

CONNECTICUT VALLEY HOSPITAL OPERATIONAL POLICY AND PROCEDURE MANUAL

SECTION I - PATIENT FOCUSED FUNCTIONS

POLICY 2 - PROVISION OF CARE, TREATMENT, AND SERVICES

VALUE - In accordance with the Mission and Vision Statements of the Department of Mental Health and Addiction Services (DMHAS), Connecticut Valley Hospital (CVH) provides the highest quality patient care based on accurate, comprehensive, and timely assessments; individualized, therapeutic, patient-centered services; collaborative, interdisciplinary patient and family education within a seamless system of care.

GOAL - To improve the lives of persons with psychiatric and/or addiction issues by appropriately providing services to meet their identified biological, psychological, social and spiritual needs for as long as the individual is within our care.

POLICY -

I. Assessment of Patients

A. Prior to Admission

1. All patients are screened to determine appropriateness for hospitalization at CVH. This screening service may be performed by designated CVH staff or by other agencies with whom the hospital has letters of agreement.

B. Admission

1. All patients who are admitted to CVH are assessed from a multi-dimensional standpoint using assessment tools that have been developed and approved by each discipline and by the Medical Staff.
2. Specifically, each patient is evaluated on admission using the following tools:
 - a. Evaluation by a psychiatrist/physician begins at admission and is completed within 24 hours;
 - b. Admission Nursing Assessment by a Registered Nurse begins at admission and is completed within 24 hours;
 - c. Admission History and Physical by a Psychiatrist, Physician, APRN, or Physician Assistant at admission or within 24 hours;
 - d. Admission Psychosocial History and Assessment by a Social Worker within 10 days of admission, except on the Detoxification Unit where it must be done within 3 days;
 - e. Admission Rehabilitation Services Assessment is a functional assessment performed by a Rehabilitation Therapist within 10 days of admission, except on the Detoxification Unit where it must be completed within 3 days of admission;

- f. Admission Nutrition Screening by a nurse during the Admission Nursing Assessment within 24 hours. Any patient with a positive nutrition screening is referred to a Dietician for Nutrition Risk Assignment or Nutrition Assessment. (*Refer to Nutrition Assessment Policy in the Clinical Dietary Manual Pages 12 and 13*);
 - g. Abnormal Involuntary Movement Scale (AIMS) by a psychiatrist/physician upon admission; and
 - h. Discharge planning assessment is begun upon admission within 72 hours on every admitted patient.
3. As part of the initial assessment, CVH physicians order diagnostic procedures to clarify the patient's physical/functional treatment needs. The ordering physician provides additional information as necessary to conduct and clinically interpret the test results.
 4. As part of the initial assessment, an evaluation of all patients as potential victims of abuse and/or neglect is conducted using observable evidence in addition to the patient's self-report (*Refer to the Nursing Policy and Procedure Manual Procedure 6.2 and OP&P Procedures 2.2 and 2.3*).
 5. Additional assessments will be performed as needed based on findings of the Assessments listed above, as well as on the patient's wishes, diagnosis, response to prior interventions, established program goals, and projected length of stay.
 6. Additional assessments may involve but are not limited to: *dental, ocular, auditory, speech and language, dietary, and psychological services*. A physician initiates the process by ordering a consultation from the specified service (*refer to the Medical Staff Rules and Regulations*).
 7. Pain is assessed in all patients upon admission throughout the course of hospitalization. (*See Operational Procedure 2.5, Assessment and Management of Pain*)
 8. All assessments form the basis for the development of the patient's individualized comprehensive treatment plan which is due no later than 10 days following admission.
 9. The patient is expected/encouraged to participate in the development of his/her treatment plan.

C. Re-assessments

1. The CVH patient is re-assessed when there is a significant change in the patient's status as determined by an interdisciplinary team member. These changes would include:
 - a. when there is a significant change in the patient's diagnosis as determined by the physician or psychiatrist; and
 - b. following reports of abuse and/or neglect of the patient and/or evidence suggesting abuse/neglect observed by any staff member.

2. The patient is reassessed by an interdisciplinary team 30 days from the date of completion of the Master Treatment Plan in the case of General Psychiatry or Forensic patients, and within 21 days in the case of Addiction Services patients and regularly thereafter until he/she is discharged.
3. Annually by the Psychiatrist/Physician, Registered Nurse, and Social Worker, and Rehabilitation Therapist.
4. In an ongoing basis via progress notes in the medical record entered by the Psychiatrist/Physician, Registered Nurse, Social Worker, and Rehabilitation Therapist and other clinicians as appropriate.

Laboratory Services

1. Laboratory services are utilized as needed to meet the needs of the patients in a prompt manner.
2. With the exception of waived tests, laboratory testing for CVH is performed by Hartford Medical Lab, an approved contract laboratory meeting all applicable standards for clinical laboratories.

