Date of Hire

Class start times vary and include a ½ hour lunch break

FULLNAME	BUILDING	UNIT		FULLNAME	BUILDING	UNIT		TRANSFER/NEW	BUILDING	UNIT		TRANSFERS/NEW	BUILDING	UNIT

***Times, location and content subject to change**

Monday Day 2	Tuesday Day 3	Wednesday Day 4	Thursday Day 5	Friday Day 6
8:30AM-4:30PM **Day Two** **New Employee Orientation**	8:30a-4:00p **CSS New Page Hall room 364**	8:30a-4:00p **CSS New Page Hall room 364**	8:30a-4:00p **CSS New Page Hall room 364**	8:30a-2:30p **CPR New Page Hall room 364** 2:30p-4:30p **Complete Access Forms (Mut/Phillips)**
Monday Day 7	Tuesday Day 8	Wednesday Day 9	Thursday Day 10	Friday Day 11
Staff Development Classroom 8:00a-9:00a **Infection Control (Paparello)** 8a-9a **WFH Infection Control (Olabisi)** 9:00a-11:30a **CVH / WFH Overview (Williams)** 11:30p -12:00p **Lunch** 12:00p-1:00p **Incident Management (Naughton)** 1:00p-2:00p **Patient Panel (Beavers)** 2:00p-3:00p **Dysphagia (Buckingham)** 3:00p-3:15p **Break** 3:15p-4:30p **Computer Based Training**	**Staff Development Classroom** 8:00a-9:30a **FOM, Pt. Privileges, Elopement/AWOL procedures, Pt. Safety in Community, Searches (Loomis)** 9:30a-9:45a **Break** 9:45a-12:00p **Admission/Transfer/Discharge, Emergency and Involuntary Meds, Crash Cart (Loomis)** 12:00p-12:30p **Lunch** 12:30p-1:15p **ACS/CVH Overview (Kennedy)** 12:30-1:15p **ACS/WFH Overview (Olabisi)** 1:15p-3:00 **Computer based training** **2:00-2:15p: Lakisha Meet and Greet** **3:00p-3:15p Break** 3:15p-4:30p **Understanding side effects of Psychotropic medications – EPS (Video)- (Scott/Galinsky)**	**Staff Development Computer Room** 8:00a-9:00a **WITS 101 (Williams)** 9:00a-10:00a **WITS for Nurses (Williams)** ***Non-nurses to continue with Computer-Based training*** 10:00a-10:15a **Break** 10:15a-12:15p (**RMS) Recovery Management System – Computer Based Training (Williams)** 12:15p-12:45p **Lunch** 12:45p-2p **RMS Group Notes (Williams)** 2p-2:15p **Break** 2 :15p-4 :15p **Bathing without a Battle (FTS/MHA) (Scott) then 3:15p-4:30p Computer Based Training** 2:15p-4:30p ***Other Clinical Staff: Computer based training***	**Staff Development Classroom** 8:00a-10:15a- **Restraint/Seclusion Procedures, Routine/Special Observations (Loomis)** **10:15a-10:30a Break** 10:30a-12:00p **Diet and meal monitoring, Vital signs I&O, Dehydration assessment (Loomis)** 12p-12:30p **Lunch** 12:30p-1:45p **Understanding Trauma and Recovery – The Journey of Tonier Cain (Video) (Scott)** 1:45p-2p **Break** 2p-4p **Therapeutic Communication (Williams/Scott)** 4p-4:30p **Computer Based Training**	**Staff Development Classroom** 8:00a-10:30a **Fundamental Concepts of Suicidality (Scott)** 10:30a-10:45a **Break** 10:45a-12p ***ALL CLINICAL STAFF* - Fundamentals of Documentation (Scott)** 12p-12:30p **Lunch** 12:30p-3:30p ***Nursing Specific* - Progress Note Documentation (Scott)** 3:30p-3:45p **Break** 3:45p-4:30p **Neuroleptic Malignant Syndrome (DVD) (Galinsky)**

Date of Hire

Class start times vary and include a ½ hour lunch break

Monday	Tuesday Day 12	Wednesday Day 13	Thursday Day 14	Friday Day 15
	Staff Development Classroom 8:00a-12p **Nursing Change of Shift Report/Daily Assignment of Care (Scott)** 12p-12:30p **Lunch** 12 :30p-4:30p **Computer Based Training** 1:30-4:30p **MHA/FTS Fundamentals of Vital Signs with Demonstration of Competency (Galinsky) then computer based training**	**Staff Development Computer Room** **CVH MHA ONLY 730a-9:30a PT CLASS then computer based training** **RNs** 8:00a-9:00a **Computer Based Training** 9a-11:15a **Nurses, MD'S** **Oxygen & E Cart (Loomis/Galinsky)** 11:15a-12p **MD's and Nurses Computer based training.** 12p-12:30p **Lunch** 12:30p-4:30p **Computer Based Training**	**Staff Development Classroom** 8:00a-4:30p **Nurses – Med Admin Day 1 (Class Room) (Galinsky/Scott)** **Others Computer based Training or** Unit Based Orientation Complete the following: ➢ Shift Evaluations ➢ Unit Based Checklist	**Staff Development Classroom** 8:00a-12:00p **Nurses – Med Admin Day 2 (Class Room) (Galinsky/Scott)** 12p-12:30p **Lunch** **12:30p – 4:30p** **Automated Medication System-Pyxis training (Galinsky/Scott)** **Others Computer based Training or** Unit Based Orientation Complete the following: ➢ Shift Evaluations ➢ Unit Based Checklist
Monday Day 16	**Tuesday Day 17**	**Wednesday Day 18**	**Thursday Day 19**	**Friday Day 20**
Staff Development Computer Room 8a -10:30a ***APO Orientation to Whiting Building (*Whiting employees only*)** 8a-12p**Tours/Badges (Loomis)** 10:45 – 12:00pm *** After completing APO orientation in Whiting continue with Computer Based Learning** 12:00-12:30 **Lunch** 12:30-1:30p **Badges (Loomis)** **1:30p-4:30p Computer based training**	**Staff Development Computer Room** **Nurses only 8a-8:30a Glucometer** 8a – 4:30p Continue Computer Based Learning or Unit Based Orientation Complete the following: ➢ Shift Evaluations ➢ Unit Based Checklist	**Staff Development Computer Room** **Nurses:** 8a – 4:30p Continue Computer Based Learning or Unit Based Orientation Complete the following: ➢ Shift Evaluations ➢ Unit Based Checklist	**Staff Development Computer Room** **Nurses:** 8a – 4:30p Continue Computer Based Learning or Unit Based Orientation Complete the following: ➢ Shift Evaluations ➢ Unit Based Checklist	**Staff Development Computer Room** **7:30a-9a CVH Nursing staff only; Physical Therapy Class** 8a – 4:30p Continue Computer Based Learning or Unit Based Orientation Complete the following: ➢ Shift Evaluations ➢ Unit Based Checklist

Staff Development New Employee Orientation Program
Page Hall - Room 258

In Person/Live Core Courses
(Courses that all direct clinical staff must complete)

Core Courses	Time Frame
Infection Control/Ambulatory Care Training	1.0 Hour
CVH / WFH Overview	2.0 Hours
Incident Management	1.0 Hour
Patient Panel Discussion Group	1.0 Hour
Recovery Support Discussion Group	30 Minutes
Dental	1.0 Hour
Dysphagia	1.0 Hour
Web Infrastructure for Treatment Services (WITS)	2.0 Hours
Recovery Management System (RMS)	3 Hours and 30 Minutes
Admission, Transfers, Discharges, Emergency and Involuntary Medications, Crash Cart	2 Hours and 15 Minutes
FOM, Patient Privileges, Elopement/AWOL Procedures, Patient Safety in The Community, Searches	1.5 hours
Therapeutic Communication	2.0 Hours
Fundamental Concepts of Suicidality	2.5 Hours
Restraint/Seclusion Procedures, Routine/Special Observations	2.5 Hours
Diet and meal monitoring, Vital signs, I&O, Dehydration assessment	1 Hour and 15 Minutes
Fundamentals of Documentation (all Clinical Staff)	1 Hour and 15 Minutes

In Person/Live Discipline Specific Courses

Courses for Clinical Medical Staff (MD, APRN, etc.)

