

WHITING FORENSIC HOSPITAL OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 5:	Improving Organization Performance
PROCEDURE 5.6:	Risk Management
Governing Body Approval:	6/5/18
REVISED:	

PURPOSE: The purpose of the Hospital's Risk Management Procedure is to provide a structure that includes performance improvement processes to identify and reduce risk for patients served. In implementing the Risk Management Procedure, the hospital will provide patients with interventions and take corrective actions commensurate with the level of risk to maintain a safe and therapeutic environment. This procedure is supported and supplemented by the Incident Management Procedure.

POLICY:

The hospital will provide a safe, therapeutic environment that utilizes a Risk Management process involving a continuous and direct approach to identifying and analyzing risks and implementing measures to protect patients, staff, and visitors by reducing or eliminating the risk of harm. Staff will ensure that standardized procedures are used when addressing identified behavioral, psychiatric, and medical risk conditions, as well as other high-risk situations.

PROCEDURE:

- I. The Risk Management process will support timely identification of high-risk behaviors, conditions, or situations of an immediate nature, as well as long-term systemic problems that need corrective actions to remedy risks, and timely interventions to prevent or minimize harm to patients, staff, and visitors.
 - A. The Risk Management process includes the following components:

1. Data collection tools and a centralized-database to collect and provide information on various categories of high-risk incidents and behaviors.
2. Identification of triggers and thresholds that address various levels of risk involving patients and that require timely review by the Interdisciplinary Team.
3. Formalized mechanisms for notification of Interdisciplinary Teams and disciplines to support timely corrections.
4. Monitoring systems to support timely implementation of interventions.
5. Identification and management of long-term trends and patterns.
6. An oversight mechanism that ensures data are tracked, trended, and analyzed using a performance improvement methodology in an effort to provide ongoing oversight and monitoring of the effectiveness of the hospital's Risk Management process.

B. The Performance Improvement Department will maintain and utilize risk management data as follows:

1. Ensure that all risk management data (incident reports) are entered into a hospital-wide database;
2. Sort data by individual, unit, program, and division, as required;
3. Sort the data by incidents, triggers, and thresholds, as required; and
4. Utilize the database to analyze risk management data, monitor triggers and thresholds, and identify potential patterns and trends.

- II. The hospital will identify patients at risk for harm as a result of meeting Triggers and Thresholds or other behavioral, psychiatric, and medical conditions. The hospital's triggers and their thresholds are presented in Appendix A. Sample high risk behavioral, psychiatric and medical conditions are presented in Appendix B.
- III. For newly admitted patients, the General Medical Service provider identifies medical risks using information from the Admission History and Physical and the Attending Psychiatrist identifies behavioral and psychiatric risks using information from the Admission Psychiatric Evaluation to ensure risk conditions are reviewed and addressed in the initial treatment plan. Risks are identified throughout the course of hospitalization based on ongoing assessments.
- IV. The hospital will use an established hierarchy of reviews that correspond to the level of risk in order to address the risk and reduce the potential or actual harm to patients involved in any incident, who meet the threshold for a trigger behavior or meet the threshold for high-risk behavioral, psychiatric, and medical conditions.

