Clinical Departments: Behavioral Health

Name of Hospital: _____

Date: _____ Hospital Contact: _____

Behavioral health services offered at the facility include (please identify all that apply):

___ Pediatric   ___ Drug/Alcohol   ___ Behavioral health services
                                                         are not offered. (Please
___ Adolescent   ___ Outpatient   continue even if
                                                         behavioral health services
___ Adult   ___ Inpatient   are not offered.)

___ Geropsychiatry   ___ Other _____

Always/ Yes	Sometimes	Never/ No	N/A	
				DEPARTMENT MANAGEMENT
☐	☐	☐	☐	1. Suicidal patients are always admitted to behavioral health units.
☐	☐	☐	☐	a. If "No", policies are in place regarding observation, ongoing assessments and documentation of the behavioral health patient on a non-behavioral health unit.
☐	☐	☐	☐	2. There are policies and procedures addressing the transfer of a patient from patient care areas to the behavioral health unit or to a behavioral health facility.
				Confidentiality
☐	☐	☐	☐	3. The hospital has a policy/procedure for the release of confidential information.
☐	☐	☐	☐	a. The policy complies with state and federal statutes.
☐	☐	☐	☐	b. Staff is trained in procedures for responding to requests for information from outside individuals or organizations (e.g., telephone inquiries, visitor/family questions).
☐	☐	☐	☐	4. If the behavioral health unit is in a general hospital, the switchboard and information desk have policies in place for responding to inquiries regarding behavioral health and substance abuse patient treatment.
☐	☐	☐	☐	a. All appropriate employees and volunteers are trained in this procedure, which is documented and repeated annually.

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Always/ Yes	Sometimes	Never/ No	N/A	
				Duty to Warn
☐	☐	☐	☐	5. There is a policy defining when a patient's confidentiality may be broken (i.e., duty to warn).
☐	☐	☐	☐	a. The policy identifies who is responsible for notifying law enforcement and/or potential victims.
☐	☐	☐	☐	b. The policy includes a process to follow when there is a conflict between caregivers on the duty to warn.
☐	☐	☐	☐	c. The policy outlines documentation requirements.
				MEDICATION MANAGEMENT
☐	☐	☐	☐	6. There is a policy, which complies with state laws, that outlines when a patient can be medicated against his or her will.
☐	☐	☐	☐	7. There are medication dosage guidelines to ensure that patients are not receiving excessive doses.
☐	☐	☐	☐	a. If prescribing exceeds guidelines, the physician is required to document the justification in the medical record.
☐	☐	☐	☐	8. Drug utilization review includes psychotropic medications.
☐	☐	☐	☐	9. There is documented informed consent before administration of psychotropic medications, or informed consent is obtained when a patient is well enough to consent, especially if tardive dyskinesia is a possible side effect.
☐	☐	☐	☐	10. There is proper monitoring and testing of patients on psychotropic medications (e.g., vital signs, daily weights, assessment for orthostatic hypotension, temperature, lithium levels, and appropriate lab tests when necessary).
☐	☐	☐	☐	11. Patients who receive new medications or increased doses of medications are placed on fall precautions.
☐	☐	☐	☐	12. Nursing staff is trained in psychotropic pharmacology.
☐	☐	☐	☐	a. Training includes recognition and treatment of extrapyramidal symptoms and neuroleptic malignant syndrome.
☐	☐	☐	☐	b. There is periodic reevaluation of nursing staff competency in psychotropic pharmacology.

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Always/ Yes	Sometimes	Never/ No	N/A	
				PATIENT CARE
				Admission Procedures
☐	☐	☐	☐	13. There is a special consent form for behavioral health admission that complies with statutory requirements.
☐	☐	☐	☐	14. There is documentation that the patient received a copy of his or her patient rights, including how to request a discharge and how to file a grievance.
☐	☐	☐	☐	15. There are specific admission criteria for the unit/service that identify the type of patient the facility can or cannot accept.
☐	☐	☐	☐	16. A behavioral health staff member accompanies the behavioral health patient on any transfer to or from the behavioral health unit.
☐	☐	☐	☐	17. The initial admission assessment is completed by an RN within one hour of admission.
☐	☐	☐	☐	18. Each patient is assessed and identified for a potential elopement risk.
☐	☐	☐	☐	19. Each patient who is admitted on an "involuntary hold" status is seen within 72 hours of admission or sooner by a qualified practitioner, as required by state law.
☐	☐	☐	☐	a. There is a system in place to track involuntary holds that verifies the patient is seen within 72 hours or sooner, as required by state law.
☐	☐	☐	☐	20. Each patient has a comprehensive history and physical done within 48 hours of admission or sooner, as required by state law, by a practitioner who has been granted the appropriate privileges.
☐	☐	☐	☐	21. Behavioral health consultation is available 24 hours a day to assess behavioral health problems that arise in patient care areas.
				Suicide Prevention/Precaution
☐	☐	☐	☐	22. A suicide assessment is done by appropriately licensed staff on every patient upon admission.
☐	☐	☐	☐	a. The assessment includes past attempts, current plans, the ability to carry out the plans, and risk factors (e.g., recent loss, family history, finalizing affairs, mood changes).
☐	☐	☐	☐	b. When a patient is identified as at risk, a reassessment is documented at least every shift.
☐	☐	☐	☐	c. There is documentation of staff education regarding the use of "no-suicide contracts," which does not eliminate the requirement of suicide assessment and appropriate precautions.