Course Name	Time Frame
Oxygen & E Cart	2 Hours and 15 Minutes

Notes:

Courses for Clinical Registered Nurse & Clinical Licensed Practical Nurse

Course Name	Time Frame
Nursing Documentation	3.0 Hours
Glucometer	30 Minutes
Oxygen & E Cart	2 Hours and 15 Minutes
Nursing Change of Shift Report/Daily Assignment of Care	4.0 Hours
Medication Administration	2-3 Days (may change per class size)

Courses Clinical Para-Professional Nursing Staff (Forensic Treatment Specialist, MHA)

Course Name	Time Frame
Nursing Documentation	3.0 Hours
Nursing Change of Shift Report/Daily Assignment of Care	4.0 Hours
MHA/FTS Fundamentals of Vital Signs with Demonstration of Competency	3.0 Hours

Courses for Clinical Other staff (i.e., State School Teacher, Pharmacists, etc.) and Non-Direct/Non-Clinical (Administrative Support Services Division, Fiscal, Clerical, Maintenance) – Day One Training only

Course Name	Time Frame
Infection Control	1.0 Hour
CVH / WFH Overview	2.0 Hour
Incident Management	1.0 Hour
Patient Panel Discussion Group	1.0 Hour

Note: All direct clinical staff, including the Clinical Psychologist, Clinical Social Worker, BH Manager, Clinical Rehab Therapies, Clinical Occupational, Speech, Physical Therapist, Speech Language Therapists, Patient Service Advocates, etc. are required to take the in person/live core courses.

All staff must complete the Web-Based Training (WBT) online using the Learning Management System (LMS). Please refer to Annual and Mandatory LMS Listing of online courses.

DEPT OF MENTAL HEALTH
WFH Staff Development
New Staff Orientation Checklist

Form
WFH AD Exchange Request Form
Acknowledgement of Receipt
Badge Form
DMHAS-CVH/WFH Alert
Key Request Form
RMS Authorization Form
WITS Access Request
MD's ONLY: Unit Access Form
MD's ONLY: RXNT Enrollment

Handouts
Legionnaires Disease CDC
Infection Prevention Orientation

Handouts
What Rights do Clients Have?

Handouts
12.e.7 Description of Diet Consistency Levels

Handouts
NP&P 9.1 Freedom of Movement
NP&P 9.1.2 Freedom of Movement (Dutcher Services)
OP&P 2.10 Elopement/Escape and Unauthorized Absence
OP&P 5.4 Transportation and Assessment of Risk
WFH 473 Risk Assessment for Transport Risk Form
OP&P 5.5 Patient and Staff Safety in the Community
WFH 627 Off Grounds Treatment Activities/ WFH 466 On Grounds Treatment Activities
NP&P 8.2 Escorting Patients
WFH 627a Transportation for TV/TL
OP&P 1.11 Patient Searches

DEPT OF MENTAL HEALTH
WFH Staff Development
New Staff Orientation Checklist

All Staff Handouts
OP&P 2.32 Admission of Patient
WFH 639 WFH Admission Checklist (admission check list)
NP&P 8.1 Patient Transfer
NP&P 8.2 Escorting Patients
OP&P 3.1 Emergency and Involuntary Medication
NP&P 8.3 Patient Discharge

ACS Clinician Handouts
WFH 301 Medical History and Physical Examination (H&P)

MD, APRN, PA, DO, RN, LPN Handouts
WFH 581a-b Admission Medication List and Verification Form
WFH 8 Physicians Order Sheet
WFH 8b Antibiotic Order Form
WFH 8f Physician Order for Patients with Diabetes Mellitus
WFH 8h Physician Order Sheet for Patients with skin infections, wounds, abscesses.
W-10 Form

MD, APRN, DO, PA Handouts
WFH 593 ECT Patient Preparation Checklist (ECT)
WFH 2 Transition of Care-Discharge/Aftercare Plan (WFH 2 Transition of Care Form)

RN Handouts
WFH 171 Admission Nursing Assessment
WFH 171a Annual Nursing re-Assessment
WFH 593 ECT Patient Preparation Checklist (ECT)
WFH 254 Nursing Transfer Re-assessment
WFH 2 Transition of Care-Discharge/Aftercare Plan (WFH 2 Transition of Care Form)

Psychology Handouts
WFH 638 Integrated Initial Psychological Evaluation (Initial Psychological Eval)

Rehabilitation Division Handouts
WFH 659 Rehabilitation Therapy Assessment (Rehab Assess)

DEPT OF MENTAL HEALTH
WFH Staff Development
New Staff Orientation Checklist

Social Work Handouts
WFH 625 Admission Psychosocial History and Assessment Admit PSA)
WFH 2 Transition of Care-Discharge Aftercare Plan

MHA WITS Handouts
Bed Movement for Unit Staff

RN/LPN WITS Handouts
Bed Movement for Unit Staff
Leaves for Unit Staff
Daily Census for Unit Staff
Program Disenrollment

MD/APRN/DO Handouts
WITS Encounters Only
WITS Diagnosis

All Non-Nursing Clinical Staff WITS Handouts
WITS Collateral Contacts

Nursing Supervisor WITS Handouts
WITS for ADT
WITS 110: Client Creation and Contacts

Handouts
Points to Remember Treatment Planning 101/Joint Commission
Objectives, Recovery Samples
Sampler
Group Notes
Treatment Notes and Alternative Treatment (How to write a TURPP note.)
Treatment Planning Nursing Interventions Power point slides
Barriers/Treatment Planning Power point slides

DEPT OF MENTAL HEALTH
WFH Staff Development
New Staff Orientation Checklist

Handouts
NP&P 9.2 Routine Observation
NP&P 9.1 Freedom of Movement/ 9.1.2 Freedom of Movement (Dutcher Services)/ 9.1.3 Dutcher Forensic Services/9.4 Milieu Management
WFH 63 Routine Observation Form 24 Hour Census (Census Sheet)
WFH 613a Medical Equipment
WFH 688 Electronic Equipment Monitoring Form
On Grounds Patient Sign in/Sign out, Off Grounds & TL Sign in/Sign Out
Activity Call in Sheet
Environmental Safety Checks ABC
RN/Nurse Supervisor Accountability Rounds
OP&P 2.11 Special Observation
WFH 670 Special Observation Review Form
WFH 665a Positive Behavioral Support Plan or Special Observations
OP&P 2.27 Restraint Use for the management of Violent or Self Destructive Behavior
WFH 618 Request for use of Non Standard Mechanical Restraint
WFH 8 R/S Physician order for Restraint or Seclusion (17a Sec Res Physician Orders)
WFH 480a Part I Initial Assessment by RN and MD/DO
WFH 480b Part II Nursing Observation and Care of the Patient
WFH 480c Restraint/Seclusion Reorder
WFH 480d Seclusion /Restraint Patient Debriefing
WFH 480e Staff Debriefing Form
OP&P Policy 2.26 Seclusion Use
Behavioral Criteria for Discontinuation of Restraints/Seclusion from Dr. Boyntn and Dr. Dike

Handouts
NP&P 13.1.6 Aspiration Risk Precautions
NP&P 13.2.3 Fluid Volume Assessment
WFH Nursing Dietary and Aspiration Risk Tracking form (Dietary Tracking Form)
NP&P 16.1 Vital Signs Notification
WFH 165 Vital Signs Flow Sheet
WFH 170 Intake and Output Chart
WFH 671 Nursing Dehydration Assessment

DEPT OF MENTAL HEALTH
WFH Staff Development
New Staff Orientation Checklist

Handout
What are Personal Boundaries?
Boundaries Fast Facts
9 Therapeutic Communication Techniques
Erikson's Stages of Development
Verbal De-escalation
Therapeutic Communication Matching
What are Personal Boundaries
Communication Techniques

Handouts
OP&P 2.8 Evaluating and Managing Suicide Risk
WFH 103 Columbia- Suicide Severity Rating Scale (C-SSRS)
WFH 632 Reassessment of Suicide Risk

Handouts
Joint Commission Prep Points to Remember Documentation 101
OP&P 2.16 Documentation of Patient Progress and Care
WFH 674 MHA/FTS Engagement Progress Notes
WFH Alternative Active Treatment

Handouts
NP&P 7.5 Integrated Progress Notes
WFH 136 Integrative Progress Note
HIM P&P 6.4 Prohibited Documentation and Abbreviations

