

**RESPONSE TO  
2014-2015 GRAND JURY REPORT  
Riverside County Regional Medical Center Emergency Treatment  
Services/Inpatient Treatment Facility  
Arlington Campus**

Following is the response of the Riverside County Regional Medical Center Emergency Treatment Services/Inpatient Treatment Facility Arlington Campus (RCRMC Arlington) to the above referenced Grand Jury Report.

**FINDING NO. 1:**

**Pharmaceutical Incidents**

1. The review of the incident report log disclosed several instances of pharmaceutical mishaps. Some examples are:
  - Wrong medications were sent home with the patient
  - Inventory disclosed missing or expired medications
  - Unauthorized person was granted access to the pharmacy room
  - Medication administered at the wrong time
  - Medication transcribed with the wrong dispensing frequency
  - Medication ordered but not transcribed or dispensed
  - Doctor transcribed medication to the wrong patient chart

**Response: RCRMC Arlington partially agrees with this finding.**

RCRMC has been and continuously remains committed to patient safety. The incident log reviewed by the Grand Jury covered a six month time period (July 1, 2014 through December 31, 2014). Our records indicate that there were a total of 18 incidents related to medication administration during that time period. Several of these incidents were "near misses" which meant that patients were not affected because the error was identified prior to the medication being administered. The ETS/ITF strives to have a zero medication error rate and it should be noted that during the six-month time frame in question, 25,931 doses of medication were dispensed to ETS/ITF patients amounting to a less than one percent error rate.

**RECOMMENDATION NO. 1:**

**Pharmaceutical Incidents**

1. Hospital Administration shall require ETS/ITF nursing and pharmacy staff to participate in ongoing training for the proper distribution of pharmaceuticals and the importance of pharmaceutical safety.

**Response: RCRMC Arlington agrees with this recommendation.**

RCRMC has numerous policies and procedures in place which address patient safety as well as other important topics with regard to legal and regulatory compliance. Patient safety is foremost at RCRMC. All reported medication incidents are reviewed in detail by a multi-disciplinary team, MERIT (Medication Error Review Improvement Team). The medication management system, which is composed of the following 11 elements – Prescribing, order communications, product labeling, packaging, compounding, dispensing, distribution, administration, education, monitoring and use – is first reviewed to see what system changes can be implemented to make it more difficult for this incident to be repeated. If it is determined that this was incident was the result of an unsafe act by an employee then appropriate disciplinary action will occur. Staff education regarding medication administration is ongoing and occurs frequently to ensure a high degree of compliance with policies and industry standard of practice. Reported incidents are reviewed on a daily basis by Administration, Managers, Pharmacy and the Chair of Psychiatry.

**FINDING NO. 2:**

**ETS/ITF Arlington Campus is inadequate**

~~1.2.~~ ETS/ITF Arlington Campus is inadequate

- The average patient load of 36-42 patients per day at ETS exceeds the 20 patients per day capacity the facility was designed to serve
- Fire safety requires external doors to remain unlocked allowing patients held involuntarily the opportunity to leave the facility
- There are not enough interview rooms for the current patient load
- Nurses' stations are cramped
- Medical equipment is antiquated
- Computer systems are several generations behind current standards
- The lack of wireless communication within the facility requires manual charting
- No connectivity to RCRMC main campus servers prevents consolidation of patient records compounding the opportunity for charting errors

The quagmire of EDA and the Office of Statewide Hospital Planning and Development (OSHPD) policies hinder any efforts to repair the facility.

**Response: RCRMC partially agrees with the finding.**

RCRMC agrees that the inadequacies of the ETS/ITF facility noted in the Grand Jury Report exist. Some inadequacies can be attributed to the age of the facility, the limited number of available mental health beds within and external to the County of Riverside, and the lack of available community placements for patients requiring after-care following treatment in a Mental Health Facility. These issues have resulted in the ETS/ITF average daily census that exceeds the facility's patient capacity on a routine basis. Nevertheless, availability of funding is an ongoing issue. There are plans underway to address some of these issues.

**RECOMMENDATION NO. 2:**

ETS/ITF Arlington Campus is Inadequate

2. The Riverside County Board of Supervisors (BOS) shall "Fast Track" through EDA the scheduled repairs to the Arlington Campus while simultaneously negotiating with an experienced hospital construction firm to design and begin construction of a new facility.