All laboratory tests conducted by Hartford Medical Lab are performed or supervised 24 hours a day, 7 days a week by staff who have been sufficiently oriented and trained and who demonstrate current competence.

Waived Tests

1. The Pharmacy, Nutrition, and Therapeutics Committee, as a sub-committee of the Medical Staff, have approved the following procedures as waived tests to be performed at CVH:
 - a. The Accucheck procedure, which provides a quick approximation of blood glucose level, is performed or supervised by a licensed member of the Nursing staff who has been sufficiently oriented and trained and who demonstrates current competence; and
 - b. The Hemocult procedure, which screens for the presence of blood in stool, is performed by a licensed member of the Medical Staff who has been sufficiently oriented and trained and who demonstrates current competence.

Policies and procedures governing waived testing processes are readily available and address the following:

1. specimen collection and preservation;
2. instrument calibration;
3. quality control, remedial action and documentation of quality control checks;
4. equipment performance evaluation; and
5. instructions for performing tests. (Refer to *Chapter 10, Nursing Policy & Procedures Manual*)

II. Provision of Care

A. Planning and Providing Care

1. Settings and services are designed to meet patient needs and care goals.
2. CVH provides care, treatment, and rehabilitation to address the individual patient's impairment, condition, or disability. Patient needs are identified through the assessment/reassessment process.
3. Patient assessment/reassessment occurs during the screening process, at admission and throughout their hospitalization, according to standards outlined in the Health Information Management (HIM) Manual.
4. CVH is comprised of three divisions:
 - a. Addiction Services Division;
 - b. General Psychiatry Division; and
 - c. Whiting Forensic Division.
5. Written policies and procedures define the care, treatment, and rehabilitation provided by each of the three divisions.
6. The Governing Body provides the Medical Staff with written policies and procedures regarding the assessment, initial treatment, and referral process for emergency care. Emergency medical/surgical services are provided by area care centers, through agreements with CVH.
7. All identified treatment needs are prioritized. The rationale for deferring identified needs is documented in the medical record.
8. Interdisciplinary treatment plans are developed collaboratively in treatment team meetings by qualified individuals from the various disciplines, the patient, the family and community providers, as appropriate to the care needs of each patient. The assessment, treatment, and discharge planning process is articulated in the HIM Manual.
9. Interdisciplinary team members are qualified to participate in the planning and care of patients by virtue of the following:
 - a. education;
 - b. training;
 - c. experience;
 - d. competence;
 - e. applicable licensure;
 - f. law or regulation; and/or
 - g. registration or certification.
10. The hospital performs all patient care procedures in a manner that respects the patient as a person, ensuring dignity and the utmost privacy.
11. The Master Treatment Plan is evaluated and revised periodically, as articulated in the HIM Manual, based on the patient's response to care.

B. Anesthesia Care

CVH does not perform anesthesia care.

C. Medication Use Processes

1. CVH formulary and medication selection are guided by patient needs, safety, pharmaceutical and therapeutic equivalence, bio-equivalence, cost and pharmacokinetic properties.
2. CVH has a procedure for obtaining medications not in the formulary. (See Pharmacy Policy and Procedure Manual).
3. To achieve safe medication prescription ordering, CVH has procedures for the following (refer to the Pharmacy Policy and Procedure Manual for details):
 - a. the distribution and administration of controlled medications;
 - b. the storage, distribution and control of investigational medications;
 - c. permanently discontinuing or temporarily holding a patient's medication;
 - d. PRN medications;
 - e. the control of sample drugs;
 - f. distribution of medications to patients at discharge or on leave from the Hospital; and
 - g. procurement, storage, control and distribution of pre-packaged medications.
4. Procedures for preparing and dispensing medications adhere to law, regulation, licensure and professional standards of practice. (Refer to Pharmacy Policy and Procedure Manual).
5. Preparation and dispensing of medication is controlled to ensure safe and accurate pharmacological management.
6. CVH has a procedure for drug preparation and dispensing, wherein important patient medication information is considered. (Refer to Pharmacy Policy and Procedure Manual.)
7. Pharmacy services are available when the pharmacy is closed.
8. Emergency medications, selected by the Pharmacy, Nutrition, and Therapeutics Committee, are located in standard, locked, emergency carts in designated areas.
9. A Medication Recall Procedure is in place at CVH and is activated when notification of a discontinuation or a recall is received from the manufacturer or the FDA. (Refer to Pharmacy Policy and Procedures Manual.)
10. CVH has a procedure which addresses verification of prescriptions or orders and identification of patients before medication is administered. (Refer to *Pharmacy Policy and Procedure Manual* and *Nursing Policy and Procedure Manual*.)
11. CVH has a procedure for administration of medications brought in by patients. (Refer to Pharmacy Policy and Procedure Manual.)