Handouts
OP&P 2.22 Hand-Off Communication Among Caregivers
WFH 24 Hour Nursing Report Form
WFH 7.3.1 Nursing Care Assignment Sheet

Handouts
NP&P 15.1 Bayer Contour Blood Glucose Monitoring System
Glucose Skills Monitoring Checklist/Bayer Contour Written Test
WFH 15.1a Bayer Contour Glucose Monitoring System Quality Control Testing Form

Handouts
NP&P 16.1 Vital Signs Notification
WFH 165 Vital Signs

DEPT OF MENTAL HEALTH
WFH Staff Development
New Staff Orientation Checklist

Handouts
NP&P 13.6 Oxygen Administration
Oxygen Tank Handout
Procedure 12.2.1 Emergency Cart, Contents and Use
12.2.2a Daily Emergency Cart Checklist
Emergency Cart Medications
WFH 344 Patient Data for Evaluation/Admission to Another Hospital
WFH 346 Emergency Medical Patient Record
W-10
WFH 12.2.1a Medical Emergency Monitor form

Handouts
Psychiatric Pharmacotherapy Review Power Point slides
CVH Drug Therapy Guidelines
NP&P 23.3 Preparation and Administration of Medication
NP&P 23.2 Medication Transcription
NP&P 23.12 Twenty-Four Hour Medication Transcription Review
NP&P 23.6 Medication Documentation
NP&P 23.1 Automated Medication System: Pyxis
Insulin Types Handout

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

ALL WFH Staff: Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

WEB-BASED TRAINING	**COURSE ID#**	**CLASS #**	**STATUS**	**FUNCTION FIELDS**
OP& P 2.6 Integrated Treatment Planning Process	DMHAS_T9421	00091910	Web-based Read & Sign	Clinical Staff
NP & P 13.4.4 CPAP (Continuous Positive Airway Pressure)	DMHAS_T9438	00086972	Web-based Read & Sign	CRN & CLPN (as needed)
NP& P 19.3 Wound Monitoring and Documentation	DMHAS_T9430	00090570	Web-based Read & Sign	CRN & CLPN
OP& P 8.34 Investigation of Alleged Violations of DMHAS Policies, Procedures, Regulations, or Work Rules	DMHAS_T9419	00091955	Web-based Read & Sign	All Staff
Reducing Patient Harm Associated with the use of Anticoagulation Therapy	DMHAS_T9418	00092019	Web-based	CPPN

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

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Improving Safe Use Of Anticoagulant Therapy: A guide for Medical Staff, Pharmacists, Dieticians and Nurses	DMHAS_T9417	00092051	Web-based	CMS, CRN, CLPN, Dietician & Pharmacist
OP & P 7.15 Allowable Patient Property	DMHAS_T9388	00095304	Web- based	Clinical Staff
NP&P 12.3 Automated External Defibrillator (AED)	DMHAS_T9406	00093925	Web- based	CRN & CLPN
Engagement Progress Note	DMHAS_T9391	00095164	Web- based	CRN,CLPN & CPPN
Property Policy and Suicide Risk	DMHAS_T9413	00092405	Web- based	Clinical Staff
The Use of Weighted Modalties	DMHAS_T9390	00095257	Web- based	Clinical Staff
Procedure 2.35 Patient Identification	DMHAS_T9368	00097551	Web- based	Clinical Staff
Medication Safety Events	DMHAS_T9367	00097782	Web-Based	CRN, CLPN & Pharmacy Staff

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

ALL WFH Staff: Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

Workplace Violence Prevention Training	DMHAS_AGWPV001	00029818	Web-Based	All Staff-except for new hires
Nursing Implications from a Serious Medication Event	DMHAS_N9711	00042132	Web-Based	CRN & CLPN
Nursing Documentation and Review Requirements for Patients on Special Observation	DMHAS_N9712	00041849	Web-Based	CPSY, CRN, CLPN, & CPPN
Nursing Provision & Supervision of Care and Treatment Planning	DMHAS_NCMS9701	00043206	Web-Based	CRN, CLPN, & CPPN
NP&P 6.5 Clinical Assessment of the Patient	DMHAS_N6164	00040711	Web-Based	CRN
Admission & Transfer Procedure Between CVH ₩ WFH & Middlesex Hospital	DMHAS_N9702	00043075	Web-Based	CRN Staff
Respiratory Services	DMHAS_N9699	00043435	Web-Based	CRN & CLPN
Appropriate Assessment & Documentation in Special	DMHAS_NGPOC9917	00044145	Web-Based	CMS (MD & APRN)

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

ALL WFH Staff: Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

Observation				
OP&P 1.17 Conservatorship	DMHAS_N9695	00044290	Web-based Read & Sign	CMS & CSW
OP&P 3.1 - Emergency and Involuntary Medication	DMHAS_N7171	00044289	Web-based Read & Sign	CMS
Protecting Patient Confidentiality and Information	DMHAS_ T9390	00095257	Web-Based	All Staff
Acceptable Use of State Property	DMHAS_N9693	00044821	Web-Based	All Staff
NP&P 24.12 Sharps Count of Restricted Items	DMHAS_N9692	00044849	Web-Based	CPPN, CRN & CLPN
Public Safety Orientation (DMHAS Middletown Campus)	DMHAS_N9752	00059799	Web-Based	All staff
Donning and Doffing PPE (10/14)	DMHAS_N9662	00048920	Web-Based	CRN, CLPN, CMS & CPPN
Special Medical Supply Protocol	DMHAS_N9658	00051202	Web-based Read & Sign	CRN, CLPN

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

ALL WFH Staff: Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

DSM-5: A Brief Introduction	DMHAS_ACREC117	00042260	Web-Based	CMS
DSM-5: Substance-Related and Addictive Disorders	DMHAS_ACREC118	00042261	Web-Based	CMS
WITS-Collateral Contacts	DMHAS_N9656	00051637	Web-Based	CSW
Nursing Plans of Care and Supervision of Nursing Care	DMHAS_N9618	00057131	Web-Based	CPPN, CRN & CLPN
Fluid Volume Assessment NP&P 13.2.3	DMHAS_N9780	00057548	Web-Based	CRN & CLPN
OP&P 2.28 Critical Clinical Alarm Systems	DMHAS_N9628	00058178	Web-Based	Clinical Staff
Blood Pressure & Korotkoff Sounds	DMHAS_N9610	00058602	Web-based	CPPN
Importance of Wheelchair Seat Belts (2-11-16)	DMHAS_N9609	00058668	Web- based	CPPN, CRN & CLPN
Inpatient Care of the Person with Dementia.	DMHAS_ACCL1002	00055777	Web- based	Clinical Staff
Dysphagia	DMHAS_N2536	00059291	Web-Based	CPPN, CRN, CLPN
TJC POC Treatment Planning and Documentation 2016	DMHAS_N9581	00059710	Web-Based	Clinical Staff

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

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OP&P 2.48 Guideline for Appropriate Fingernail Hygiene	DMHAS_N9579	00059718	Web-Based	Clinical Staff
Nursing Pain Assessment	DMHAS_N9578	00059789	Web-Based	CRN, CLPN
OP&P 2.49 Critical Test Results	DMHAS_N9574	00060031	Web Based	CMS, CRN, CLPN
Review of Medical Records by Court Appointed Physicians (6-1-16)	DMHAS_N9570	00060509	Web Based	CRN, CLPN, CPPN, HIM, OA'S
NP & P 13.3.5 Shaving (7/12/16)	DMHAS_N9560	00061696	Web Based	CPPN
Nursing Assessment of Physical Health Problems	DMHAS_NGPOCNUR9949	00063217	Web Based	CRN
Basics of Motivational Interviewing	DMHAS_N9802	00063350	Web Based	***Optional***
Addressing Behavioral Health Needs of Veterans (9-19-16)	DMHAS_ACREC169	00063037	Web based	CMS,CPSY, CSW, CAC
Nursing Scope of Practice & Delegation (9-27-16)	DMHAS_N9640	00063479	Web Based	CRN, CLPN
NP&P 16.2 Neurological	DMHAS_N9550	00063524	Web Based	CRN