**Response: RCRMC partially agrees with this recommendation.**

The Board of Supervisors has provided direction to expedite repairs at the RCRMC Arlington campus to complete repairs as noted below. The Board has approved the initiation of negotiations with a developer to develop medical facilities at the Moreno Valley RCRMC campus that will include a new mental health facility. Other plans are as follows:

Short Term Plans include:

- The Riverside County Economic Development Agency (EDA) is working with a consultant to evaluate and create a plan to lock the external hallway doors which should result in a decrease in involuntary patients exiting the ETS/ITF facility prematurely.
- Modifications are being planned for the nursing stations in Units B and C and the Emergency Treatment area which will open up the space and alleviate the cramped nurses' stations.
- Since the time of the Grand Jury Survey, new computers and monitors have been installed throughout the facility. The Information Technology department is conducting an assessment to determine the feasibility of installing wireless communication on the ETS/ITF Campus. If wireless communication is possible, the facility will move towards migrating from paper medical records to the main hospital Electronic Health Record System.

Long Term Plans include:

- Plans are currently underway to build a new 100+ beds Behavioral Health facility. RCRMC, EDA and an external developer are working toward rapid planning. The goal is to have the new facility completed within approximately three years.

**FINDING NO. 3:**

ETS/ITF Policies and Procedure No. 15.1 – Patient Death

3. Policy No. 15.1 describes procedures to be followed upon the death of a patient. The policy written is not clear.

Section 1 of Policy 51.1 prioritizes internal staff notification without suggesting “911” be called to assess the patient.

Section 1-c indicates a call to the Coroner/Public Administrator be made “when appropriate,” while Section 1-d indicates the Coroner must **always** be notified.

Section 2 requires that staff call an ambulance to transport the patient to the emergency room for pronouncing death, but Section 1-d indicates the Coroner will pick up the body.

Section 3 requires a call to OneLegacy, an organ transplant facilitator, without regard to patient or family desires (See Attachment #1).

**Response: Respondent agrees with the finding.**

**RECOMMENDATION NO. 3:**

ETS/ITF Policies and Procedure No. 15.1 – Patient Death

3. Policy 15.1 shall be rewritten:

- Section 1 “Notify” shall state that “911” shall be called first
- In accordance with Section 1-d the Coroner shall always be notified, therefore Section 1-c is redundant and shall be removed
- The responsibility to call OneLegacy shall be transferred to the emergency room staff

**Response: RCRMC partially disagrees with this recommendation.**

Development of content and writing of hospital policies is the responsibility of the hospital and its trained health care practitioners. All policies noted in the Grand Jury report have been reviewed and revised as appropriate. Staff were re-educated on the policy updates, as appropriate.

Policy 15.1 Death of a Patient – has been retired and was incorporated into – Policy 5.1- Medical Emergency Response. This policy addresses the procedures to be followed upon the death of a patient. A copy of Policy 5.1 is attached as Exhibit 1.

**FINDING NO. 4:**

Policy No. 12.1 Levels of Observation

4. This policy is dated “3/12.” The policy is incomplete, consisting of pages “1 of 5,” and “3 of 5” and “5 of 5” (see Attachment #2).

**Response: RCRMC partially disagrees with the finding.**

The policy is complete. Even numbered pages of the policy, inadvertently were not included in the document provided to the Grand Jury.

**RECOMMENDATION NO. 4:**

Policy No. 12.1 Levels of Observation

4. Policy No. 12.1 shall be revised to include:

- Policy shall be rewritten to be complete with full dates and all policy information included

**Response: RCRMC partially disagrees with the recommendation.**

Policy No. 12.1 is a complete policy. The Grand Jury was missing certain pages, that, upon request, could (and would) have been provided to the Grand Jury. The Effective date has been corrected to include the complete date, e.g. (3-12-12). Additional revisions were made to this policy which is attached as Exhibit 2.

**FINDING NO. 5:**

Policy No. 20.1

5. There are two policies numbered 20.1

One is dated “3/12” and titled “Therapeutic Groups (Process)” superseding Policy No. N8.03. This policy contains page “1 of 2,” but page 2 is missing.

The second policy has a revision date of “6/7/2013” and titled “EMERGENCY TREATMENT SERVICES (ETS)/ INPATIENT TREATMENT FACILITY (ITF) DISCHARGE PROCEDURE” superseding Policy No. N12.05 (see Attachments #3 and #4).

**Response: RCRMC partially agrees with this finding.**

Policy 20.1 ETS/ITF Discharge Procedures and Therapeutic Groups Process policies – the Grand Jury report indicated that two policies were numbered “20.1.” Both policies were reviewed and changes were made to the numbering. Policy 20.1 was assigned to ETS/ITS “Discharge Procedures” and 13.2 was assigned to “Therapeutic Groups (Process)”

Former Policy No. 20.1 “Therapeutic Groups (Process)” was a complete policy. The Grand Jury was missing the second page, that, upon request, could (and would) have been provided to the Grand Jury.

#### **RECOMMENDATION NO. 5:**

##### Policy No. 20.1

5. RCRMC shall make the following changes:

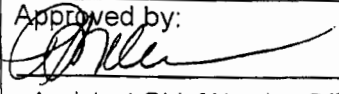
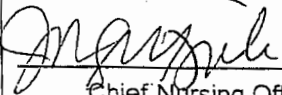
- Policy numbers shall be corrected to be unique
- Policy titled “Therapeutic Groups (Process)” shall be rewritten to be complete with full dates and all policy information included.