12. Medication effects on patients are continually monitored. Monitoring medication effects is a collaborative process with medical staff, nursing, and pharmacy. (Refer to Pharmacy Policy and Procedure Manual, Nursing Policy and Procedure Manual, Drug Usage Evaluation Studies, and Minutes of the Pharmacy, Nutrition, and Therapeutics Committee.)

D. Nutrition Care

1. Nutrition care addresses all medical nutrition therapy needs, with consideration for the patient's cultural/ethnic and religious background.
2. Nutrition care processes are collaboratively integrated with other aspects of care.

These processes consist of:

- a. screening, assessing and reassessing nutrition needs;
 - b. developing the plan for nutrition therapy;
 - c. providing appropriate nutrition education to patients and/or families;
 - d. prescribing or ordering food and other nutrients;
 - e. preparing and distributing or administering food and other nutrients; and
 - f. monitoring patient response to nutrition care.
3. All Clinical Nutrition Policies and Procedures can be found in the Dietary Services Clinical Policy and Procedure Manual. This manual is available on the CVH Network T-drive.
 4. All Food Services Policies and Procedures can be found in the CVH, Dietary Services, Administrative Manual. This manual is available on the CVH network T drive.
 5. Nutrition Care practices are standardized throughout the hospital. The CVH Nutrition Care Manual is an adaptation of the Manual of Clinical Dietetics of the American Dietetic Association. The manual is reviewed and revised as needed to reflect advances in nutrition knowledge. The manual serves as the basis for all diet prescriptions and nutrition products. A copy of the Nutrition Care Manual can be found on each patient unit.
 7. When indicated, a nutrition care plan is integrated into the Master Treatment Plan. Follow up care is provided and documented in accordance with policies and procedures as described in the Dietary Services Clinical Policy and Procedure Manual.
 8. Patients are screened for nutritional issues within 8 hours of admission during the Initial Nursing Assessment and annually during the Annual Nursing Reassessment. Any patient with a positive Nutrition Screen is referred to a Registered Dietitian for Nutritional Risk Assignment. Individuals determined to be at High or Moderate Nutritional Risk receive a Nutritional Assessment. Nutritional Assessment can also be requested at any time that a change in nutrition status occurs. For the complete Nutritional Assessment/Reassessment Policy, refer to the Clinical Nutrition Policy and Procedure Manual.

E. Operative and Other Procedures (with the exception of Dental)

CVH does not perform surgery or other operative procedures. Patients requiring surgery and other operative procedures are referred to area care centers.

F. Rehabilitation Care and Services

1. The Discipline of Rehabilitation Therapy Services is an integrated system of patient-centered services provided by the following specializations:
 - a. Occupational Therapy;
 - b. Physical Therapy;
 - c. Vocational Rehabilitation;
 - d. Academic Education;
 - e. Speech-Language Pathology and Audiology;
 - f. Patient Library;
 - g. Chaplaincy/Spiritual Services;
 - h. Music Therapy;
 - i. Dance Therapy;
 - j. Therapeutic Recreation;
 - k. Art Therapy; and
 - l. Barber/Hairdresser.
2. Qualified professional rehabilitation staff are responsible for:
 - a. assessing the rehabilitation needs of each patient admitted to the Hospital and reassessing each patient at least annually;
 - b. formulating a plan of services based on identified patient's needs which are integrated in the patient's Master Treatment Plan (MTP);
 - c. providing skill development and practice in functional life activities for optimal hospital and community adjustment thus fostering self-sufficiency, dignity, respect and quality of life; and
 - d. implementing treatment and documentation processes are outlined in the Rehabilitation Services Manual, the Learning Center Manual and Rehabilitation Discipline Manuals.
3. Qualified, competent professionals with a gradation of expertise, academic training and work experience provide rehabilitation services consistent with their specified clinical credentials.
4. The Rehabilitation Services credentialing process ensures the quality of its staff through the implementation of an initial and biennial review of staff credentials in addition to annual performance appraisals.
5. Rehabilitation outcomes are defined in terms of restoration, improvement, or maintenance of the patient's optimal level of functioning, self care, self responsibility, independence, and quality of life. Based on an assessment/reassessment of the patient's needs, a plan to provide Rehabilitation Therapy Services is formulated to achieve positive outcomes.

6. The Rehabilitation Therapist encourages patients to become actively involved in:
 - a. setting their own treatment goals;
 - b. planning realistically for their future based on their strengths, weaknesses, and capability to adapt to their chosen environment; and
 - c. gaining a sense of personal achievement and mastery over their lives and environments through treatment, education, experience, and support.
7. The rehabilitation portion of the MTP is developed and implemented by qualified professionals in collaboration with the patient, the family (if applicable), other treatment disciplines and community support groups. Patient treatment modalities and progress towards goals and objectives are documented in the patient's medical record.
8. Patients are provided opportunities to explore, enhance, or develop optimal daily living skills, leisure, vocational, and educational capabilities in order to successfully adapt to their living situation.
9. A patient is discontinued from a particular Rehabilitation Therapy Service or discharged from the Hospital based on continuing reassessment and progress made toward achieving the goals and objectives as outlined on the patient's Master Treatment Plan.

