

The patient may not sign a three-day notice until this form has been accepted.

****

**

I, a designated physician* of this facility, hereby (check all applicable boxes):

4. ☐ **Accept** this application for conditional voluntary hospitalization:
   - ☐ A. Patient is applying for admission and all criteria for admission are met.
   - ☐ B. Only boxes "1.A", "1.B" or "2" are checked "No" and continued hospitalization is necessary to prevent serious harm due to the absence of a more appropriate placement alternative.
5. ☐ **Reject** this application for conditional voluntary hospitalization. Reasons:

_____

_____

_____

_____ _____

Designated Physician's Signature Date

_____

Printed Name

_____

Title

This patient's competency to remain on Conditional Voluntary status must be reassessed at the time of each periodic review.

FILE IN PATIENT'S RECORD IMMEDIATELY

* A physician who meets the criteria in 104 CMR 33.03

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

NOTICE OF RIGHTS

To be given to all patients 16 years of age and older

Conditional Voluntary Hospitalization
M. G. L. Chapter 123, Sections 10 & 11

You have the right to consult with an attorney or paralegal concerning the legal effect of conditional voluntary hospitalization before you sign an Application for Care and Treatment on a Conditional Voluntary Basis. You may consult your own attorney. Alternatively, you may consult with someone at the **Center for Legal Representation** (local legal assistance office) by calling **617-965-0776** during regular working hours, or you may consult with the facility's Human Rights Officer by calling extension **224** during regular working hours.

Once you sign the application for conditional voluntary hospitalization and excluding your application has been accepted by the facility, you must sign a three-day notice if you decide to leave the facility. You can request help with this notice from facility staff. You man not be permitted to leave the facility until three (3) days (excluding Saturdays, Sundays and holidays) after you sign and submit the notice.

During the three (3) days after you submit your notice, the facility may decide that your release would create a likelihood of serious harm to yourself or to others by reason of your mental illness. If so, the Superintendent or other head of the facility may file a petition for your civil commitment to the facility for a period of up to six (6) months. If a petition is filed, the District Court will begin the hearing within five (5) business days, not including Saturday, Sunday and holidays. You will have to remain in the facility until the hearing is completed unless the facility decides to discharge you before the hearing is completed. You will be represented by an attorney at the hearing.

Alternatively, the facility may decide, after reviewing your situation, to seek a Probate Court guardianship with authority to consent to your admission to the facility.

However, if a civil commitment petition is not filed or if a Probate Court order is not issued, you will be discharged no later than the end of the third day after you file your three-day notice (excluding Saturday, Sunday and holidays).

The Commonwealth of Massachusetts
Committee for Public Counsel Services
Mental Health Litigation Division
44 Bromfield St., 2nd Fl., Boston, MA 02108

TEL: 617-988-8341
FAX: 617-988-8488

ANTHONY J. BENEDETTI
CHIEF COUNSEL

MARK A. LARSEN
DIRECTOR

To Persons Admitted Involuntarily under G.L. c. 123, § 12(b)

Notice of Your Right to an Attorney

You were admitted to this mental health facility because the doctor thinks that you have a mental illness and that if you are not hospitalized you would be a danger to yourself or others, or unable to care for yourself. The hospital can hold you involuntarily for up to three (3) business days. Business days do not include weekends or holidays. After three business days, the hospital must either let you leave or ask a court to order that you stay in the hospital for up to six (6) more months. This court proceeding is called a civil commitment hearing.

✓ **YOU HAVE THE RIGHT TO A LAWYER** during this three-day period and for any commitment hearing

- The lawyer will be a trained mental health lawyer.
- The lawyer is provided at no cost.
- The lawyer will represent you at a commitment hearing, if one is necessary.

✓ **THIS ATTORNEY REPRESENTS YOU AND ONLY YOU!**

- The lawyer will:
  - Explain the law.
  - Help you understand the law.
  - Protect your rights during the commitment process.
  - Demand an emergency hearing, if your admission was improper.
  - Help you prepare your defense if the hospital files a petition for your civil commitment.
- The lawyer can also help you find a legal advocate to help with other issues while you are in the hospital.

If you want a lawyer, tell the hospital staff immediately. The hospital must contact the Committee for Public Counsel Services so that we can assign a lawyer to represent you. The lawyer will visit with you no later than the next business day. **Please note that the right to a lawyer does not apply if you are in the hospital voluntarily. However, you can still call the number below to ask questions about your legal rights.

If you need more information about your right to counsel, or if you have questions about your legal rights when you are a patient of this facility, please contact the

CPCS Mental Health Staff Attorney at: 617-988-8341

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

NOTICE OF RIGHTS

To be given to <u>all</u> patients admitted under M.G.L. c. 123, s. 12 (b)

Temporary Involuntary Hospitalization
M.G.L. Chapter 123, Section 12 (b)

You have been admitted to this facility under M.G.L. c. 123, s. 12 (b) for a period of up to three (3) business days. By the end of the third (3rd) business day, if the Superintendent or other head of the facility decides that your release would create a likelihood of serious harm to you or others by reason of your mental illness, he or she may file a petition for your civil commitment to the facility for a period of up to six months. If a petition is filed, the District Court will begin the hearing within five (5) business days, not including Saturday, Sunday or holidays, during which time you will have to remain in the facility.

At your request, we will notify the Committee for Public Counsel Services (CPCS) of your name and location. CPCS will then appoint an attorney to meet with you. Would you like CPCS contacted at this time?

Yes ☐
No ☐

If you say No and change your mind later, CPCS will be contacted at that time.