**Response: RCRMC partially agrees with this recommendation.**

Development of content and writing of hospital policies is the responsibility of the hospital and its trained health care practitioners. All policies noted in the Grand Jury report have been reviewed and revised as appropriate.

Both policies were reviewed and changes were made to the numbering. Policy 20.1 was assigned to ETS/ITS “Discharge Procedures” and 13.2 was assigned to “Therapeutic Groups (Process).” These policies are attached as Exhibit Nos. 3 and 4.

**RIVERSIDE COUNTY REGIONAL MEDICAL CENTER  
DEPARTMENT OF PSYCHIATRY  
POLICY**

<b>Subject: EMERGENCY TREATMENT SERVICES (ETS)/INPATIENT TREATMENT FACILITY (ITF) DISCHARGE PROCEDURE</b>		Effective date:	Page 1 of 3
		Revised Date: 6/7/2013	Policy No. 20.1 Supersedes: Policy No. N12.05
Departments Consulted:  Nursing Department	Reviewed & Approved by:  Assistant Chief Nursing Officer  Chief Nursing Officer	Approved by:   Assistant Chief Nursing Officer   Chief Nursing Officer	

**POLICY:**

Nursing will ensure that all items on the Discharge Checklist have been addressed. The Nurse will either initial (in the appropriate space on the form) as completed or mark "NA" (Not Applicable). The Discharge Checklist will be signed off by the Registered Nurse and the licensed nurse escorting the patient off the unit. The Admitting staff member will review the Discharge Checklist (provided by the escort nurse), and ensure all items have been addressed before finalizing the patient's discharge.

All discharges must be reviewed with the Duty Officer/House Supervisor by the Charge Nurse. The Duty Officer/House Supervisor will assist in coordinating the discharge as soon as possible.

**ITF PROCEDURE:**

1. Obtain doctor's discharge order as soon as possible after the decision was made to discharge the patient.
2. Forward a copy of the doctor's order for discharge medications, to the pharmacy.
3. Verify discharge plan. Complete one of the following:
  - a. Contact family/friend and re-verify actual time patient will be picked up.
  - b. Contact Hospital Transportation and obtain an estimated time that patient will be transported. Follow up as needed.
  - c. Verify that request for bus tickets or Greyhound voucher is in patient's chart.
4. If the patient is being discharged to him/herself but no specific placement has been identified, e.g., the patient is homeless and wishes to continue to be so, the Registered Nurse will verify that a Consent for Discharge and Transportation to a Non-Home Residence Location have been completed.
5. Check the 5150 Application to determine if law enforcement has indicated they are to be notified before the patient is discharged. If yes, contact the law enforcement agency indicated on the 5150 Application, and document in the Progress Note having done so, including the name of the person spoken with, telephone number and outcome of the conversation, including any pertinent quotes.

*Distribution: Department of Psychiatry Nursing*

6. A Firearms Prohibition must be completed and explained to the following patients, if applicable:
- Patients admitted to ITF on 5150 for danger to self and/or others.
  - Patients in ITF on 5250 for danger to self, danger to others, and/or grave disability.
  - Patients in ITF on Temporary Conservatorship or permanent Conservatorship.

**NOTE:** Patients admitted to ITF voluntarily or 5150 as Gravely Disabled ONLY do not require a Firearms Prohibition.

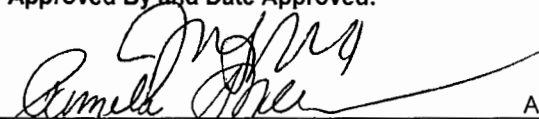
7. Obtain discharge medications and patient's personal medications (if patient brought medications to the hospital with him).
- Compare medication bottles with the physician's discharge order.
  - Confirm medications are for the correct patient, correct medications, dosages, and frequency.
  - Confirm medication information sheets are included from pharmacy, and that information sheets are for the correct medication.
8. At time of discharge, complete the following:
- When other disciplines have completed their portions of the Aftercare Instructions, the Registered Nurse will sit with the patient and review and complete Aftercare Instructions with the patient ensuring confidentiality.
  - Ask the patient if she/he would like a designated person (e.g., family member, friend, significant other, etc.) to join the Registered Nurse and the patient, to hear the discharge instructions. Nursing staff will sit with the patient in the day room to discuss the aftercare instructions with the patient (and family/significant other if present) while maintaining patient confidentiality. (Obtain written consent from the patient as needed, and indicate so on the form). Aftercare Instructions will also include follow-up appointments and may include special dietary needs.
  - If the patient is under conservatorship, the Conservator must be notified of the pending discharge. Private Conservator's number should be in the chart or contact Riverside County Conservators Office at (951) 341-6440.
  - Have the patient verbalize understanding of instructions, and indicate so on the form.
  - Review possible food/drug interactions and give the Food and Drug pamphlet to the patient, and indicate so on the form.
  - Encourage patient compliance with the Aftercare Instructions.
  - Update Treatment Plan, resolving patient problem(s) which led to admission.
  - Provide the Patient with the Client Survey, and indicate so on the form. Ask the patient if they would be willing to complete the survey before they leave the unit or they can mail it in. (Does not apply to ETS patients)
  - Assist the patient in gathering all of his/her property from the patient's bedroom.
  - Assist the patient in gathering all of his/her property from the patient's locker.
  - The Registered Nurse will write the discharge note, and ensure the time of discharge, and the time on the Safety Check sheet, coincide.