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

ALL WFH Staff: Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

Assessment (9-30-16)				
Computerized Prebook Overtime Training (11/10/16)	DMHAS_N9539	00064201	Web Based	CRN, CLPN, CPPN Middletown Campus
Dutcher Orientation-Competencies	DMHAS_N9562	00061381	Web Based	Dutcher CRN, CLPN, CPPN
Dutcher Door Alarm System	DMHAS_N9532	00064627	Web Based	*Only for **Current** Dutcher Staff
Whiting Orientation-Competencies	DMHAS_N9559	00061796	Web based	WFD Max CRN, CPLN, CPPN
Surveyor Readiness 2017	DMHAS_N9528	00065150	Web Based	All Staff
Nursing Milieu Activities Documentation	DMHAS_N9521	00065910	Web Based	CRN, CLPN, CPPN, OA, Unit Directors
Prevention of Tubing Misconnections OP&P 2.30	DMHAS_N9629	00065972	Web Based	Clinical Staff
Preparation and Administration of Medication NP & P 23.3 (3-1-17)	DMHAS_N9520	00065967	Web Based	CRN, CLPN
Process Steps for Patient Identification for Med Administration (3-10-17)	DMHAS_N9515	00066237	Web Based	CRN, CLPN

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

ALL WFH Staff: Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

Alternative Active Treatment Interventions (3-31-17)	DMHAS_N9507	00066647	Web Based	Clinical Staff
Temporary Exception for Special Observation-Privileged Conversation	DMHAS_N9503	00067037	Web Based	Clinical Staff
Importance of Body Alarms (7-21-17)	DMHAS_N9494	00068692	Web Based	CRN, CLPN, CPPN
Nursing Review of Tx Plan & Documentation Expectations (10-17)	DMHAS_NCMS9486	00071877	Web Based	CRN
OP&P 2.11 Special Observation Reeducation	DMHAS_N9464	00074431	Web Based	CRN, CLPN, CPPN, CAC, CRT
Door Monitoring for Ligature Risks During Environmental safety Checks	DMHAS_N9460	00075290	Web Based	CRN, CLPN, CPPN
Sizewise Behavioral Health Bed Product Information (1-24-18)	DMHAS_N9463	00074995	Web Based	CRN, CLPN, CMS, CPPN
(Revision 7.0) Principles of Environmental Safety Checks (3-9-18)	DMHAS_N9458	00076632	Web Based	CRN, CLPN, CPPN

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

ALL WFH Staff: Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

Revised OP&P 5.8 Patient Safety Event and Incident Management /OP&P 5.9 Assessment and Reporting of Victims of Abuse, Neglect or Exploitation - WBT Read and Sign (3-29-18)	DMHAS_N9454	00077276	Web Based	All Staff
Property Policy and Suicide Risk	DMHAS_T9413	00092405	Web Based	Clinical Staff
WFH Policies and Guidelines Memorandum	DMHAS_T9451	00079850	Web Based	All Staff
Revised OP&P 3.1 and OP&P 3.2 Dutcher Off Grounds Supervision of Patients	DMHAS_T9435	00087972	Web Based	ALL Dutcher Staff
The Commissioner's Attendance Policy	DMHAS_T9432	00089256	Web Based	All Staff
Revisions to OP&P 1.11 Patient Searches	DMHAS_T9436	00087590	Web Based	All Staff
Identifying Immediate Risk	DMHAS_T9420	00092175	Web Based	All Staff

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

ALL WFH Staff: Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

Role Clarification for Nursing	DMHAS_T9405	00093091	Web Based	CRN, CLPN, & CPPN
Guidelines for Appropriate Dress for all Employees and Visitors.	DMHAS_T9404	00093081	Web based	All staff
The Revised Patient Transport Policy 032719	DMHAS_T9383	00096133	Web based	All Staff
Suicide Risk Using the Columbia Suicide Severity Rating Scale	DMHAS_ACWBT030	00090650	Web based	CRN & CLPN
Delirium Explained	DMHAS_T9395	00094565	Web based	CRN,CLPN,CMS
Policy& Procedure 22.2.1: Food Storage Procedures	DMHAS_T9387	00095532	Web based	Clinical Staff
Policy & Procedure 23.19 Monitoring and Reporting Of Adverse Drug Reactions	DMHAS_T9386	00095535	Web based	CRN, CLPN
Sharps Count of Restricted Items	DMHAS_T9384	00095960	Web based	Clinical Staff

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

ALL WFH Staff: Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

Environmental Hot Spots	DMHAS_T9382	00096168	Web based	All Staff
MILIEU MANAGEMENT	DMHAS_T9377	00096670	Web based	CRN, CLPN, & CPPN
THE POLICY & PROCEDURE 13.7 HAIR CARE	DMHAS_T9381	00096269	Web based	CRN, CLPN CPPN,
Evaluating and Managing Suicide Risk	DMHAS_T9378	00096403	Web based	Clinical Staff
Medication Reconciliation	DMHAS_T9379	00096316	Web based	Psychiatrists, Medical Doctors, APRNs, CRN, CLPN, and Pharmacists
The WFH Integrated Treatment Planning Process	DMHAS_T9375	00096685	Web based	Clinical Staff
Guidelines Concerning the Prohibition on Sexual or Otherwise Exploitative Relationships	DMHAS_ T9370	00097452	Web based	All Staff
Agency Compliance Code of Conduct	DMHAS_T9369	00097456	Web based	All Staff

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

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WEB-BASED TRAINING	**COURSE ID#**	**CLASS #**	**STATUS**	**FUNCTION FIELDS**
OP& P 2.6 Integrated Treatment Planning Process	DMHAS_T9421	00091910	Web-based Read & Sign	Clinical Staff
NP & P 13.4.4 CPAP (Continuous Positive Airway Pressure)	DMHAS_T9438	00086972	Web-based Read & Sign	CRN & CLPN (as needed)
NP& P 19.3 Wound Monitoring and Documentation	DMHAS_T9430	00090570	Web-based Read & Sign	CRN & CLPN
OP& P 8.34 Investigation of Alleged Violations of DMHAS Policies, Procedures, Regulations, or Work Rules	DMHAS_T9419	00091955	Web-based Read & Sign	All Staff
Reducing Patient Harm Associated with the use of Anticoagulation Therapy	DMHAS_T9418	00092019	Web-based	CPPN
Improving Safe Use Of Anticoagulant Therapy: A guide for Medical Staff, Pharmacists, Dieticians and Nurses	DMHAS_T9417	00092051	Web-based	CMS, CRN, CLPN, Dietician & Pharmacist
OP & P 7.15 Allowable Patient Property	DMHAS_T9388	00095304	Web- based	Clinical Staff
NP&P 12.3 Automated External Defibrillator (AED)	DMHAS_T9406	00093925	Web- based	CRN & CLPN

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

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Engagement Progress Note	DMHAS_T9391	00095164	Web- based	CRN,CLPN & CPPN
Property Policy and Suicide Risk	DMHAS_T9413	00092405	Web- based	Clinical Staff
The Use of Weighted Modalties	DMHAS_T9390	00095257	Web- based	Clinical Staff
Procedure 2.35 Patient Identification	DMHAS_T9368	00097551	Web- based	Clinical Staff
Medication Safety Events	DMHAS_T9367	00097782	Web-Based	CRN, CLPN & Pharmacy Staff
Nursing Implications from a Serious Medication Event	DMHAS_T9353	00100012	Web-Based	CRN & CLPN
Nursing Provision & Supervision of Care and Treatment Planning	DMHAS_T9352	00100015	Web-Based	CRN, CLPN, & CPPN
NP&P 6.5 Clinical Assessment of the Patient	DMHAS_T9351	00100018	Web-Based	CRN
Admission & Transfer Procedure Between CVH \ WFH & Middlesex Hospital	DMHAS_T9349	00100058	Web-Based	CRN Staff
Respiratory Services	DMHAS_T9348	00100079	Web-Based	CRN & CLPN
Appropriate Assessment & Documentation in Special Observation	DMHAS_T9347	00100081	Web-Based	CMS (MD & APRN)