Documentation of the patient's level of functioning at the time of discontinuation or discharge may include recommendations for rehabilitation services after discharge or transfer.

G. Special Treatment Procedures (Medical, Nursing)

1. CVH has clear policies and procedures governing the safe and appropriate use of special treatment procedures.
2. Restraint and seclusion policies and procedures are in compliance with all standards of care and practice, the policies of the Department of Mental Health and Addiction Services, and the provisions of the Connecticut General Statutes. These policies are located in the Operational Procedure Manual and in the Nursing Policy and Procedure Manual.
 - a. These policies and procedures address:
 1. the roles of the M.D., R.N. and other disciplines;
 2. requirements for documenting the justification of these procedures;
 3. documenting their use, including the use of less restrictive measures, time limits, care of patient when in restraints or seclusion, special considerations; and
 4. the need to inform the patient of the reasons for use and conditions for release.

- b. Ongoing Performance Improvement and staff education activities explore ways to reduce the use of restraint and seclusion and promote preventive or alternative strategies.
- c. Restraint and seclusion use at CVH is clinically justified based on the following:
 - 1. a clear plan of treatment;
 - 2. well-trained staff;
 - 3. support of the Hospital's leaders and cultures;
 - 4. Rules and Regulations of the Medical Staff and Nursing Policy and Procedure Manual;
 - 5. staff understanding of the human resource implications for limited or reduced use;
 - 6. staff orientation and education emphasizing prevention, appropriate use, and less restrictive alternatives;
 - 7. assessment processes that identify and prevent potential behavioral risk factors; and
 - 8. review and redesign of restraint and seclusion patient care processes.
- 3. CVH's plan for improving organizational performance includes a review and assessment of all relevant hospital-wide restraint and seclusion data, at least quarterly.
 - a. All divisions and units/programs review the aggregated restraint and seclusion hours and episodes for all shifts and purposes ordered.
 - b. Trends and patterns are identified around multiple episodes and hours by individual patients and frequency of restraint use by type(s) of staff.
 - c. The interdisciplinary team at the unit/program level reviews hospital-wide and unit specific data and collaborates on the prevention or reduction of restraint and seclusion use.
- 4. The Hospital's policy and procedures guide the appropriate and safe use of restraint and seclusion.
 - a. The Hospital protects and preserves the patients' rights, dignity and safety during a restraint or seclusion episode.
 - b. Individual orders for restraint or seclusion are consistent with Hospital policy and must be ordered by an M.D.
 - c. In emergency situations, the R.N. may authorize use, but must obtain an M.D. order immediately following the institution of the procedure.
 - d. Restraint or seclusion use is based on assessment of emergency risk of injury to self or others and employs the safest, most effective, and least restrictive method.
 - e. The Hospital has trained competent staff to implement restraint or seclusion. These staff monitor and reassess patients during the procedure.

- f. Every episode of restraint or seclusion is reviewed by the Nurse Supervisor to ensure that use was justified, less restrictive interventions were tried, a physician's order is present, that all patient care needs were attended to while the patient was restrained, and plans for alternative intervention upon release from restraint were formulated and initiated as needed.
 - g. All patients requiring restraints or seclusion are reviewed at interdisciplinary team meetings by at least the next business day.
 - h. The use of restraint or seclusion is documented in the patient's medical record consistent with Hospital policy.
5. CVH does not perform Electroconvulsive Therapy (ECT) but provides for this treatment through contracted agreement with the Institute of Living Medical Group, P.C. (Refer to Medical Staff Rules and Regulations.) Clinical indication and justification for ECT are documented in the patient's records on a case-by-case basis. (See *OP&P Procedure 2.19, Electroconvulsive Therapy*)
 6. CVH does not perform psychosurgery or other surgical treatments. In the event that psychosurgery were to be considered as a therapeutic option in a specific case (See *OP&P Procedure 2.20, Psychosurgery* for details).
 7. The use of behavior-management procedures conforms to the patient's treatment plan, and Hospital policy. (See *OP&P Procedure 2.21, Behavior Modification Procedures/Behavior Management Strategies*)
 8. CVH provides for resuscitative services throughout the Hospital. Direct care staff are trained in CPR and respond to all medical emergencies.

Multicultural Needs

The multicultural needs of the patients of CVH are acknowledged through the efforts to provide ongoing education and training to all CVH staff on cultural awareness sensitivity issues in the assessment, treatment and care of patients.