**NOTE:** Interpreter/Translation Services to be utilized as needed.



9. Escort the patient off of the unit, and complete the following:
  - a. Verify the patient has copy of Aftercare Instructions and the discharge medication list.
  - b. Verify the patient has his/her medications, Medication Information sheets, bus tickets request or voucher. If the patient has a request for bus tickets, The Social Worker will issue the bus tickets.
  - c. Verify all of the patient's property has been removed from the unit (from bedroom and locker).
  - d. Retrieve patient property from the Contraband room and either confirm the patient has no property in Contraband (from the current or any previous hospitalization) or obtain the property
  - e. Accompany patient to Administration safe, and either confirm the patient has no property in the safe (from the current or any previous hospitalization) or obtain the property.
  - f. Accompany the patient to Admitting for final discharge processing. If any item on the Discharge Checklist has not been signed off, the Admitting Clerk will return the form to the accompanying nurse for completion, and the discharge will be delayed until completed (e.g., returning to Contraband room to obtain the patient's property and/or clerk's signature, etc.).
  - g. If the patient is to discharge home or non residential address. They can be escorted to the discharge lobby and they can wait for their medication and transportation if needed.
  - h. The Escorting Nurse will return to the unit and place the completed Discharge Check List in the patient's ITF Medical Record.
  - i. The ITF Unit's Charge Nurse will notify the ETS Charge Nurse and the Duty Officer/House Supervisor of the available bed, immediately after the discharging patient has left the unit.

**RIVERSIDE COUNTY REGIONAL MEDICAL CENTER  
Nursing Administration – Arlington Campus**

		Document No: 5.1	Page 1 of 2
<b>Title:</b> Medical Emergency Response / Death of a Patient	<b>Effective Date:</b> 7/8/2015	<input type="checkbox"/> Hospital-Wide <input checked="" type="checkbox"/> Departmental	
<b>Approved By and Date Approved:</b> 		<input checked="" type="checkbox"/> Policy <input type="checkbox"/> Procedure <input type="checkbox"/> Protocol <input type="checkbox"/> Guideline	
		Judi Nightingale Chief Nursing Officer Pam Shellner Assistant Chief Nursing Officer	

**POLICY:**

**Medical Emergency**

Anyone judged to be experiencing a life-threatening medical emergency will be designated as a Code Blue. Immediate emergency care (BLS level) will be rendered to sustain life until paramedics arrive and transport the person to the nearest emergency room.

**PROCEDURE:**

Anyone finding a person experiencing a medical emergency will call out "Code Blue" and immediately initiate emergency care (BLS level). Nursing staff will immediately respond.

1. One person will go immediately to the telephone, dial 103 and announce Code Blue, where located and room number. This should be repeated three times. Example: "Code Blue, , Unit \_\_\_ Room, \_\_\_.. Code Blue, Unit \_\_\_ Room, \_\_\_.. Code Blue, , Unit \_\_\_ Room, \_\_\_."
2. After announcing the Code Blue, the staff will dial 9-911 upon direction from physician or charge nurse. The following information will be given to the operator:

**Address: 9990County Farm Rd. Suite 2**

**We need and ambulance because...**

**Patient's medical problem i.e.: Respiratory Distress, Altered Level of consciousness, Not Breathing etc...**

**DO NOT HANG UP ON 911.** Be sure and wait for them to get all the information they need and let them hang up first.

Upon hanging up from 911, the calling person or his/her designee must proceed immediately to the emergency entrance. There he/she will wait for the paramedics arrival and escort them to where the Medical Emergency is in progress.

3. When Code Blue is announced over the intercom, all available RN's and physicians are to report to the area immediately.
4. Staff will assist as needed but will primarily be responsible to calm and supervise the other patients during the emergency.
5. Medical emergency procedures will remain in effect until paramedics have arrived and taken over. Physicians and nurses will continue to assist in any way requested until the patient is transported.

