

CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL

SECTION I:	PATIENT FOCUSED FUNCTIONS
CHAPTER 2:	Provision of Care, Treatment and Services
PROCEDURE 2.24	Clinical Emergency All Available Code for Psychiatric Emergencies
Revised:	11/23/03; 01/23/07; 04/26/10; 6/7/16; 02/18
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If the alarm is activated by a “Panic Button” activation it will announce Clinical Emergency All Available Staff + the incident location.

PURPOSE: The purpose for calling a Clinical Emergency code is to notify staff of a psychiatric emergency in progress in order that all available clinical staff will respond. A code is called when in the assessment of staff, the scope of the emergency is beyond the ability of the unit staff to handle without assistance. When the Clinical Emergency is announced over the intercom, all available staff will respond in order to assist the patient in regaining control and ensure the safety of the patient and staff.

SCOPE: All Clinical Staff

POLICY:

In order to ensure the safety of patients and staff during a psychiatric emergency, Connecticut Valley Hospital (CVH) has established procedures in which additional staff are summoned to respond to a call for assistance. The call for assistance shall be made over the Hospital intercom in situations in which the patient is in imminent danger of losing behavioral control, becoming violent, destroying property, and/or seriously hurting self or others and the existing unit staff are unable to handle the situation without assistance from additional staff. It is the policy of CVH, that staff shall page a “Clinical Emergency All Available Staff” if, in their opinion, the above situation exists and assistance from additional staff are required to ensure patient and staff safety.

Agency Police shall not automatically respond to a code with the exception of codes which take place in Page Hall and the Cottage Program. The role of the Agency Police in a psychiatric emergency shall be to take direction from the Registered Nurse or the Physician when present. The Registered Nurse or Physician when present may direct the police to take control of the situation based on his/her assessment considering the recommendation of the police, that such action is necessary to ensure the safety of the patient and staff.

Definitions:

Psychiatric Emergency – a situation in which a patient is in imminent danger of losing behavioral control, becoming violent, destroying property, and/or seriously hurting self or others and requires the assistance of staff in order to regain control. A psychiatric emergency is called when in the opinion of unit staff, the situation is beyond the ability of the unit staff to handle without assistance from additional staff outside of the unit.

PROCEDURE:

I. Division/Unit Response Plan

- A. Staff member determines that a psychiatric emergency is occurring which is beyond the scope of unit staff to handle without additional assistance.
- B. Staff member initiates “Clinical Emergency All Available Staff Code” in one of three ways, *Option A* being the preferred and most expedient method:

Option A: press a hard wired or wireless panic/code button:

- 1. Hardwired buttons are located in rooms throughout the building;
- 2. Wireless devices (a minimum of 3 body alarms) are located on each unit in General Psychiatric Division (GPD) (with the exception of the Cottage Program) and throughout Page Hall treatment areas;
- 3. Once the button is pressed, an alarm signal is simultaneously sent to the Telecommunications Center and/or to the alarm panel in the building.
 - a. In the Merritt ASD, GPD (with the exception of the Cottage Program), the alarm panel will activate a pre-recorded announcement through the public address system.
 - b. Neither the button nor body alarms are used in Blue Hills Addiction Services.
 - c. In Page Hall the buttons will trigger an alarm resulting in an overhead page. A secondary announcement will then be sent through the building phones.

Option B: Staff in all three divisions may dial 999 on any house telephone and request the Telecommunication Operator (TCO) to page an all available staff for a particular building and unit. The TCO will access the building’s public address system to make the announcement.

Option C: Staff in all two divisions ~~can~~ voice page their own “Clinical Emergency All Available Staff-Location (give building and unit)” by dialing into their building’s public address system directly from their unit. This is the only method of choice at the Blue Hills Addiction Services Program.

- 4. The Registered Nurse responding to the code assesses the physical and mental status of the patient throughout the emergency.
- 5. All clinical units send available staff or assigned staff to the site of the emergency.
- 6. Staff who respond to the code ensure that their immediate supervisor is informed of their whereabouts.
- 7. Staff who respond to the code exercise care and good judgement in responding to the code in order to arrive safely at the site.
- 8. The Nurse Supervisor and the Attending Physician/designee immediately respond to the site of the emergency and complete the Psychiatric Emergency Monitoring Form.
- 9. The Registered Nurse/designee assumes and retains the role of team leader and identifies him/herself as the leader to those staff who respond.
- 10. The team leader
 - a. clearly identifies specific roles and assignments to staff;