III. Education

1. CVH provides patient and family education services as an integral component of the patient's treatment.
2. At CVH, patient education is based on assessments of learning needs, abilities, preferences, readiness and barriers. The assessment process also considers psychosocial, cultural and religious values, beliefs and practices which affect responses to care, education and treatment.
3. Patient and family education is performed by staff who are competent to provide these activities within their scope of practice. These activities are a partnership between the health care team and the patient and family, and are an interactive and collaborative process.

4. All patients are expected, and families as appropriate are encouraged, to participate in the following educational activities as appropriate:
 - a. diagnosis and symptom management;
 - b. treatment planning;
 - c. safe and effective use of medications;
 - d. nutrition/diet counseling;
 - e. potential food/drug interactions;
 - f. acquisition and maintenance of ADL skills, (i.e., personal hygiene, grooming, including bathing, tooth brushing, care of hair and nails, using toilet);
 - g. safe and effective use of medical equipment;
 - h. pain management as part of the treatment plan;
 - i. special education/adult education programs as mandated by state/federal law;
 - j. rehabilitation techniques which help the patient adapt or function more independently in their environment; and
 - k. Patient and family education as it relates to discharge and aftercare.
 1. Information regarding access to community services (e.g., when and how to obtain further treatment) is provided to the patient and family by appropriate members of the treatment team.
 2. Discharge instructions relating to education are given to the patient, and family, as appropriate.
 3. Instructions are also forwarded to the agency/programs responsible for the continuing care of the patient upon discharge from CVH.
5. The roles of patients, families, staff and the Patient and Family Education Committee are interactive in the provision of Patient and Family Education. Roles include:
 - a. The role of the patient and family includes the following:
 1. being an active partner in the treatment planning process by providing information and asking questions as needed;
 2. participating with the clinical staff in the assessment of health educational needs and development of educational interventions which meet identified treatment goals;
 3. participating in relevant self-selected educational activities;
 4. following instructions and accepting anticipated benefits and at times related risks;
 5. being cognizant of how to obtain ongoing services to meet their health care needs; and
 6. evaluating the relevance, clarity and quality of the educational activity.

- b. The role of the Medical Staff in patient and family education includes the following:
 - 1. ensuring that the patient's readiness for education is assessed;
 - 2. ensuring that assessments completed by team members address the patients/families educational needs;
 - 3. ensuring that educational needs of patients are prioritized and addressed in the interventions section of Master Treatment Plan and Treatment Plan updates;
 - 4. taking the lead in providing specific education to patients and families regarding their diagnosis and treatment including medications; and
 - 5. documenting in progress notes the response of patients and their families to the educational interventions and activities provided.
- c. The role of the clinicians/staff includes the following:
 - 1. orienting the patient and family to their roles and responsibilities with regard to patient and family education;
 - 2. assessing the patient's readiness and ability to participate in educational programs and sharing assessment results with the interdisciplinary team;
 - 3. recommending specific educational experiences for the patient to the treatment team;
 - 4. collaborating with the treatment team in reviewing information and integrating the information into the treatment plan;
 - 5. implementing the educational portion of the treatment plan and evaluating the patient's and family's response;
 - 6. referring family to support services within the hospital or the community as appropriate; and
 - 7. documenting in progress notes the response of patients and their families to the educational interventions and activities provided.
- d. The role of the Unit/Program Director includes the following:
 - 1. assisting the clinician directly or as a resource person in locating and evaluating appropriate educational programs or materials to meet the patient's needs;
 - 2. ensuring that all patient education activities are documented on the treatment plan and that staff responsible for documenting interventions and responses in the medical record/progress notes are identified;

3. monitoring the integration of patient and family education in the treatment planning and documentation processes for aggregate review;
 4. discussing relevant patient and family education issues in the program planning component of the interdisciplinary team, and at the division level Performance Improvement Committee; and
 5. ensuring that monitoring activities relative to patient and family education are taking place on each unit.
- e. The role of Division Directors includes the following:
1. designating space, materials and staff resources to plan support, provide and coordinate patient education programs and activities in the treatment division. These activities include establishment of a Patient and Family Education Resource Room in the Division;
 2. identifying common patient and family education needs and problems in meeting those needs within the divisional Performance Improvement structure;
 3. appointing one or more representatives to participate on the Hospital Patient and Family Education Committee;
 4. communicating common educational needs and problems in meeting those needs to the Hospital Patient and Family Education Committee through designated representatives;
 5. researching, previewing and recommending new educational programs, materials relevant to the needs of patients and families as needed; and
 6. submitting reports to the Patient and Family Education Committee on a quarterly basis.
 7. CVH maintains an interdisciplinary Patient and Family Education Committee. Membership includes representatives from each division, department, clinical discipline, a patient rights officer, and a librarian.
- f. The role of the Patient and Family Education Committee includes the following activities:
1. establishing standards/criteria for the development and format of patient and family education activities and programs;
 2. reviewing and recommending educational programs with regard to meeting those criteria;
 3. developing and reviewing hospital policies and procedures related to patient and family education;

4. establishing an index containing all patient and family education activities presently available and revising it as new programs/ initiatives are added, replaced or deleted;
5. distributing the index to each treatment unit i.e., via the Shared Drive on the Local Area Network (LAN);
6. distributing educational materials and handouts to each Division's resource room as appropriate;
7. promoting and providing opportunities for increasing staff competency related to specific educational content areas and effective teaching methodologies;
8. monitoring patient and family education activities by reviewing data from the treatment divisions on patient and family education activities; and
9. making recommendations to hospital leadership regarding the quality of patient and family educational activities and required resources to achieve these educational.