6. The individuals who had lead roles in the Medical Emergency will be responsible to see that all charting and documentation is completed in accordance with Medical Emergency Protocol.
7. The Emergency carts will be restocked immediately with supplies used.

#### Conditions Potentially Needing Code Blue

- Seizures
- Chest Pains
- Shortness of Breath
- Loss of Consciousness
- Mental Status Change

#### IN THE EVENT OF PATIENT DEATH:

#### GUIDELINES:

1. Notify:
  - a. Patient's doctor, who notifies family.
  - b. Assistant Chief Nursing Officer, Administrator on Call and respective Nurse Manager.
  - c. Coroner, Public Administration and other agencies when appropriate.

2. Care of the body:

Follow Nursing Department procedure for POST MORTEM CARE.


3. Transportation of the body:
  - a. All deaths will be reported to the Coroner's office. The Coroner's office will pick up the body.
4. Storage of the body:
  - a. Coroner's office will pick up the body from patient room.
  - b. If the Coroner's office cannot pick up the body in a reasonable time (2-3 hours), request permission from Coroner to have courier transport to the morgue at Riverside County Regional Medical Center.

*Guidelines should be followed: however, exceptions are not viewed as violation of hospital policy if they are justified by reasonable clinical or operational consideration.*

#### Document History:

Release Dates:		Replaces Policy:	
Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
7/8/2015	Arlington Campus Policy Committee	Yes	Minor wording changes throughout document. Policy 15.1 merged into this policy.

**RIVERSIDE COUNTY REGIONAL MEDICAL CENTER  
Nursing Administration – Arlington Campus**

		Document No: 12.1	Page 1 of 6
Title: Levels of Observation	Effective Date: 3/1/2012	<input type="checkbox"/> Hospital-Wide	<input checked="" type="checkbox"/> Departmental
Approved By and Date Approved:  		<input checked="" type="checkbox"/> Policy	<input type="checkbox"/> Procedure
Judi Nightingale Chief Nursing Officer Pam Shellner Assistant Chief Nursing Officer		<input type="checkbox"/> Protocol	<input type="checkbox"/> Guideline

**POLICY:**

It is the policy of the Riverside county regional medical Center (RCRMC) Inpatient Treatment Facility/Emergency Treatment Service (ITF/ETS) that each patient admitted will be evaluated for his/her potential to harm themselves or others. It is recognized that each patient admitted to the RCRMC ITF/ETS has some level of risk for harm to self or others. However, some patients have higher risk than others. In addition, a patient may require a higher level of nursing observation and intervention related to being at high risk for falls, extreme confusion, inability to provide for his/her basic care needs or other identified risk. As a result, each patient will be assessed for risk of harm to self or others or other safety concern, and the appropriate level of nursing observation will be assigned based on the patient need. All nursing staff providing direct patient care will be trained and competency certified for the nursing management of all levels of observation.

**REFERENCE POLICIES:**

RCRMC Online policy #122, *Unauthorized Leave of Patients*

**PROCEDURE:**

1. Assessment:
  - a. Every patient shall be assessed by an ETS psychiatrist and an appropriate level of observation shall be ordered.
  - b. Every patient admitted to the ETS and ITF shall be assessed by a registered nurse (RN) for the potential to harm self or others or other safety risk, such as risk for fall, ability to provide for basic care needs and level of confusion.
  - c. Every patient shall routinely be assessed for risk of harm to self or others, or other safety risk, a minimum of once each shift by an RN.
  - d. A patient not previously identified as a risk for harm to self or others or other safety risk shall be observed at the Routine Level of Observation. At any time a patients behavior indicates a change or increased risk for harm to self or others or other safety risk, a risk assessment will be conducted by an RN or psychiatrist, and the appropriate level of nursing observation will be assigned based on the patient current need (see Levels of Observation below).
  - e. Any clinical staff member that observes patient behavior that indicates a risk for harm to self or others or other safety risk that poses an immediate threat to the safety of the patient or others may initiate continuous in-person observation pending patient assessment by an RN or psychiatrist.
  
2. Levels of Observation:
  - a. Routine: All patients shall be monitored for safety at least every 15 minutes by nursing staff. All patients will be monitored with routine observations unless otherwise ordered by an RN or MD.

## i. Criteria:

1. A patient without suicidal or homicidal thoughts.
2. A patient with suicidal or homicidal thoughts but without a plan or intent to harm self or others and is considered to be at low risk.
3. A patient with mild to moderate levels of confusion where patient behavior does not endanger self or others.
4. A patient with low fall risk where the patient is able to actively move about the milieu and participate in groups with minimal assistance or risk for fall.
5. A patient who is able to care for his or her basic needs eating, dressing and toileting with low to moderate levels of assistance.
6. A patient that is continent or able to notify nursing when he or she has toileting needs.