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Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	23. Staffing guidelines address the patient-to-staff ratio for patients on suicide precautions.
☐	☐	☐	☐	24. There are written policies and procedures to address documentation of patient observation.
☐	☐	☐	☐	25. There are written procedures for contraband detection.
☐	☐	☐	☐	26. Families/significant others are educated regarding suicide risk factors and the contraband policy.
☐	☐	☐	☐	27. Policy and procedure guide the assessment and documentation requirements for discharging a patient who was admitted with suicidal ideation.
☐	☐	☐	☐	28. Information regarding suicide risk factors, care of the patient on suicide precautions, and contraband procedures is included in new employee orientation and continuing education opportunities.
☐	☐	☐	☐	a. The members of the team have had documented, specific training in these areas.

Seclusion

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	29. Written policies and procedures are in place regarding the use of seclusion.
☐	☐	☐	☐	a. The policies and procedures reflect any mandated state requirements.
☐	☐	☐	☐	30. Physicians' orders for seclusion are time limited.
☐	☐	☐	☐	31. Patients in seclusion are assessed every 15 minutes or more frequently, as determined by state law.
☐	☐	☐	☐	32. A personal search is completed before leaving a person in seclusion.

Restraints

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	33. There are written policies and procedures to address the use and documentation of physical restraints while prohibiting the use of chemical restraints.
				34. The policy on physical restraints includes the following:
☐	☐	☐	☐	a. All restraints require a physician's order.
☐	☐	☐	☐	i. The order is time limited.
☐	☐	☐	☐	ii. There are procedures for extending or renewing the order.
☐	☐	☐	☐	b. In an emergency, the physician's order is obtained within one hour of restraint application.

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Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	c. Prior to receiving a physician's order, only an RN can authorize the use of restraints.
☐	☐	☐	☐	d. Restraints are used only when less restrictive interventions have failed, and there is a clear and well-documented threat of harm to self or others.
☐	☐	☐	☐	e. The patient's circulation is checked within the first 15 to 30 minutes of initial restraint application.
☐	☐	☐	☐	f. The patient's extremities are checked and documented for adequate circulation at a minimum of every two hours.
☐	☐	☐	☐	g. The patient's ranges of motion and position changes are performed and documented every two hours unless there is a documented reason for not making these changes.
☐	☐	☐	☐	h. Evaluation of the patient's personal needs (e.g., bathing, toileting, hydration, nutrition) is conducted and documented at a minimum of every two hours.
☐	☐	☐	☐	35. There is a system to assure that the above actions are documented in the medical record (e.g., flow sheet or checklist).
☐	☐	☐	☐	36. There is a quality review of 100 percent of seclusion and restraint charts to assure there is proper documentation and a clear indication of the need for the patient to remain in restraints and/or seclusion. (It is preferred that the review occurs within 24 hours of initiation of restraints or seclusion and during every following shift that the patient remains in restraints.)

One-to-One Observation

☐	☐	☐	☐	37. Staff members have received appropriate training before being assigned one-to-one observation duties.
☐	☐	☐	☐	38. Appropriate caregivers are selected to provide one-to-one observation based on the patient's condition and history (e.g., sexual assault, abuse).
☐	☐	☐	☐	39. Documentation is entered every 15 minutes during periods of one-to-one observation.
☐	☐	☐	☐	40. Staff members never leave a patient on one-to-one observation unattended for any reason.
☐	☐	☐	☐	41. Staff members providing one-to-one observation have the ability to summon immediate assistance if necessary.