IV. Continuum of Care

Local Mental Health Authorities (LMHA) are responsible for coordinating the care of psychiatric and forensic services for patients in a given geographic area regardless of where the care is provided. The LMHA works with CVH staff to provide patient services in a coordinated and continuous manner working together to match the patients' needs with the appropriate level and type of psychiatric, medical and other specialized services. For forensic patients, the hospital staff also collaborates and coordinates with the Psychiatric Security Review Board (PSRB) and the Judicial Courts. The Addiction Services Division is a part of a Continuum of Care in partnership with the community funded "not for profit" agencies and other agencies operated by the State.

A. Pre Entry/Screening Phase

1. Persons are referred to CVH for admission through a number of sources:
 - a. court system ;
 - b. PSRB;
 - c. Physician's Emergency Certificate (PEC);
 - d. voluntary applications;
 - e. correctional transfer; and/or
 - f. transfer from other hospitals.
2. Patients access appropriate hospital level of care through an assessment of the patient's clinical needs during the pre-screening phase. The pre-entry/screening assessments are completed by designated staff at the LMHA, Court Clinic, or emergency room and designated hospital staff in Addiction Services. Pre-screening

for hospitalization requires an assessment of target symptoms, finances, goals for hospitalization and anticipated discharge plan, including projected length of stay, and aftercare arrangements.

The following is a description of the types of patients screened for admission to CVH:

Forensic Services:

- a. Patients committed by a Superior Court Judge via Statutory Authority (54-56d) who have been screened by the Court Clinics who recommends to the court that the person is not competent to stand trial because of a mental illness. The court then admits directly to the hospital on an order to restore the patient to competency.
- b. People who are found not guilty (NGRI) by reason of mental illness and ordered to a maximum security setting by the court and the oversight of the State of Connecticut PSRB. The PSRB also may admit directly to the hospital for patients whose conditional release has been rescinded.
- c. Inmates who are transferred from State Correctional facilities and who require a level of psychiatric care that exceeds the capability of the Department of Corrections.
- d. High risk civil patients.

General Psychiatry Services:

- a. CVH accepts planned admission via transfers from other DMHAS inpatient facilities or from community hospitals, who require long term treatment or specialized services. Patients may be voluntarily admitted or involuntarily admitted through a Probate Court commitment or via a Superintendents transfer.

Addiction Services:

- a. Admission to Addiction Services is accomplished through court referrals, court commitments, PEC, and voluntary referrals either through self referral or other agencies within the Continuum of Care.
- b. The decision to admit is based on the pre-entry assessments, DMHAS uniform criteria and information documented on the pre-admission screening form. Decision to admit can also be a legal mandate.

Refer to:

- * State Plan Criteria for Admission for DMHAS Facilities, Draft 11/96
- * LMHA Agreement's for General Psychiatric Division and Whiting Forensic Division - currently in review
- * C.C.P.C. for Addiction Services
- * Statutes for Forensic Admission to Whiting,

B. Hospitalization Phase

1. Patients meeting criteria for admission are accepted in a coordinated effort involving the referring agency, the patient, family, and legal designees, and CVH staff. Clarification of the patient's status may include the need for verification of the following (either prior to or at the time of admission) and require releases of information:
 - a. legal status.
 1. ASD clients under the Office of Court Evaluations (OCE) must have a court order.
 2. WFD patients under a Not Guilty by Reason of Insanity (NGRI) must have a court order.
 3. WFD patients under 54-56d for Incompetence to Stand Trial require documentation from the court, including a court order.
 4. GPD patients who are not voluntary admissions must have a Superintendent's Transfer and a Copy of Probate form.
 5. Patients admitted on either a 5 day or 15 day Physician's Emergency Certification (PEC) must have a PEC form.
 6. All other admissions must have signed a voluntary consent to treatment.
 - b. conservatorship status, including a copy of the Probate Court decree.
 - c. medication:
 1. *Methadone* – requiring dosage verification in writing AND nurse to nurse phone contact.
 2. *Clozaril* – requiring dosage verification, most recent laboratory values, and contact with the registry.
 - d. region in catchment area.
 - e. entitlement status.
2. Upon admission, agencies with which the patient was involved should be contacted, such as the LMHA. Releases of Information are required for contact to occur.
3. Assessments completed by multidisciplinary team members and others as indicated are documented and the identified needs incorporated into the Multidisciplinary Treatment/Recovery Plan.