## ii. Patient Care Management:

1. Every patient shall be directly visualized and properly identified at least every 15 minutes. These checks shall be assigned each shift and adjusted as needed by the charge nurse.
2. The patient location will be recorded on the "24 Hour Safety Check" sheet for each patient.
3. If the patient is asleep, the patient will be assessed for respirations and any signs of distress. This requires the use of a flashlight to assure the rising and falling of the chest can be visualized, and that patient welfare can be assured.
4. If a risk for harm to self or others or other safety risk is identified, continuous in-person observation pending patient assessment by an RN psychiatrist shall be initiated.
5. If the patient cannot be located, the charge nurse will be notified immediately, and a search for the patient will be organized and conducted per policy #122 *Unauthorized Leave of Patients*.
6. In addition to checking the patient for safety, the environment will also be check for safety. Any objects or issues that may be a safety hazard will be removed if possible. All safety issues shall be reported immediately to the charge nurse.

b. **Continuous therapeutic Intervention (CTI):** A patient on CTI is monitored with continuous 1:1 in-person observation by nursing staff. CTI may be initiated by an RN or psychiatrist, but does not require an MD order.

## i. Criteria:

1. A patient with non-lethal suicidal or homicidal thought, or non-lethal risk for harm to self or others.
2. A patient with moderate to high levels of confusion where patient behavior endangers self or others. An example might include an impulsive patient that invades the space or property of others and there is imminent risk of retaliation.
3. A patient with moderate to high risk for fall or mobility issues that require constant nursing observation and assistance to permit safe participation in the milieu and groups.
4. A patient that is not able to care for his or her basic eating, dressing and toileting needs without total assistance.
5. A patient that is incontinent and unable to communicate when he or she has toileting needs and is at eminent risk for skin breakdown.
6. A patient with a high potential for elopement or escape.
7. A patient with fire starting behaviors.

8. A sexually vulnerable patient or a sexually predatory patient.
  9. A patient with significant medical conditions requiring special attention or management.
  10. A patient with repeated assaultive behaviors.
  11. Other safety issue as identified by an RN or psychiatrist.
- ii. Patient Care Management:
1. The RN or psychiatrist must complete a progress note as soon as possible to document the assessment and need for CTI, and a treatment plan initiated or updated to include the goals and interventions to be implemented.
  2. The RN will notify a psychiatrist if MD evaluation is needed.
  3. The treatment team must assess the patient as part of the daily interdisciplinary treatment process to determine the need for continuation of the CTI and need to modify the treatment plan. The psychiatrist's daily progress note must contain documentation of the treatment team's review of the CTI and any updates/amendments that were made to the treatment plan, and include specific recommendations to continue or discontinue the CTI.
  4. An RN must complete a progress note documenting the CTI at least once every shift, or more frequently as needed based upon the patient's behavior.
  5. Staff assigned to continuous direct patient observation for CTI shall:
    - a. Maintain direct visualization of the patient to maintain safety. The assigned staff should be at arm's length from the patient at all times unless the patient is an immediate danger to others. If the patient is at risk for harm to others, a distance of up to 10 feet may be maintained, allowing the staff person reasonable movement from the patient to avoid injury should the patient become physically aggressive.
    - b. Follow the patient plan of care as identified in the treatment plan and as directed by the RN assigned to the patient.
    - c. Use of potentially dangerous objects, i.e. razors, shall be monitored continuously. Consult the assigned RN if the patient is at risk for harm to self or others.
    - d. CTI assigned nursing staff should notify the assigned RN if there is a change in the patient's psychiatric behaviors or physical status (e.g., Highly agitated to suddenly calm, or vice versa; alert and oriented to suddenly confused; verbal to suddenly non-verbal/unable to speak.
    - e. Assigned nursing staff must complete a progress note at least every two (2) hours documenting a description of the patient's behaviors/condition, the interventions utilized, and the patient response to the interventions utilized. If the assigned staff is a CNA, the charge nurse will delegate the documentation to an appropriate licensed staff.
    - f. When the patient outcome is reached and the patient no longer requires CTI, the psychiatrist must be notified that CTI will be discontinued. The RN/psychiatrist will make any amendments/updates to the treatment plan as

needed.