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Always/ Yes	Sometimes	Never/ No	N/A	
				### Detoxification/Addiction Services
				42. If detoxification services are provided, please specify the American Society of Addiction Medicine (ASAM) level of care:
☐	☐	☐	☐	a. Level I-D: Ambulatory Detoxification without Extended Onsite Monitoring
☐	☐	☐	☐	b. Level II-D: Ambulatory Detoxification with Extended Onsite Monitoring
☐	☐	☐	☐	c. Level III.2-D: Clinically Managed Residential Detoxification
☐	☐	☐	☐	d. Level III.7-D: Medically Monitored Inpatient Detoxification
☐	☐	☐	☐	e. Level IV-D: Medically Managed Intensive Inpatient Detoxification
☐	☐	☐	☐	(See http://www.ncbi.nlm.nih.gov/books/NBK64109/)
☐	☐	☐	☐	43. ASAM Patient Placement Criteria guidelines are followed for patient placement, continued stay, and discharge of patients with addictive disorders.
				(See http://asam.org/publications/patient-placement-criteria)
				### Service-Specific Policies and Procedures
☐	☐	☐	☐	44. If drug/alcohol testing is performed, the policy and procedure includes:
☐	☐	☐	☐	a. a signed consent, and
☐	☐	☐	☐	b. guidance for staff on releasing results.
				45. If electroconvulsive therapy (ECT) is performed, the policy and procedure includes the following:
☐	☐	☐	☐	a. There is an independent evaluation by another psychiatrist, if required by statutory law.
☐	☐	☐	☐	b. There is a signed consent for ECT that includes:
☐	☐	☐	☐	i. the maximum number of treatments per series;
☐	☐	☐	☐	ii. documentation of the informed consent conversation between the physician and patient indicating that the patient clearly understands the risks, benefits, complications, and alternatives; and
☐	☐	☐	☐	iii. documentation that all patient questions have been answered.

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Always/Yes	Sometimes	Never/No	N/A	
☐	☐	☐	☐	c. An anesthesiologist or CRNA is present during ECT.
☐	☐	☐	☐	d. Anesthesia personnel perform a pre- and postprocedure evaluation on the patient.
☐	☐	☐	☐	e. The procedure room has emergency equipment available (e.g., crash cart, emergency medications, airway, suction, oxygen).
☐	☐	☐	☐	f. Staff members who assist in the treatment are trained in the management of medical emergencies that could arise.
☐	☐	☐	☐	g. A pre-ECT checklist is used.
☐	☐	☐	☐	h. There is a quality review of 100 percent of ECT records.
☐	☐	☐	☐	46. There is a policy on handling medically unstable patients.
☐	☐	☐	☐	a. There is documented training for behavioral health nurses on how to handle medical emergencies.
☐	☐	☐	☐	47. Annual competency reviews of staff members are conducted.
☐	☐	☐	☐	48. There is a documented patient assessment before and after any privilege-level change.
☐	☐	☐	☐	49. If the hospital allows recreational activities, there is a physician's order on the patient's level of fitness and ability to participate.
☐	☐	☐	☐	50. There is a policy addressing staff-patient relationships, including boundary issues.
☐	☐	☐	☐	a. This policy includes the process for filing a grievance by the patient or staff.
☐	☐	☐	☐	51. There is a policy on room assignments, including separation of the following:
☐	☐	☐	☐	a. children/adolescents from adults,
☐	☐	☐	☐	b. males from females, and
☐	☐	☐	☐	c. violent/suicidal patients.
☐	☐	☐	☐	52. The hospital has a policy and procedure for conducting searches of patients, personal belongings, and rooms.
☐	☐	☐	☐	a. The policy specifies that personal searches are done by two staff members of the same gender as the patient.
☐	☐	☐	☐	b. Personal searches take place in a private room.
☐	☐	☐	☐	c. Belongings and room searches are done by two staff members.

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Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	d. The patient is present during a room search or when his/her personal belongings are being searched.
☐	☐	☐	☐	e. Any personal items confiscated are inventoried and stored for the patient.
☐	☐	☐	☐	f. Searches are performed when a patient returns from passes or has been away without permission.
☐	☐	☐	☐	53. There is a policy defining "crisis intervention teams" that respond to patients acting out.
☐	☐	☐	☐	a. The members of the team have had specific training in this area.
☐	☐	☐	☐	54. There is a procedure on responding to an elopement and any AWOL patients (e.g., notifying law enforcement, notifying family, patient evaluation, and determining whether there is a duty-to-warn issue).
☐	☐	☐	☐	55. The unit has a chain-of-command policy to follow when there is a conflict among health care providers.