4. Re-assessments of the patient and his/her status and progress inform the content of progress notes and treatment plan reviews.
5. To the extent possible and appropriate, the patient, the patient's family/ significant others, and legal designees participate in the patient's treatment, including assessment, planning, service delivery, education, passes and special events.
6. Services provided to the patient, if not provided directly by CVH staff, are arranged through consultants or contracted providers.
7. Planning for discharge occurs as early as possible in the hospitalization phase and includes coordinating passes and aftercare services with outside agencies and providers.

C. Transfer/Movement of Patients

1. Based on the services available and the patient's needs, patients may be transferred between units within divisions or across divisions.
2. Planning for a transfer involves the staff (from both the sending and the receiving units), the patient, the patient's legal designee, and involved family members significant others as appropriate, and includes discussion of:
 - a. the reason for the transfer; and
 - b. any reasonable alternatives to transfer.
3. The planning of the transfer needs to include consideration for the amount of time the patient may need to prepare for the move.
4. Unplanned transfer due to emergent situations are to be managed with primary consideration for the need to reassure, comfort, orient, and educate the patient to the need for the transfer and to inform family, legal designee, staff involved in the patient's care.
5. Those not immediately involved in the transfer, such as community providers, the LMHA and others, are to be informed of the change in the patient's unit and new contact information.
6. The medical record is transferred with the patient. Documentation required for transfer is as follows:
 - a. a transfer note by the psychiatrist/physician from the sending unit summarizing the status of the patient;
 - b. the Nursing Transfer Reassessment (CVH-254) due upon transfer by the sending and the receiving nurse;
 - c. the Rehabilitation Service Assessment (CVH-437) within 10 days of transfer by the receiving Rehabilitation Therapist/Counselor;

- d. a transfer note by the Social Worker from the sending team incorporating pre-scheduled appointments, court dates, etc. to inform the receiving Social Worker/team members;
- e. reassessment of the patient and a treatment plan review (CVH-550(c)) within 10 days of transfer, unless the goals of treatment have changed such that a new MTP is preferable. This is the responsibility of the receiving team.

7. Special transfers

- a. If the court finds a WFD patient “non-restorable” (54-56m), his/her legal charges are dropped and the patient is either discharged or, if indicated, placement is located on a GPD unit or on another psychiatric unit within DMHAS. Keeping the patient would necessitate a probate court commitment.
- b. Infrequently, GPD may accept the transfer of a “Not Guilty by Reason of Insanity” (NGRI) patient given the approval of the Psychiatric Security Review Board (PSRB).

D. Transfer of Patients Between DMHAS Facilities

1. Based on the services available, the patient’s assessed needs, and the patient’s legal status, patients may be transferred between DMHAS facilities.
2. Planning for a transfer involves staff (from both the sending and receiving facilities), the patient, the patient’s legal designee, involved family members/ significant others as appropriate, and often includes representation from DHMAS management and includes:
 - a. the reason for the transfer; and
 - b. any reasonable alternatives to transfer.
3. The planning of the transfer needs to include consideration for the amount of time the patient may need to prepare for the move.
4. The medical record as a whole is not transferred with the patient. Documentation which is sent from the sending to the receiving facility is as follows:
 - a. Discharge Summary, W-10 (*if available*);
 - b. The initial or most recent assessments of Psychiatry, Social Work, Nursing, and Rehabilitation Therapy;
 - c. The most recent history and physical;
 - d. The initial MTP;
 - e. The most recent TPR;
 - f. The most recent two weeks of progress notes;
 - g. Conservator documentation, as appropriate;
 - h. A signed voluntary, as appropriate;
 - i. A “Superintendent’s Transfer” and copy, as appropriate;
 - j. The original probate order;
 - k. PEC, as appropriate;
 - l. Appropriate laboratory test results;

- m. Medication information for:
 - i. Methadone – dosage verification and direct nurse to nurse phone contact.
 - ii. Clozaril – dosage verification, most recent laboratory values, and contact with the registry.
- n. The results of consultations;
- o. A DOC transfer form for DOC patients;
- p. Mitemus for court ordered patients;
- q. A transfer form; and
- r. A court evaluation report by the court clinic for 54-56d patients.

5. Special Transfers

- a. In cases where a voluntary conserved patient is admitted, a Probate Court evaluation of his/her competency to sign a voluntary admission is conducted. The court may allow the voluntary status to continue or may require a probate hearing on the case.
- b. Patients probated to DMHAS may be transferred between facilities by a Superintendent's transfer.
- c. A voluntary patient may request to be transferred to another DMHAS facility.
- d. Extenuating circumstances such as the admission of a patient who has a family member/significant other as a staff member or fellow patient may prompt a between-facilities transfer.