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

<u>ALL WFH Staff:</u> Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

OP&P 1.17 Conservatorship	DMHAS_T9346	00100083	Web-based Read & Sign	CMS & CSW
OP&P 3.1 - Emergency and Involuntary Medication	DMHAS_T9345	00100084	Web-based Read & Sign	CMS
Protecting Patient Confidentiality and Information	DMHAS_T9449	00080430	Web-Based	All Staff
Acceptable Use of State Property	DMHAS_N9693	00044821	Web-Based	All Staff
Sharps Count of Restricted Items	DMHAS_T9356	00099534	Web-Based	All Staff
Public Safety Orientation (DMHAS Middletown Campus)	DMHAS_N9752	00059799	Web-Based	All staff
Donning and Doffing PPE (10/14)	DMHAS_N9662	00048920	Web-Based	CRN, CLPN, CMS & CPPN
Special Medical Supply Protocol	DMHAS_N9658	00051202	Web-based Read & Sign	CRN, CLPN
DSM-5: A Brief Introduction	DMHAS_ACREC117	00042260	Web-Based	CMS
DSM-5: Substance-Related and Addictive Disorders	DMHAS_ACREC118	00042261	Web-Based	CMS
WITS-Collateral Contacts	DMHAS_N9656	00051637	Web-Based	CSW

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

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Nursing Plans of Care and Supervision of Nursing Care	DMHAS_N9618	00057131	Web-Based	CPPN, CRN & CLPN
Fluid Volume Assessment NP&P 13.2.3	DMHAS_N9780	00057548	Web-Based	CRN & CLPN
OP&P 2.28 Critical Clinical Alarm Systems	DMHAS_N9628	00058178	Web-Based	Clinical Staff
Blood Pressure & Korotkoff Sounds	DMHAS_N9610	00058602	Web-based	CPPN
Importance of Wheelchair Seat Belts (2-11-16)	DMHAS_N9609	00058668	Web- based	CPPN, CRN & CLPN
Inpatient Care of the Person with Dementia.	DMHAS_ACCL1002	00055777	Web- based	Clinical Staff
Dysphagia	DMHAS_N2536	00059291	Web-Based	CPPN, CRN, CLPN
TJC POC Treatment Planning and Documentation 2016	DMHAS_N9581	00059710	Web-Based	Clinical Staff
OP&P 2.48 Guideline for Appropriate Fingernail Hygiene	DMHAS_N9579	00059718	Web-Based	Clinical Staff
Nursing Pain Assessment	DMHAS_N9578	00059789	Web-Based	CRN, CLPN
OP&P 2.49 Critical Test Results	DMHAS_N9574	00060031	Web Based	CMS, CRN, CLPN
Review of Medical Records by Court Appointed Physicians (6-1-16)	DMHAS_N9570	00060509	Web Based	CRN, CLPN, CPPN, HIM, OA'S

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

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NP & P 13.3.5 Shaving (7/12/16)	DMHAS_N9560	00061696	Web Based	CPPN
Nursing Assessment of Physical Health Problems	DMHAS_NGPOCNUR9949	00063217	Web Based	CRN
Basics of Motivational Interviewing	DMHAS_N9802	00063350	Web Based	*Optional*
Addressing Behavioral Health Needs of Veterans (9-19-16)	DMHAS_ACREC169	00063037	Web based	CMS,CPSY, CSW, CAC
Nursing Scope of Practice & Delegation (9-27-16)	DMHAS_N9640	00063479	Web Based	CRN, CLPN
NP&P 16.2 Neurological Assessment (9-30-16)	DMHAS_N9550	00063524	Web Based	CRN
Computerized Prebook Overtime Training (11/10/16)	DMHAS_N9539	00064201	Web Based	CRN, CLPN, CPPN Middletown Campus
Dutcher Orientation-Competencies	DMHAS_N9562	00061381	Web Based	Dutcher CRN, CLPN, CPPN
Dutcher Door Alarm System	DMHAS_N9532	00064627	Web Based	*Only for <u>Current</u> Dutcher Staff
Whiting Orientation-Competencies	DMHAS_N9559	00061796	Web based	WFD Max CRN, CPLN, CPPN
Surveyor Readiness 2017	DMHAS_N9528	00065150	Web Based	All Staff
Nursing Milieu Activities Documentation	DMHAS_N9521	00065910	Web Based	CRN, CLPN, CPPN, OA, Unit Directors
Prevention of Tubing Misconnections OP&P 2.30	DMHAS_N9629	00065972	Web Based	Clinical Staff

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

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Preparation and Administration of Medication NP & P 23.3 (3-1-17)	DMHAS_N9520	00065967	Web Based	CRN, CLPN
Process Steps for Patient Identification for Med Administration (3-10-17)	DMHAS_N9515	00066237	Web Based	CRN, CLPN
Alternative Active Treatment Interventions (3-31-17)	DMHAS_N9507	00066647	Web Based	Clinical Staff
Temporary Exception for Special Observation- Privileged Conversation	DMHAS_N9503	00067037	Web Based	Clinical Staff
Importance of Body Alarms (7-21-17)	DMHAS_N9494	00068692	Web Based	CRN, CLPN, CPPN
Nursing Review of Tx Plan & Documentation Expectations (10-17)	DMHAS_NCMS9486	00071877	Web Based	CRN
OP&P 2.11 Special Observation Reeducation	DMHAS_N9464	00074431	Web Based	CRN, CLPN, CPPN, CAC, CRT
Door Monitoring for Ligature Risks During Environmental safety Checks	DMHAS_N9460	00075290	Web Based	CRN, CLPN, CPPN
Sizewise Behavioral Health Bed Product Information (1-24-18)	DMHAS_N9463	00074995	Web Based	CRN, CLPN, CMS, CPPN
(Revision 7.0) Principles of Environmental Safety Checks (3-9-18)	DMHAS_N9458	00076632	Web Based	CRN, CLPN, CPPN
Revised OP&P 5.8 Patient Safety Event and Incident Management /OP&P 5.9 Assessment and Reporting of Victims of Abuse, Neglect or Exploitation - WBT Read and	DMHAS_N9454	00077276	Web Based	All Staff

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Sign (3-29-18)				
WFH Policies and Guidelines Memorandum	DMHAS_T9451	00079850	Web Based	All Staff
Revised OP&P 3.1 and OP&P 3.2 Dutcher Off Grounds Supervision of Patients	DMHAS_T9435	00087972	Web Based	ALL Dutcher Staff
Revisions to OP&P 1.11 Patient Searches	DMHAS_T9436	00087590	Web Based	All Staff
Guidelines for Appropriate Dress for all Employees and Visitors.	DMHAS_T9404	00093081	Web based	All staff
The Transport and Assessment Risk Policy 071819	DMHAS_T9354	00099948	Web based	All Staff
Suicide Risk Using the Columbia Suicide Severity Rating Scale	DMHAS_ACWBT030	00090650	Web based	CRN & CLPN
Delirium Explained	DMHAS_T9395	00094565	Web based	CRN,CLPN,CMS
Policy& Procedure 22.2.1: Food Storage Procedures	DMHAS_T9387	00095532	Web based	Clinical Staff
Policy & Procedure 23.19 Monitoring and Reporting Of Adverse Drug Reactions	DMHAS_T9386	00095535	Web based	CRN, CLPN
Environmental Hot Spots	DMHAS_T9382	00096168	Web based	All Staff

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ALL WFH Staff: Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

THE POLICY & PROCEDURE 13.7 HAIR CARE	DMHAS_T9381	00096269	Web based	CRN, CLPN CPPN,
Evaluating and Managing Suicide Risk	DMHAS_T9342	00100544	Web based	Clinical Staff
Medication Reconciliation	DMHAS_T9379	00096316	Web based	Psychiatrists, Medical Doctors, APRNs, CRN, CLPN, and Pharmacists
The WFH Integrated Treatment Planning Process	DMHAS_T9375	00096685	Web based	Clinical Staff
Guidelines Concerning the Prohibition on Sexual or Otherwise Exploitative Relationships	DMHAS_ T9370	00097452	Web based	All Staff
Agency Compliance Code of Conduct	DMHAS_T9369	00097456	Web based	All Staff
Erik Erikson's Stages of Development (annual and mandatory)WBT	DMHAS_T9363	00098899	Web based	Clinical staff
MILIEU MANAGEMENT-Revised	DMHAS_T9359	00099040	Web based	CRN, CLPN CPPN
Outpatient and Emergency Visits to Acute Care Hospitals, Staff Expectations and Responsibilities-Revised	DMHAS_T9358	00099041	Web based	CRN, CLPN CPPN, CMS, APRN and Police
Assessment of Fall Risk and Falls Revised	DMHAS_T9350	00100057	Web based	All Staff
Role Clarification for Nursing	DMHAS_T9405	00093091	Web based	CRN, CLPN

Whiting Forensic Hospital - MANDATORY (One Time) WEB-BASED TRAINING

<u>ALL WFH Staff:</u> Any references to CVH mentioned in the web based trainings are to be replaced with WFH (i.e. policies & procedures, etc.)