Smoking

56. If patients are allowed to smoke, the smoking policy provides the following:

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	a. a designated area for smoking that is in view of the nurses' station, and
☐	☐	☐	☐	b. a policy on monitoring patient smoking material.

57. If smoking is prohibited in patient rooms or in the hospital:

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	a. patients are attended outside by nursing staff per physician order; and
☐	☐	☐	☐	b. in extreme situations, when a patient is unable to leave the unit, there is a procedure for supervised smoking.

ENVIRONMENT OF CARE

Seclusion Rooms

58. Safety measures that have been taken in the seclusion rooms include the following:

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	a. Exterior doors to rooms are made of solid metal or wood, with no gaps around the frame.
☐	☐	☐	☐	b. There is an unbreakable glass/acrylic window for observation.
☐	☐	☐	☐	c. There is direct visual/video supervision at all times.

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Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	d. If a bed is used, it is secured to the floor with no sharp edges or parts that can be broken off.
☐	☐	☐	☐	e. The entire seclusion room is visible when the door is shut.
☐	☐	☐	☐	f. There are no sharp objects in the seclusion room.
☐	☐	☐	☐	g. Outlets are covered or removed.
☐	☐	☐	☐	h. The ceiling is made of solid material (i.e., no ceiling tiles).

Nursing Unit

59. Environmental alterations and precautions are taken that include the following:

☐	☐	☐	☐	a. Furniture is secured and cannot be used to barricade a door.
☐	☐	☐	☐	b. Window treatments in all patient access areas are free of cords, hooks, or wands and cannot bear weight of more than 50 pounds in the event of a hanging attempt.
☐	☐	☐	☐	c. All windows are made of unbreakable safety glass or acrylic and are locked or have impenetrable screens.
☐	☐	☐	☐	d. Closets and showers are designed with hardware to minimize risk (e.g., shower curtain tracks, breakaway lightweight rods, doors unable to lock from the inside).
☐	☐	☐	☐	e. Pull handles on drawers and closets are recessed to reduce the potential for self-inflicted injury.
☐	☐	☐	☐	f. Doors to patient rooms and bathrooms can be opened from the outside in the event of a barricade or emergency situation.
☐	☐	☐	☐	i. Staff knows how to open the doors to these rooms.
☐	☐	☐	☐	ii. Door hinges are sloped or flush in all patient access areas.
☐	☐	☐	☐	iii. All door handles are flush with the door.
☐	☐	☐	☐	g. Toilets are constructed so there are no exposed pipes or open hardware that could be used during a hanging attempt.
☐	☐	☐	☐	h. All fixtures are recessed (e.g., sprinklers, smoke detectors, light fixtures).
☐	☐	☐	☐	i. The use of electric beds is restricted unless medically necessary.
☐	☐	☐	☐	j. Any electric cords are shortened to no more than 18 inches in length.
☐	☐	☐	☐	k. Only plastic clothes hangers are allowed.

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Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	l. All unoccupied rooms are kept locked, including patient rooms, offices, community showers and baths, and linen and utility rooms.
☐	☐	☐	☐	m. The ceilings in patient rooms and bathrooms are constructed with drywall or another solid material.
☐	☐	☐	☐	n. If the ceilings are not constructed with a solid material but have ceiling tiles, the staff considers this risk in their safety assessment (e.g., suicide attempts by hanging from pipes, hiding contraband).
☐	☐	☐	☐	o. Documented routine safety rounds are done to assure the continued safety of the environment.
☐	☐	☐	☐	p. Only tape is used to secure documents on bulletin boards (no tacks or push pins).

PROCESS IMPROVEMENT/PATIENT SAFETY

☐	☐	☐	☐	60. Adverse events and near misses are reported according to policy.
☐	☐	☐	☐	a. The department provides constructive and timely feedback on each reported adverse event and near miss.
☐	☐	☐	☐	b. Staff members are able to describe how information on adverse events and near misses is used to improve patient safety.
☐	☐	☐	☐	61. The department has a patient safety plan with specific goals and objectives, including a protocol for handling patient medical emergencies.
☐	☐	☐	☐	62. The department collects data needed to track progress toward the department patient safety goals.
☐	☐	☐	☐	a. Staff members are able to describe how they use data to determine which safety projects to adopt.
☐	☐	☐	☐	b. Staff members are able to describe how they use data to improve patient care.