If you have been admitted to this facility under M.G.L. c. 123, s. 12 (b) and have reason to believe that such admission is the result of an abuse or misuse of the admissions process, you may request, on your own or through counsel, an emergency hearing in the District Court in whose jurisdiction this facility is located. If you wish to file such a request, the facility will provide you with the appropriate form.

I have received and read this Notice:

_____ _____
Name Date

_____ _____
Staff witness signature Date

Respecting Your Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital employees, volunteers, and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. Many of our doctors follow the practices contained within this Notice.

Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You have the right to receive confidential communications of PHI from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH

You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at 1-800-852-3449. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C.20201 or call 1-877-696-6775.

CONTACT FOR ADDITIONAL INFORMATION

If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser Unless:

(1) The patient consents in writing;

(2) The disclosure is allowed by a court order; or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Effective date 11/29/13

MANUAL PRIVACY PRACTICES PROCEDURE-BH

ARBOUR-HRI HOSPITAL
RECEIPT OF NOTICE OF PRIVACY PRACTICES
VERSION 10403

- Over 18 years of age
- Under 18 years of age
- Emancipated minor child
- Over 18 but still dependent

ACKNOWLEDGEMENT

I acknowledge that I have received the Hospital's notice of privacy practices.

_____ _____
Patient's Signature Date

_____ _____ _____
Patient's authorized representative signature Relationship to patient Date

_____ _____ _____
Witness Signature Witness Job Title Date

Patient is unable to sign this receipt because: _____

Patient has requested no exceptions to the use or disclosure of PHI at this time.

HIM STAFF entered receipt on chart _____ initials _____
Date HIM Staff

Intake/Admissions Staff Attach original to patient's chart

REQUEST FOR EMERGENCY HEARING

AFTER INVOLUNTARY ADMISSION TO MENTAL HEALTH FACILITY

G.L. c. 123, § 12(b)

DOCKET NO. *(to be added by court)*

Trial Court of Massachusetts
District Court Department

_____ **District Court**

To be completed after consultation with a lawyer, if any, and then filed with the court by FAX and a copy given to the facility Director.

NAME OF PATIENT

IN THE MATTER OF

I, the patient named above, have been involuntarily admitted to _____.
NAME OF FACILITY

I hereby request an emergency court hearing because I have reason to believe that my admission resulted from an abuse or misuse of the admission procedure of Massachusetts General Laws c. 123, § 12(b):

1. ☐ The hospital did not inform me of my right to request a lawyer.
2. ☐ The hospital did not notify the Committee for Public Counsel Services of my request to have a lawyer.
3. ☐ The Committee for Public Counsel Services did not appoint a lawyer to represent me, or the lawyer appointed to represent me did not meet with me.
4. ☐ A psychiatric examination was not conducted by a physician designated by the Department of Mental Health.
5. ☐ A psychiatric examination was not conducted within two hours.
6. ☐ Other abuse or misuse of the § 12(b) admission procedure *(describe the alleged abuse or misuse):*

*Please note that a designated physician's clinical decision that failure to hospitalize the patient would create a likelihood of serious harm by reason of mental illness is **not** subject to review at an emergency hearing.*

I give permission to the facility to release my mental health records to the court solely for the purpose of the requested hearing.

DATE SIGNED	COUNSEL'S SIGNATURE *(if any)*	PATIENT'S SIGNATURE
	X	X

COURT'S RULING ON REQUEST

To be completed by judge and returned to patient and admitting facility by FAX

Upon review of the above request, the Court hereby **ORDERS** that:

☐ The request for hearing is **ALLOWED** and a **HEARING IS SCHEDULED** for _____
DATE & TIME

☐ IN THIS COURT. ☐ AT THE FACILITY NAMED ABOVE.

The patient shall be present at such hearing unless through counsel he or she waives the right to be present.

☐ The request for hearing is **DENIED** because:

☐ The above request does not allege any abuse or misuse of the admission procedure of § 12(b).

☐ Other *(describe):*

DATE	JUDGE
	X

(rev. 08/08)

Arbour-HRI Hospital
227 Babcock Street
Brookline, MA 02446
617-731-3200

Patient Sticker

Informed Consent
For The Use of Psychiatric Medication

Physician: Please indicate the name of medication(s) and check ALL applicable boxes that were reviewed with patient and/or guardian.

Name of Medication:____
☐ Risks ☐ Dosing ☐ Benefits ☐ Scheduling ☐ Reason(s) for treatment ☐ Length of treatment ☐ Alternatives
Comments: ____

Name of Medication:____
☐ Risks ☐ Dosing ☐ Benefits ☐ Scheduling ☐ Reason(s) for treatment ☐ Length of treatment ☐ Alternatives
Comments: ____

Name of Medication:____
☐ Risks ☐ Dosing ☐ Benefits ☐ Scheduling ☐ Reason(s) for treatment ☐ Length of treatment ☐ Alternatives
Comments: ____

Name of Medication:____
☐ Risks ☐ Dosing ☐ Benefits ☐ Scheduling ☐ Reason(s) for treatment ☐ Length of treatment ☐ Alternatives
Comments: ____

Name of Medication:____
☐ Risks ☐ Dosing ☐ Benefits ☐ Scheduling ☐ Reason(s) for treatment ☐ Length of treatment ☐ Alternatives
Comments: ____

If the patient/guardian was unable to give informed consent, document the reason(s) and plan for completion:____
____

Physician Signature: ____________________________ Date: ____________________

Patient: I have been informed as to the uses of these medications, possible adverse reactions and the purpose of their use in my treatment at this time. I hereby give permission to my physician(s) at Arbour HRI Hospital to prescribe these medications.

Comments: ____

____ ____________________

Patient Signature/ Legal Guardian or Parent if Patient is under 18 Date

____ ____________________

Witness Signature Date