Patient Safety/De-Escalation Tool

Instructions: Request that patient complete Safety De-Escalation Tool, and then review it with them. Assist patient in completing tool if unable to complete by self. Request family/caregiver input when clinically indicated. Place a copy of this tool in front of chart. 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

_____ ask for a particular medication

_____ reading a newspaper/book

_____ pacing

_____ lying down

_____warm/cold face cloth

_____Scented candles or scented spray

_____weighted blanket

_____ other sensory items _____

_____ other _____

_____ Staff Observations _____

_____ putting hands under cold water

_____ 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

_____ stress ball

_____calming stones

_____ other _____

- How would staff observe your behavior before becoming upset?

_____

- Are there triggers/warning signs 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 day; When? _____
_____ Particular time of year; When? _____
_____ not having control/input

Other: _____

- 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?

_____

_____

OVER

- 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? ____ no ____ yes
  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: _____

Staff Signature: _____ Date: _____

Chart Contents

Patient Safety –De-Escalation Tool

Patient Admission Documents

Referral Information

Legal

Doctors' Orders

Labs

Graphics

Discharge Documents

Correspondence

Patient Name:
Patient ID Number:
Physician:

OMB Approval No. 0938-0692

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 *Human Rights Officer x224..*

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

Signature of Patient or Representative	Date/Time

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 oriented 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 restricted items and the use of the personal bin
   _____ Explained valuable/belonging policy, and explained how to request and receive medication
   _____ Given a unit tour; including showers, bathrooms, linen closet, laundry, group board, and team board
   _____ Explained use of the 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 _____

Staff Initials

1. Record Vital Signs and Height and Weight. _____

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

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

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

5. If valuables cannot be sent home, list and place in valuables envelope and send to safe (wallets, cell phones keys, etc.) For all currency notify nursing supervisor.
Valuable envelop in Supervisor Office? Yes ☐ No ☐
Belongings stored in basement? Yes ☐ No ☐ _____

6. Provide tour of unit. _____

7. Explain:
   - phone numbers
   - meals
   - visitor protocols
   - smoking policy (on and off unit)
   - use of phone
   - laundry
   - restricted items
   - patient boundaries
   - general unit guidelines

_____

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: _____ Print name: _____
(9/11)

rbour 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

ne undersigned jointly, severally, and unconditionally agree to pay the Arbour Health System hospital indicated above in ll. Upon demand, all charges the hospital is entitled to receive which are not covered by health insurance for services endered. 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

rev 3/06

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

PROBATION OFFICER:

NAME: _____

ADDRESS: _____

_____

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

OUTPATIENT THERAPIST:

NAME: _____

ADDRESS: _____

_____

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

APPROPRIATE SCHOOL PERSONNEL:

NAME: _____

ADDRESS: _____

_____

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

OTHER INVOLVED AGENCY PERSONNEL OR RELATIVES:
NAME: _____

ADDRESS: _____

_____

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

SUPERVISOR OF DSS WORKER:

NAME: _____

ADDRESS: _____

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

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

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

DEPARTMENT OF MENTAL HEALTH

NOTICE OF RIGHTS

To be given to all 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

MANUAL PRIVACY PRACTICES PROCEDURE-BH

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

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

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

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

NOTICE OF RIGHTS

To be given to all patients 18 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 Repres. (local legal assistance office) by calling 617-988-8324 (phone number) 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 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 may not be permitted to leave the facility until three days (excluding Saturday, Sunday and holidays) after you sign and submit the notice.

During the three 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 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).

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 Cour

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):*

D	JUDGE
	X

d)

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

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

____
...ess Signature

____
Date

...rt documents