6. **CTI 2:1 monitoring (at Hours of Sleep):** A patient on CTI is not at risk for harm to self or others may be placed in a room with another CTI patient that is not at risk for harm to self or others (during hours of sleep) at a 2:1 ratio, and monitored by one nursing staff member (2 patients with 1 nurse monitoring). The two cohabitated patients on CTI 2:1 are to be monitored with continuous 2:1 in-person observation by nursing staff. CTI 2:1 may be initiated by an RN or psychiatrist but does not require an MD order.
  - a. Criteria:
    - i. A patient with issues identified in CTI observation that does not include risk of harm to self or others, but where there is a need for some monitoring during hours of sleep. An example might include a patient at high risk for fall that is able to ask for assistance when getting out of bed.
  - b. Patient Care Management:
    - i. As noted in CTI "Nursing Management" except that there are two cohabitated patients during hours of sleep.
    - ii. If both patients are up or trying to get out of bed at the same time, the staff assigned to the 2:1 patient monitoring will call for assistance.
    - iii. If the charge nurse determines that a patient requires 1:1 continuous nursing observation for safety, the supervisor will be notified and staffing obtained.
7. **CTI W/A (while awake):** A patient on CTI that is not at risk for harm to self or others may be monitored with continuous in-person observation by nursing staff during waking hours only.
  - a. Criteria:
    - i. A patient with issues identified in CTI observation that does not include risk of harm to self or others and there is not a need for monitoring during hours of sleep. An example might include a patient that is at moderate risk for fall or is confused and intrusive, and the 15 minute Routine Observation Safety Checks are sufficient for patient safety during hours of sleep. CTI W/A may be initiated by an RN or psychiatrist, but does not require an MD order.
  - b. Patient Care Management:
    - i. As noted in CTI "Nursing Management" except that monitoring is only during waking hours.
    - ii. If the charge nurse determines that the patient requires continuous 1:1 or 2:1 nursing observation, the supervisor will be notified and staff obtained.
8. **Suicide Precautions (SP):** A patient on SP is an imminent risk for self harm as determined and ordered by a psychiatrist. A patient on SP is monitored with continuous 1:1 in-person observation by nursing staff. SP may be initiated by an RN or psychiatrist, but does require an MD order.
  - a. Criteria:

- i. A patient with a high risk for suicide or self harm that could be lethal.
- b. Patient care Management:
  - i. The RN or psychiatrist must complete a progress note as soon as possible to document the assessment and need for SP, and a treatment plan initiated or updated to include the goals and interventions to be implemented.
  - ii. If SP is initiated by an RN, the psychiatrist must be notified within on hours of initiation of SP.
  - iii. The psychiatrist will assess the patient and either order the SP or notify the nursing staff to discontinue the SP and advise regarding the appropriate level of observation needed.
  - iv. The treatment team must review SP as part of the daily interdisciplinary treatment process to determine the need for continuation of the SP and need to modify the treatment plan. The psychiatrist's daily progress note must contain documentation of the treatment team's assessment of the patient and any updates/amendments that were made to the treatment plan, and include specific recommendations to continue or discontinue the SP.
  - v. Continuation of SP requires a new MD order every 24 hours.
  - vi. An RN must complete a progress note documenting the SP at least every 4 hours, or more frequently as needed based upon the patient's behavior.
  - vii. Staff assigned to continuous direct patient observation for SP shall:
    1. Maintain direct visualization of the patient at all times. If the patient uses the bathroom, the door must be kept ajar so that there is sufficient visualization of the patient to maintain safety. The assigned staff should be at arms length from the patient at all times unless the patient is an immediate danger to others.
    2. Follow the patient plan of care as identified in the treatment plan and as directed by the RN assigned to the patient.
    3. Use of potentially dangerous objects, i.e. razors shall not be allowed without authorization from the RN assigned to the patient. If permitted, the use must be monitored continuously.
    4. SP assigned nursing staff should notify the assigned RN of any self-injurious behaviors, or if there is a change in the patient's psychiatric behaviors or physical status (e.g., Highly agitated to suddenly calm, or



vice versa; alert and oriented to suddenly confused; verbal to suddenly non-verbal/unable to speak).

5. Assigned nursing staff must complete a progress note at least every two (2) hours documenting a description of the patient's behaviors/condition, the interventions utilized, and the patient response to the interventions utilized. If the assigned staff is a CNA, the charge nurse will delegate the documentation to an appropriate licensed nurse.
9. The psychiatrist will discontinue the SP when he or she determines that the patient outcome has been reached and the patient no longer requires SP. The psychiatrist/RN will make any amendments/updates to the treatment plan as needed.

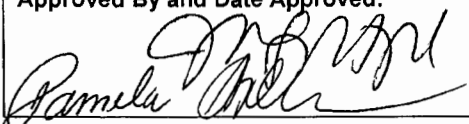
*Guidelines should be followed: however, exceptions are not viewed as violation of hospital policy if they are justified by reasonable clinical or operational consideration.*

**Document History:**

<b>Release Dates:</b>		<b>Replaces Policy:</b>	
<b>Date Reviewed</b>	<b>Reviewed By:</b>	<b>Revisions Made?</b>	<b>Revision Description</b>
7/8/2015	Arlington Campus Policy Committee	Yes	Minor wording changes throughout document.