Verbal De-escalation	DMHAS_T9372	00098093	Web based	All staff
Antimicrobial Stewardship Why the Imperative?	DMHAS_T9357	00099084	Web based	All staff except CPPN and Nondirect
Assessment and Management of Pain	DMHAS_T9362	00098954	Web based	All staff except CPPN and Nondirect

Dutcher-MHA

Division-Based Orientation Competency Checklist

NAME: _____

EMPLOYEE ID#: _____

UNIT ASSIGNED: _____

ASSIGNED SHIFT: _____

Dutcher/DS2 MHA Orientation Information

While on orientation, the new Mental Health Assistant employee will report to the nursing supervisor. Someone from Staff Development will speak with you throughout your on unit orientation. Please report to the **Dutcher Nursing Supervisor if you need assistance during your orientation.**

Breaks- while in and upon completion of orientation, you are allowed thirty minutes for mealtime and two fifteen minute breaks (not allowed to combine all breaks and leave early).

Keys/ID badge- Your Division Education Coordinator will get you your Dutcher and Battell pass keys prior to your orientation on the units. If you come to work and happen to forget your pass keys, you can sign out a pass key for the shift from the Dutcher Nursing Support office.
Lost pass keys need to be reported immediately and there is a charge for obtaining new keys.
If you come to work and forget your ID badge, you can obtain a temporary ID for the shift from the WFH Police **(262-5555).**

When you are assigned to a patient care area, always report to the charge person (Nurse/Mental Health Assistant 2) upon arrival to the unit and whenever you depart from your designated work area.

Paychecks –Paychecks are distributed Bi-weekly on Thursday, beginning at 3:00 pm. Dutcher staff can get their paychecks in the Dutcher Lobby. After that time, checks may be obtained through the Dutcher Nursing Support Office or the Dutcher Nursing Supervisor.

Emergencies- all employees are responsible for knowing the medical, fire and psychiatric emergency procedures for each clinical area (Dutcher Forensic Service and Page Hall) along with knowing the location and how to use required equipment.

Entering/Exiting- not all doors lock automatically when closed. You must always lock the door with your key. Assure the door is closed behind you when you swipe your ID to enter/exit. If you have problems with entrance/exit access, call the WFH police anytime at **262-5555.**

Personal items- employees are responsible for knowing what items are considered unsafe for the patient care areas. All personal items are to be locked in designated staff areas. Never leave personal items in patient areas. Nurses, personal Items are not to be stored in the Medication Room.

Employee Identification- all employees are required to wear their Identification badge in the work site. If you forget your Identification Badge, you may obtain a temporary ID form the WFH Police department in Shew Hall **(**phone number **262-5555).** Lost badges will be replaced by WFH police with a designated fee.

Employee number- all employees are required to know their employee number (suggestion, write your employee number on the back of your badge).

Union- state employees are under Collective Bargaining. Refer to the New England Health Care Union, District 1199 NP-6 contract.

Orientation Schedule- during orientation to the Dutcher units, you will work Monday through Friday and have State holidays off. You will be given an orientation schedule of your assigned duties and classes.

Job Description- all units have a specific unit job description, please speak with your Unit Director or Human Resources to provide you with your unit specific job description since your performance appraisals will be done based on your unit specific job description.

Sign and Sign Out Procedures for Dutcher Patients

Periodically a patient does not call the treatment unit on time for his/her hourly call-in from a work assignment or other activity. Other times, a patient will not return to the treatment unit and sign in on time from work, a group, or a grounds pass. In some of these instances the patient has not failed to follow the proper procedure, rather other factors have contributed to the apparent lateness.

(1) Time Errors. Often what has caused or contributed to a patient calling late or returning to the unit late is that the time on the patient's watch and/or the time on the wall clock at their work site does not match the time on the treatment unit's clock.

What would help prevent such problems is if the time of day on the clocks/watches that are used by unit staff, patients, and work site supervisors was coordinated and the same for everyone.

Therefore, to help avoid such problems, **effective** immediately the following procedure is to be implemented by all Dutcher staff and treatment units; and it is recommended that a similar procedure be used by work supervisors at the Page Hall library.

(1) Each treatment unit will make a specific assignment for a unit staff member on nights to compare the time shown on the unit computers with the time shown on the unit wall clock/clocks that staff and patients use; if the wall clocks do not show the exact same time as on the unit computers, the assigned staff will correct the wall clocks so that they do match the time on the computers. This check is to be conducted each night at or shortly after 12:00 midnight.

2) Unit staff will regularly remind all patients to check and adjust their watches to match the time on the (now accurate and coordinated) unit clock before signing out.

(3) Similarly, work site supervisors should check and ensure that the time on the clocks patients and staff use at their work sites have the same time as that on the computers in the staff office. This check could be conducted each morning at the beginning of the work day.

(2) Sign-Out Issues. Another factor that contributes to problems is that patients often are not signing out properly. When patients sign out on the "On Grounds Sign-Out Sign-In Sheet" to go to work, a group, or to use their grounds passes, for the "Time Out" they are to put the *actual time they are signing out* and ***not*** the time that the job, group, or grounds pass begins (e.g., they might put 8:50 for a job or group that starts at 9:00 a.m. in Page Hall).

Similarly, and more importantly, for the "Time Due In" patients should *not* put the time the job or group ends (e.g., 11:00 a.m.), they should put a Due-In time that *includes the travel time they are allowed* to return to the treatment unit (e.g., 11:05 for a Dutcher job/group; 11:10 for a Page Hall job/group; or 11:15 for a job at the

greenhouse. For grounds passes the “Time Due In” should be exactly on the hour (except for the 2:00 to 2:45 p.m. pass time), but for most jobs or groups the "Time Due In" will not be exactly on the hour. Further, when staff initial the Sign-Out sheet after the patient has signed out, it is their responsibility to check and ensure that the patient signed out correctly, including legibly writing their names and putting the correct time they are signing out, as described above.

(3) Call-In Issues. Another factor that sometimes causes problems is confusion about the procedure for patients calling in at the end of their scheduled work assignment, specifically, expecting patients to call in at the end of their scheduled work assignment within 10 minutes before the hour. At the end of their scheduled work shifts, patients are *not* supposed to call the treatment unit, the work supervisor calls at the end of the work shift to inform the unit that the patient is leaving the work site to return to the unit. Therefore, for a job that ends at 2:00 p.m., the patient does *not* call between 1:50 and 2:00, the work supervisor calls at 2:00 p.m. (+/–), and then the patient has the approved time for travel back to the treatment unit. If the patients signed out correctly, unit staff should know when patients are at the end of their scheduled work shifts and that unit staff will not get a call until the work supervisor calls to say the patient is leaving the work site to return to the treatment unit.

GENERAL SAFETY TIPS

Do not enter a patient's room by yourself for any reason (such as a medical emergency, psychiatric emergency) -- get help first.

- **If you have to take a chart off the unit- sign it out by filling out the form and place in the patient's slot.**

- **Patients are not to be in the nursing station at any time for any reason.**

- **If you are meeting with a patient, you need to let staff know what patient you are meeting with, location and an approximate duration of your planned meeting. Under no circumstances are you to meet with a patient without appraising the unit staff or to take a patient off the unit for a meeting- this is for your own personal safety.**

- **You should never meet with a patient in the patient's own room -- this is not safe. Although space is limited, choose a safe location, treatment room/dinning room and inform staff where and for how long you intend to meet with the patient.**

- **When you meet with a patient- make sure you are close by the phone and or the code button.**

- **Code Buttons are only to be used for psychiatric emergency, *not medical or fire situation.***

- **You are responsible for knowing the location of all emergency equipment and use in an emergency including Medical Emergency, Psychiatric Emergency and Fire Safety Procedure.**

- **The Emergency Cart is located in all the Treatment rooms on all the units in Dutcher , in the basement just outside the Dutcher kitchen and one just outside of DS1.**

- **Do not let patients carry their own chart when you are escorting the patient to a scheduled appointment, this is not the patient responsibility, but staff responsibility.**

- **If you lose your keys, you need to immediately notify your supervisor, and fill out an Incident Report. A fee will be charged to have your keys replaced.**

- **Do not throw personal items in the patient garbage. *Discard in staff, not patient trash.***

MHA /MHA 2 shifts are as follows:

First Shift: 7:00am – 3:30 pm
Second Shift: 3:00 pm – 11:30 pm
Third Shift: 11:15 pm – 7:15 am

All employees reporting on their designated shift need to sign in the book located in the lobby at the start of shift and check the shift assignment for their assigned unit. Employees are required to report to their unit on time prior to shift start. Late slips will be given by the Nurse Supervisor for employees who do not report on time.