A. Each Interdisciplinary Treatment Team will perform the following routine functions:

1. Develop and maintain an updated risk profile for all patients in their care. The risk profile will be documented in the patients' Present Status section of the Case Formulation in the treatment plan;
2. Review all patients who (a) are involved in any incident (b) exhibit a trigger or threshold behavior or exhibit a new behavioral, psychiatric, or medical high risk condition;
3. Identify predisposing factors for behaviors and/or conditions that may occur in the absence of preventative interventions for each high-risk condition identified in the patient's risk profile, focusing on factors that impact the patient's health and wellness.
4. Identify precipitating factors for each high-risk condition identified in the patient's risk profile, focusing on those factors that will precipitate adverse outcomes for the patient.
5. Identify perpetuating factors for each high-risk condition identified in the patient's risk profile, those factors that are maintaining adverse conditions or outcomes for the patient.
6. Incorporate the analysis of the patient's predisposing, precipitating, and perpetuating factors into specific goals, objectives, and treatment interventions to eliminate or reduce the identified behavioral, psychiatric, or medical risk condition.
7. Review all incidents, as well as trigger and threshold behaviors, that involve patients in their care to determine the nature and context of the incident or behavior, contributing (predisposing, precipitating and perpetuating) factors and appropriate behavioral, psychiatric, or medical interventions;
8. Review the current treatment plan in terms of the effectiveness of specific goals, objectives, and treatment interventions already in place in eliminating or reducing the risk associated with involvement in an incident, trigger, or threshold behavior or high-risk behavioral, psychiatric, and medical conditions;
9. Revise the current treatment plan as indicated or document the rationale for continuing with the current goals, objectives, and treatment interventions that are relevant.
10. Continue to update and build upon the individual's treatment plan based on new assessments, consultations, other information and the patient's progress for the first 60 days of admission or the first 60 days from a newly exhibited risk behavior or condition.
11. Incorporate recommendations from the Hospital Review Committee, as applicable, into the individual's treatment plan.
12. The Consulting Forensic Psychiatrist (CFP) participates in weekly Levels meetings with the Dutcher Service interdisciplinary teams to discuss risk issues related to PSRB patients, including privilege increases, trip requests, Temporary Leave (TL) applications, and Conditional Release (CR) applications.

B. *First Level Review:* WFH Daily Morning Report

1. The CEO/designee chairs this meeting.
2. Attendance required:
 - a. Chief Executive Officer

- b.Chief Medical Officer
- c.Chief Operating Officer
- d.Service Medical Director(s)
- e.Nursing Supervisors
- f. Program Director(s)
- g.Unit Directors
- h.Attending Psychiatrists
- i. Performance Improvement Manager

3. Daily review of all WFH patients for psychiatric and medical stability since the last business day.
4. When indicated, recommend further medical consultation with the General Medical Service and/or Specialty Service (for example, Neurology).
5. Review all Incident Reports (IR) since the last business day.
6. Review and approve daily transportation Risk Forms (WFH -473) for appropriate transport level.
7. Review all special observation orders since the last business day.
8. Review daily WFH admissions with respect to psychiatric, medical, and legal issues.

C. *Second Level Review: Hospital Review Committee (HRC)*

1. The CEO /designee will serve as the chair.
2. The HRC will hold regular weekly meetings.
3. Committee Membership:
 - i. CEO
 - ii. COO
 - iii. CMO
 - iv. Service Medical Directors
 - v. Supervising Forensic Psychologist
 - vi. Director of Social Services
 - vii. Nurse Executive
 - viii. Performance Improvement Manager
 - ix. Supervising Psychologist -2
 - x. Chief of Forensic Services
4. Review risk assessment and risk management issues with regard to the readiness of patients to attain increasing levels of freedom and responsibility including:
 - i. Changes in level to 3B or above for PSRB patients;
 - ii. All off-grounds activities;
 - iii. Transfer of civilly committed patients between Whiting Max and Dutcher Service;
 - iv. Periodic review of the clinical status and risk management plans for voluntary or civilly committed patients;

- v. Any patient whom the team feels is “discharge ready”;
 - vi. Level 4/TL proposals for Dutcher 1 North patients;
 - vii. Specialized funding needs;
 - viii. Discharge planning challenges (for civil, PSRB and competency patients);
 - ix. Patients meeting risk factor “thresholds” per Performance Improvement Manager;
 - x. Behavioral Intervention Service updates;
5. Review incident reports of patients who meet defined Trigger and Threshold criteria (see Appendix A).
 6. Review treatment plans of patients meeting Trigger and Threshold criteria. When indicated, recommend intervention to the primary interdisciplinary team to manage various medical or psychiatric risk factors.