E. Treatment at a General Hospital

Patients are sent to Middlesex Hospital and other hospitals as appropriate for medical care that cannot be provided by the level of medical services at CVH. These medical services can include emergency medical situations, surgical procedures, and/or special treatments, i.e. oncology. This is facilitated through the medical clinic and the nursing staff on the unit. Transportation arrangements are made and staff escorts and/or security are provided as appropriate. For patients sent for preplanned medical appointments, conservator approval is required. For probated patients sent to the general hospital on Medical Discharge/Acute Care (MD/AC), their probated status is unchanged despite their hospital stay.

F. Interstate Compact Transfer

Connecticut is a member of the Federal Interstate Compact, permitting transfer of inpatients criteria. To initiate a transfer, the CVH patient must request a transfer and sign a consent form him or herself. Conservators of person cannot sign for a patient, and signature may require evaluation that the patient is clinically competent to do so, aside from legal competency. The consent form, a completed application, and other clinical information are sent to the Interstate Compact Coordinator for the Connecticut Department of Mental Health and Addiction Services (DMHAS). Additional criteria for eligibility include no pending legal charges in Connecticut and the presence of family and/or significant others in the state to which the patient is requesting transfer. Finalizing the details of the documentation and transportation is the responsibility of the Interstate Compact Coordinators involved.

G. Discharge

1. Discharge occurs when the psychiatrist, in collaboration with the treatment team, determines that one or more of the following criteria are met for patients AND arrangements for discharge/aftercare have been made by staff.

For a patient to be discharged:

- a. all the goals on the MTP have been accomplished; or
 - b. a voluntary patient requests discharge and is not probatable; or
 - c. the level of care provided by CVH is no longer beneficial or no longer indicated; or
 - d. he/she has violated sufficient program rules in the ASD Rehabilitation Program that not only the patient, but his/her community of peers is compromised; or
 - e. legal authorities provide official documentation for the removal of a patient (in such cases, consultation with program management is required to determine the appropriateness of releasing the patient. Consultation with the Agency Police may also be indicated.)
2. The following is required of staff:
 - a. For GPD and WFD:
 - i. The patient's post discharge housing, finances, and treatment services have been arranged (*Refer to Commissioner's Policy Statement #20*); and
 - ii. If under the jurisdiction of the PSRB or court, approval for discharge from these authorities has been granted; or
 - b. For ASD:
 - i. the client's post-discharge housing or residential placement has been established and treatment services and appointments scheduled; and

Note: In ASD, a patient deemed not to be a danger to self or others may refuse to have aftercare arrangements made.

3. Planning for discharge begins early in the patient's hospitalization, but evolves with changes in the patient's needs, capabilities and preferences in conjunction with what is available. Discharge planning involves the staff, patient, patient's legal designee, family members/significant others as appropriate, and providers with whom discharge arrangements are being made as much as reasonably feasible.
4. When discharge arrangements have been finalized, the patient should be clear about why he/she is being discharged and what kinds of services are being arranged to continue to meet his/her needs. Additionally, the patient, the patient's family/significant other and legal designee are educated about diet, medication, medical equipment, and other services in the community. As needed, they should also be educated about how to access services in the community. As with other education, such should be documented in the patient's medical record.

5. Planning for discharge needs to include consideration for the amount of time the patient may need to prepare to leave.
- 6a. When patients are discharged, they retain a copy of the CVH-2, Discharge and Aftercare form. Copies may also be sent by CVH to aftercare providers, assuming releases of information are in place. This form describes the arrangements made for the patient, including appointments at the next level of care. Note: Only in ASD, a patient deemed not to be a danger to self or others may refuse to have aftercare arrangements made.
- b. Agencies to which CVH refers patients as part of discharge planning may request patient information prior to discharge. Assuming releases of information are in place, CVH staff will provide the requested information in order to smooth the transition for the patient.
7. Unplanned discharges due to emergent situations are to be managed with primary consideration for the need to reassure, comfort, orient, and educate the patient to the need for the discharge and to inform family, legal designee and staff involved in the patient's care.

H. Denial of Care Conflicts Over Care, Services, or Payment

The Utilization Review function at CVH is responsible for monitoring the requirements and standards for external Peer Review Organizations such as Medicare and Medicaid and other insurance companies. Criteria utilized in the review processes are delineated in the Utilization Review Plans for each division and the Umbrella Utilization Review Plan for CVH.

Refer to the following resources for details:

- * LMHA Agreements for General Psychiatry and Forensic Services;
- * C.C.P.C. Criteria;
- * Program descriptions as updated;
- * Medical Records Policies and Procedures;
- * Utilization Review Plans – Division; and
- * Utilization Review Plan for CVH.