- b. continually assesses the patient and communicates the plan;
 - c. talks with the patient;
 - d. provides clear and specific direction to staff throughout the intervention; and
 - e. redirects staff as needed based on his/her ongoing assessment.
11. The Registered Nurse may assume charge or transfer the team leadership role to another person. When this occurs, s/he must be present to continually assess the psychiatric emergency. When this happens, the change must be communicated verbally in order to ensure all team members are informed.
 12. All staff who respond to the code takes direction from the team leader and use approved physical/behavioral management techniques during physical intervention.
 13. Staff responding to the code, may be assigned by the team leader to remove other patients from the location of the code and remain with them for supervision and reassurance.
 14. When a situation exists which is beyond the control of staff to handle safely, DMHAS Agency Police will be contacted for assistance.
 15. The DMHAS Agency Police take direction from the team leader in the same manner as other staff members responding to the code, including the use of approved physical/behavioral management techniques, unless the emergency is beyond the scope of responding staff and/or a serious crime has been committed.
 16. The Registered Nurse or Physician may call DMHAS Agency Police as an additional deterrent or resource to de-escalate a potentially dangerous situation.
 17. The RN or Physician when present may direct the police to take control of the situation based on his/her assessment, considering the recommendation of the police, that such action is necessary to ensure patient and staff safety.
 18. When Agency Police assume direction of a Clinical Emergency All Available Staff, they retain control until the patient is safely restrained and the emergency is under control. Immediately following the psychiatric emergency, the physician **or** registered nurse will assess for injuries to patients and staff and conduct a debriefing session:
 - a. Critique the process of crisis management;
 - b. Review the planning and implementation of the Clinical Emergency; and,
 - c. Recommend changes if indicated.
 19. The use of DMHAS Agency Police restraining devices such as handcuffs and leg irons will only be utilized if DMHAS Agency Police cannot gain control of a violent patient in any other way. The use of these devices occur only in extremely rare situations and are clearly documented by the DMHAS Agency Police on the Use of Force form and by the Registered Nurse and the Physician in the patient's progress notes.
 20. When the patient is safely under control following Police intervention, the designated team leader resumes leadership and directs further clinical management of the patient.
 21. When the emergency is resolved, the team leader authorizes the page over the intercom indicating an "all clear."
 22. Immediately following the emergency, a Registered Nurse checks patients and/or staff for injuries, seeks treatment for injuries if any, and documents on the appropriate forms and informs the Nursing Supervisor and appropriate leadership.

22. Unit staff conduct the patient community debriefing as needed in order to re-establish the therapeutic milieu.

II. Page Hall Response Plan

- A. When an emergency occurs in Page Hall, staff activate the emergency button. The announcement will advise on the general location of the activated emergency button, including the floor. The 999 call to the Telecommunications Operator may also be used to call a Clinical Emergency All Available Staff code. If this method is used staff need to indicate the location of the emergency to the Telecommunications Operator. The building is divided into several zones.

On the first floor, there are five corridors that run east and west. These corridors are labeled A through E. Corridor designations are posted on both ends of each corridor. The A corridor is located adjacent to the Beauty Parlor/Barber Shop; the E corridor runs from the Physical Therapy waiting area. Emergencies occurring in areas where an emergency button is not available such as the lobby or mall storefronts will be paged overhead by the Telecommunications Operators, call 999 and report the location.

The second floor is not currently utilized by patients.

On the third floor, the alarms are designated by zones and include the Solarium, the Library, the South West group rooms and the North group rooms.

- B. The DMHAS Agency Police respond to all Clinical Emergencies in Page Hall. Their role is similar to that described above.
- C. Staff responding to the code begin de-escalation procedures while taking direction from the team leader.
- D. The doctor and/or nurse responding to the clinical emergency determines the interventions necessary which may include:
1. evaluation for and administration of STAT medications; or
 2. the need to transport the patient back to his unit with or without police assistance.
- E. If the patient is transported back to the unit, the unit staff accompanies him/her in the police cruiser, if necessary.
- F. If the patient has sufficiently regained self-control, staff may transport the patient back to the unit with other patients in the usual manner.
- G. The designated leader of the clinical emergency conducts a staff debriefing with the staff responding, including the mall administrator.

III. The Cottage Response Plan

- A. When an emergency occurs in the Cottage, staff shall dial 999 on any house telephone to request the Telecommunication Operator (TCO) to page the Agency Police, GPD Nursing Supervisor, On-Call Physician, and GPD Administrator(s). Every effort should be made to utilize clinical and administrative resources prior to the occurrence of a true behavioral emergency.
- B. Should additional assistance be required, DMHAS Agency Police will call for back-up. Telecommunications may overhead page other buildings to the "Clinical Emergency All Available Staff" as necessary.

- C. Staff responding to the Clinical Emergency begin de-escalation procedures while taking direction from the team leader.
- D. The physician and/or nurse responding to the clinical emergency determines the interventions necessary which may include:
 - 1. evaluation for and administration of STAT medications; (if ordered medications are not available in the Cottage, medication will be obtained from a PYXIS medication station in Battell/Woodward Halls)
 - 2. the need to transport the patient back to GPD for admission, Cottage Program staff will accompany the patient in the police cruiser to the designated GPD unit.
- E. If the patient sufficiently regains self-control, staff will debrief the patient and provide comfort measures based on the individual's preferences.
- F. The designated leader of the Clinical Emergency conducts a staff debriefing with the staff responding, including the Cottage Administrator. The Clinical Emergency Monitor is completed.