D. Third Level Review: Forensic Review Committee (FRC)

1. The FRC primarily focuses on risk management issues regarding patients (acquittees) who have been committed by State Superior Courts to the jurisdiction of the Psychiatric Security Review Board (PSRB), but also reviews issues regarding high-risk civil and competency restoration patients in the enhanced security Dutcher Service and the maximum security Whiting Service of the WFH.
2. FRC meets weekly.
3. FRC is chaired by the Chief Executive Officer (CEO)/designee.
4. Members:
 - a. Chief Operating Officer
 - b. Chief Medical Officer
 - c. Service Medical Directors
 - d. Chief of Forensic Services
 - e. Supervising Forensic Psychologist
 - f. Director of Social Services
 - g. Director of Rehab Services
 - h. Consulting Forensic Psychiatrists (CFP), DMHAS
 - i. Other persons may be invited to attend FRC meetings on an ad hoc or ongoing basis at the discretion of the Chair
5. FRC reviews risk assessment and risk management issues including, but not limited to:
 - a. Issues regarding acquittees’ Temporary Leaves, the temporary leave process and procedures, or compliance with PSRB orders or hospital conditions for Temporary Leaves;
 - b. Whiting Service treatment team recommendations for transfers of PSRB acquittees from the maximum security Whiting Service to the enhanced security Dutcher Service;

- c. Whiting Service treatment team recommendations for referrals to the Transition Group or other groups outside of the Whiting Maximum Security service;
- d. Periodic reviews of PSRB patients transferred from Dutcher to Whiting due to increased risk;
- e. Significant incidents involving WFH patients (e.g., assaults, attempted escapes, breeches of security);
- f. Significant changes in the clinical status of Dutcher or Whiting Service patients (including hold/suspension or reduction of patient privileges) that may have risk management implications;
- g. Voluntary or emergency transfers of patients from the Dutcher Service to the maximum security Whiting Service;
- h. Issues regarding the *Roe v. Hogan* Agreement of Settlement, including differences of opinion between an acquittee and his/her treatment team, or between the treatment team and the Forensic Liaison team about an acquittee's privileges or treatment plan;
- i. Upcoming or recently held PSRB and Probate or Superior Court hearings and testimony;
- j. The current status of PSRB acquittees nearing the end of their commitments to the jurisdiction of the PSRB and issues regarding recommitment to the PSRB of these acquittees;
- k. WFH policies and procedures regarding risk assessment and risk management or that are related to or may have implications for risk assessment and risk management; and
- l. Forensic questions regarding competency patients.

V. Review of Transfer Recommendations

Whiting Service Transfers to Less Secure Treatment Settings. Whiting Service treatment team recommendations for transfer of PSRB acquittees from maximum security to the enhanced security Dutcher Service are done as follows:

1. The Whiting Service treatment team first reviews the case with the Chief of Forensic Services, who may confer with the Whiting Service Medical Director about the case.
2. If the Chief of Forensic Services believes it to be appropriate, the treatment team requests a date and time from the Supervising Forensic Psychologist to present their recommendation for transfer at the weekly FRC meeting.
3. If there is consensus in the FRC to proceed further, the CEO requests that one of the Consulting Forensic Psychiatrists (CFP) conduct an evaluation of the acquittee's readiness for transfer. As part of the evaluation, the CFP reviews the acquittee's medical record and other relevant documents, speaks with members of the treatment team, and interviews the acquittee.
4. The CFP presents the results of his/her evaluation and his/her recommendation, after which the FRC discusses the case and arrives at a consensus as to whether or not to concur with the treatment team's recommendation.

5. If the FRC concurs with the team's recommendation, the Supervising Forensic Psychologist (SFP) informs (usually by e-mail) the team's attending psychiatrist and unit director.
6. If the FRC does not concur, or concurs but with specific recommendations for treatment, further evaluation, and/or waiting an additional period of time before proceeding, the SFP sends a memorandum to the treatment team stating the FRC's questions, concerns, or recommendations for the treatment team's follow-up.
7. The Whiting treatment team informs the patient of the outcome regarding the transfer recommendation, and the Unit Director/designee documents this information in the patient's medical record, including the fact that the patient was informed of this information.