**RIVERSIDE COUNTY REGIONAL MEDICAL CENTER**  
**Nursing Administration – Arlington Campus**

Document No: 13.2      Page 1 of 3

<b>Title:</b> Therapeutic Groups (Process)	<b>Effective Date:</b> 3/1/2012	<input type="checkbox"/> Hospital-Wide <input checked="" type="checkbox"/> Departmental
<b>Approved By and Date Approved:</b> 		<input type="checkbox"/> Policy <input type="checkbox"/> Procedure <input type="checkbox"/> Protocol <input checked="" type="checkbox"/> Guideline
Judi Nightingale Chief Nursing Officer Pam Shellner Assistant Chief Nursing Officer		

**PURPOSE:**

Riverside County Regional Medical Center (RCRMC) Inpatient Treatment Facility/Emergency Treatment Service (ITF/ETS) has established process for the development and coordination of Therapeutic Groups. The goal is to have a well-rounded treatment program that assists the patient post-discharge with the resources and skills necessary to achieve and maintain the highest level of function in the community. The core multi-disciplinary "Therapeutic Group" team will consist of nursing services, social services / case management, psychology, occupational / recreational therapy and pharmacy. Other disciplines will also participate as possible, e.g. rehabilitative services, patient rights and patient disability rights.

**REFERENCE POLICIES:**

1. RCRMC Arlington ITF/ETS #12.1, *Levels of Observation*

**GUIDELINES:**

**THERAPEUTIC GROUP MODEL**

1. The groupwork model used is the *Tidal Model*. The aims of the model are:
  - a. To share experiences of difficulty, distress and disability.
  - b. To obtain support from other group members.
  - c. View problems from a different perspective and learn from the experiences of others.
  - d. Experience helping others.
  - e. Sharing of information
  - f. Exploring options for resolving problems.
  - g. Developing assertiveness, social skills and problem solving skills.
  
2. Within the model there are 3 types of Groups:
  - a. The Recovery Group:
    - i. Is focused on a set of questions that aim to generate simple reflection and informal conversation and helps people to identify their strengths – ideally it should be held in the morning when people often need a boost.
  - b. The Information Group:
    - i. Aims to demystify the language of psychiatry and develop the person's understanding of their illness, situation and treatment. Such sessions might include discussions on medication management, benefit information, illness education, self-help groups, housing issues etc.
  - c. The Solutions Group:
    - i. Supports and builds upon the one-to-one work and is focused upon bringing about and recognizing change. Ideally it should be held in the

afternoon and allow people time to reflect and unwind afterwards. A separate information sheet provides further details about this group session.

## **PROCESS:**

1. **Development and Coordination:**
  - a. The Assistant Chief Nursing Officer, or designee will:
    - i. Periodically implement patient surveys to assess the types of groups that patients believe will benefit them most, and these surveys will then be reviewed and discussed by the multi-disciplinary team. Patient suggestions will be integrated whenever appropriate and possible.
    - ii. Meet with the therapeutic Group team to review and discuss current groups offered, patient surveys, therapeutic need and value, and explore the need for additions or changes to the Therapeutic Group program.
  - b. The Therapeutic Group program for each unit will be developed in response to the needs of the patient population of the unit, acknowledging for example the differences in needs and learning styles of adults and adolescents.
  - c. The Therapeutic Group program will include topics such as psychosocial issues, medication management, life skills, substance abuse, discharge planning, exercise/recreational activities, nutrition, peer support, AA, NA and/or other appropriate issues.
  - d. A schedule of Therapeutic Groups will be developed for each unit by the Therapeutic Group Team.
  - e. Therapeutic Groups and group materials will be developed by each cored discipline and other disciplines as appropriate.
  - f. Staff involved in leading or supporting Therapeutic Groups will be trained as needed.
2. **Group Management:**
  - a. Patient participation in Therapeutic Groups is essential to the best outcomes for sustained recovery.
  - b. Patient participation in Therapeutic Groups is to be strongly encouraged. Groups are an essential component to the overall treatment program.
  - c. Non-nursing lead groups will be supported by the nursing department for safety. If the group leader does not want nursing staff present during the group, a nursing staff person will sit immediately outside the group where they can visualize patients unless the patient is on a CTI or SP, in such case the assigned nurse will maintain continuous direct observation per policy #12.1, *Levels of Observation*.
3. **Documentation:**
  - a. Patient participation in groups is to be documented in the Group Notes. The notes should include the level of participation, ability to process information and level of tolerance.
  - b. Patient refusal to attend or participate in groups will be documented.

*Guidelines should be followed: however, exceptions are not viewed as violation of hospital policy if they are justified by reasonable clinical or operational consideration.*

---

### Document History:

<b>Release Dates:</b>		<b>Replaces Policy:</b>	
<b>Date Reviewed</b>	<b>Reviewed By:</b>	<b>Revisions Made?</b>	<b>Revision Description</b>
7/8/2015	Arlington Campus Policy Committee	Yes	Policy was renumbered, formally 20.1.