If the employee is running late or calling out, you need to call the Nurse Supervisor. You may not leave a message on the answering machine.

The Nurse Supervisors (RNS) are as follows:

First Shift:	***Second Shift:***	***Third Shift:***
Debra Corcoran, RNS Licelia Levy RNS	Althea Clarke, RNS	Rich Barbieri, RN Marie Cosgrove RN

The Nurse Supervisors office number: (860) 262- 6237 **(860) 262-6253**	**Nursing Support Office** ***(provide scheduling, payroll, overtime pre-booking, time off, etc)*** **Kyle Vontz** **(860) 262-6242**

If you are unable to reach the Dutcher RNS in the office, have the Dutcher RNS paged through the Whiting Forensic Hospital Operator by calling **(860) 262- 5000**

Unit and tele. #	Unit Director and tele. #
D3S **6275/6216**	**Elizabeth Brayshaw, SW, 6575**
DS1 **5961 / 5960**	**Raymond Gentile,RN 5797**
DS2 **5621**	**Carol Knight, SW 5417**
DN2 **6272 / 6270**	**Karen Graff SW 6894**
DN3 **6273 / 6258**	**Charlotte Stanley SW,5482**

SPECIFIC
UNIT BASED
COMPETENCIES

It is your responsibility to provide the Staff you are orienting with an Evaluation Form for each shift that you spend on orientation.

Once completed please put in the mailbox of the person coordinating your orientation.

Please do not hold on to them and wait to submit them, they provide important information and feedback that helps identify any experiences that we need to provide for you or areas that you need to work on during your clinical orientation.

DUTCHER FORENSIC SERVICE/DUTCHER S2
UNIT BASED ORIENTATION

Nursing Orientation Competency Skill List for MHA

The supervising staff must review all listed items with the orientee in the clinical area. Signature indicates that the orientee understands, can demonstrate, and is able to clinically apply all items below to the patient care areas. The orientee should also able to identify his/her role as it applies to each of these areas. Send completed form to WFD Orientation Coordinator.

Employee Name	**Employee Number**	**Program Unit**	**Start Date**	
Topic			**Lead's initials**	**Employee Initials**
Introduction to Dutcher Service & Dutcher S2:				
Organizational Structure of Whiting Forensic Division				
Mission and Goals				
Use of ID badge to get in and out of building				
Overview of roles/responsibilities of MHA:				
Roles/Decision Making Process/Chain of Command				
Introductions to staff/patients				
Patient Population				
Legal Status of Patients				
Intra and Inter-shift communication and Shift Report				
Patient Identification				
PNT Notes				
Other documentation requirements				
Job Description (Reviewed by Nursing Supervisor/Unit Director)				
• Detailed Explanation of job description and expectations				
• Explain why job important/how it relates to others in organization				
• Discuss common problems and how to avoid them				
• Performance appraisals				
Working Conditions (Reviewed by Nursing Support Office)				
• Sign in on Duty Procedure /Shift assignments				
• Staffing Levels				
• Hours of work/Time sheets/Rotation Schedule/ Comp time/ Late slips				
			Lead's Initials	**Employee Initials**

• Request for time off//Leave requests/Vacation/ Unauthorized leave		
• Call- in process (cannot leave a phone message- need to speak with a person directly)		
• Meals/Breaks		
• Payday procedures/Time Sheets/Paycheck pick-up		
• Voluntary Overtime/Mandatory Overtime/ Shift pre-booking process		
• Leave time/early closing- late opening		
Tour of Dutcher Unit (s), Location and use of:		
Police Sub-Station, Treatment Mall, Dining Room, Medical Records, Pharmacy, Physical Therapy, Activity Room, Mail, Ambulance Entrance, Admission Area, Parking, Courtyard		
Work space / Equipment/Tools/Supplies		
Materials storage/supplies/files/forms		
Break room/kitchen/coffee/vending machines		
Coat closet/restrooms/ Staff Lockers		
Phones/messages/mail/copier/fax machines		
Psychiatric code buttons/Panic and body alarm use		
State Cell phones/sign out / State vehicles (to transport patients)		
Medication Rooms/Treatment Rooms		
Seclusion, Restraint Rooms, and Restraints and Restraint key		
Tour of DN1 Unit/Building & Location and use of:		
Parking, Dining Room, Courtyard, Rooftop		
Work space / Equipment/Tools/Supplies		
Materials storage/supplies/files/forms		
Break room/kitchen/coffee/vending machines		
Coat closet/restrooms/ Staff Lockers		
Medication/quiet/restraint-seclusion rooms		
Psychiatric code buttons/ Panic and body alarm use		
Pressure Sensitive Door Alarm		
Patient Visiting Room		
Medication Rooms/Treatment Rooms		
Restraint, Seclusion Rooms-Restraints & Restraint Keys		
Daily Shift Assignment/ Unit Assignment/ Staff Schedules		
• Unit Assignment/sign in procedure		
• Staff Assignment sheet		
• Unit Tasks/routines		
• Patient assignment sheets		
• Patient sign out/in sheet		
• Meal Breaks		
	Lead's Initials	**Employee Initials**

• Reporting to MHA 2/ charge nurse		
• Change of Shift Report/24 hour report sheet		
• Nursing Report and Change of Shift Procedure		
• Patient assignment sheets		
• Patient sign out/in sheet		
• Medication Pass: Bring/Call patient to med room. Provide patient identification for Float nurses and other nurses as needed, minimize distractions at med room door, encourage patient's cooperation with medication including encouraging mouth checks to be performed by nurse.		
Fire/Safety Regulations and Locations in Dutcher		
• Fire Stations		
• Fire and Emergency Exits		
• Fire Extinguishers		
• Roles/ Responsibilities/Evacuation procedure		
Fire/Safety Regulations and Locations in DN1		
• Fire Stations		
• Fire Exits		
• Fire Extinguishers		
Freedom of Movement/ Dutcher		
• Privilege Levels and Procedures/ Request to Meet with Team Form		
• Weekly Levels Meeting		
• Privilege Recommendation Form to (Dutcher Risk Management Committee)		
• Privilege Recommendation Form to (WFH Forensic Review Committee)		
• Criteria Guidelines for Privilege Levels		
• Privilege Levels and Escort/Supervision Ratios		
• Dutcher Treatment Mall Supervision		
• Transportation Requirements /Cell Phone Procedures		
• Page Hall Treatment Mall Supervision		
• Restriction of Privileges		
• Patient Status Change Report		
• Access to Outdoor/Fresh Air/ Curfew		
• Level Hold and Review		
• Escorting Patients to and from appointments		
Freedom of Movement/ DS2		
• Privilege Levels and Procedures/ Request to Meet with Team Form		
• Weekly Levels Meeting		
• Criteria Guidelines for Privilege Levels		
• Privilege Levels and Escort/Supervision Ratios		
• Page Hall Treatment Mall Supervision		
• Restriction of Privileges		
• Patient Status Change Report		
• Access to Outdoor/Fresh Air/ Curfew		

• Criteria Guidelines for Privilege Levels		
• Level Hold and Review		
• Escorting Patients to and from appointments		
	Lead's Initials	**Employee Initials**
• Daily Census Movement		
• Building and Courtyard Activities		
Patient Treatment Services		
• Treatment Planning/ Collaboration with Community Providers/Families and Significant Others		
• Dutcher Treatment Mall		
• Page Hall Treatment Mall		
• Vocational Rehabilitation Assessment &Planning		
• Work Assignment Considerations		
• Patient Work Program-Treatment Unit Responsibilities		
• Building and Courtyard Activities		
• On- Grounds Treatment Activities and Forms		
• Off-Grounds Treatment Activities and Forms		
• Community Activities Form		
• Weekly Community Trips/Dutcher Form		
• Patient Clothing Description Form		
• Patient Profiles/Profile Bags		
Infection Control Measures		
• Types of Precautions		
• Hand washing		
• Personal Protective Equipment		
• Location of Isolation Room		
• Care of Patients with and Infection/ Transporting Patients		
• Medical Supplies (ordering/delivery/checking)		
• Food Storage Procedures/Checking of Refrigerator Temperatures		
• Refrigeration Maintenance Procedures		
• Employee Health Service		
• Equipment Cleaning		
• Hazardous Waste		
Risk Management		
• Custody/Supervision of Patients at a Community General Hospital		
• PSRB Patient Use of Temporary Leaves (TL)		
• Compliance with PSRB TL Orders		
• Temporary Leave Call-Ins		
• Transport of Patients on (TL) by WFH Staff		
• Transportation of Patients on TL by Community Agency Staff		
• Supervision of Patients on TL at Community Programs		
• Civil Patients: Visits/Leaves of Absence		

• AWOL Risk		
• Patient Searches		
• Incident Report (complete)		
	Lead's initials	**Employee Initials**
Psychiatric Interventions and Special Procedures		
• Voluntary time out procedure and documentation		
• Psychiatric Emergency Code ("All Available")		
• Silent Code Procedure		
• Response to a psychiatric emergency		
• Location of psychiatric code buttons and belt packs		
• Paging System		
• Roles and responsibilities of staff- Team Leader		
• BMS/De-escalation strategies		
• Documentation/Care of the Patient		
Restraint and Seclusion Procedures		
• Unlocked and locked seclusion procedure, paperwork, assessment, monitoring of patient and documentation		
• Restraint policy and procedure		
• Seclusion/Restraint Form WFH- 480 a-c		
• Notifications/ Documentation/ Care of the patient		
• Patient/Staff Debriefing following a restraint/seclusion		
Levels of Observation		
Routine observations/Census Monitoring		
Special Observations: Continuous, 15 minute checks/1:1 Obs.		
Documentation		
Special Observation Flow Sheet		
Special Observation Communication Tool		
Emergency Procedures		
• Paging (calling Telecommunication Operator) - announcement		
• Medical Emergency procedure		
• Emergency Cart- Locations:		
Dutcher		
DN1		
• Oxygen-Location		
Dutcher		
DN1		
• Automated External Defibrillator (AED) Locations:		
Dutcher		
DN1		
• Documentation of Medical Emergency		
Examinations and Special Tests		
• Specimen Collection and Storage		

• Patient Scheduled Health Care Appointments WFH- 543- documentation		
• Chain of Custody Urine Collection (COC) - documentation		
• Routine blood work/lab slips/documentation/notifications		
	Lead's Initials	**Employee Initials**
Admission/Transfers/Discharge		
• Admission of the Patient-MHA roles and responsibilities		
• Patient Personal Safety Preference and (WFH 469)		
• Suicide Risk Assessment and Management (reporting, documenting and assuring patient safety)		
• Clinical Assessment of Patient (Mental Status Evaluation)		
• Assessment/Management and documentation of Pain		
• Fall Risk Screening Assessment and Management/Reporting		
• Voluntary transfers		
• Non-Voluntary transfers		
• Transfers to Dutcher from Whiting Service		
• Transfers to Dutcher from GPD		
• Transfers to other units within Dutcher		
• Transfer procedures to other services (ASD/GPD)		
• Conditional Release Application & Community Provider Approval Form		
• Discharge Planning process		
• Conditional Release and Discharge of PSRB patients		
• Discharge of Civil Patients		
Medication Policies and Procedures		
• Daily Patient Medication Procedure and MHA responsibility		
• Patient Identification Procedure		
• Needle Syringe Disposal		
• Emergency and Involuntary Medication (Patient Management)		
• Reporting of Patient Medical Concerns		
Patient Assessment		
• Suicide reporting and documentation		
• Clinical assessment of patient prior to leaving the unit		
• Demonstration of Vital Signs (3 times)		
Support Services		
• Patient Accounts		
• Mail Services		
• Visitation		
• Health Care Services		
• Release of Responsibility of Minor Children		
• Health Care Services		
Performance Improvement		
• Management of Environment of Care (MEC)		
• Unit Specific Indicators		

• Roe v. Hogan agreement monitoring program		
• Compliance with PSRB and TL orders		
• PSRB hearings		
	Lead's Initials	**Employee Initials**
Safety and Security Policies and Procedures		
• Patient Identification System: Badges		
• Whiting Agency Police: Dutcher Substation		
• Building Entry/Exit by authorized staff		
• Building Entry/Exit by Patients		
• Building Entry/Exit by Visitors and Community Providers		
• Courtyard Security		
• Screening of incoming packages		
• Unit based sharp count		

I confirm that I demonstrated competence in the above skills. Orientee Signature:
I confirm that this employee demonstrated competence in the above skills. MHA Lead
I have reviewed this document and agree with this assessment. Nurse Supervisor:

WHITING FORENSIC HOSPITAL

Mental Health Assistant and Forensic Treatment Specialist
Performance Evaluation while in Orientation

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16. Follows work rules				

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WHITING FORENSIC HOSPITAL

NEW EMPLOYEE ORIENTATION

EVALUATION

After orientation, please answer the following questions. Your responses will remain anonymous, only collated/trended data will be shared with appropriate persons for the purpose of improvement of the program; therefore, please be as honest and thorough as possible.

Use the following scale when answering the following questions:

1=Strongly Agree
2=Agree
3=Neutral
4=Disagree*
5=Strongly Disagree* *Any Score of 4 or 5 please provide a comment.

I. RN/MHA Orientation Classes

	Strongly Agree				**Strongly Disagree**
1. Class content was applicable to your practice.	1	2	3	4	5

Comments:

2. Class content was not redundant with general orientation content.	1	2	3	4	5

Comments:

3. The computer training class met my needs.	1	2	3	4	5

Comments:

4. The length of time in general orientation classes was sufficient.	1	2	3	4	5

Comments:

5. The instructors were knowledgeable, approachable, & able to answer questions.	1	2	3	4	5

Comments:

6. The class materials were useful. 1 2 3 4 5

Comments:

7. The audiovisuals enhanced the learning experience. 1 2 3 4 5

Comments:

II. <u>Unit Orientation</u>

1. The unit-based orientation program was well organized. 1 2 3 4 5

Comments:

2. The length of the unit-based orientation was appropriate to prepare me to function independently. 1 2 3 4 5

Comments:

3. There was ample time for discussion and follow-up. 1 2 3 4 5

Comments:

4. The transition between orientation to regular shift went well. 1 2 3 4 5

Comments:

5. The teaching tools (e.g. manuals, articles, practice equipment, quick look guides etc.) were effective. 1 2 3 4 5

Comments:

6. The skills list was effective in facilitating the orientation process. 1 2 3 4 5

Comments:

7. Expectations were realistic and minimum for my work area. 1 2 3 4 5

Comments:

III. <u>Division Educator</u>

1. Introduced me to the unit resources (staff & materials). 1 2 3 4 5

Comments

2. Clearly communicated performance expectations to me. 1 2 3 4 5

Comments:

3. Assessed my learning needs and assisted me in developing weekly goals that were mutually agreed upon. 1 2 3 4 5

Comments:

4. Used a variety of education resources to meet my learning needs. 1 2 3 4 5

Comments:

5. Used effective communication techniques. 1 2 3 4 5

Comments:

6. Provided both positive and constructive feedback. 1 2 3 4 5

Comments:

7. Was approachable when questions arose. 1 2 3 4 5

Comments:

8. Was receptive and accommodating to my input. 1 2 3 4 5

Comments:

9. Provided adequate and appropriate supervision and support. 1 2 3 4 5

Comments:

10. Provided consistent information. 1 2 3 4 5

Comments:

11. Served as a positive and professional role model. 1 2 3 4 5

Comments:

IV. <u>The Unit Staff</u>

1. Assessed my learning needs and developed goals that were mutual. 1 2 3 4 5

Comments:

2. Was approachable when questions arose. 1 2 3 4 5

Comments:

3. Provided both positive and constructive feedback. 1 2 3 4 5

Comments:

4. Used effective communication techniques. 1 2 3 4 5

Comments:

5. Served as a positive and professional role model. 1 2 3 4 5

Comments:

6. Provided adequate and appropriate supervision and support. 1 2 3 4 5

Comments:

7. Provided a schedule that was coincident with my preceptor (applicable) 1 2 3 4 5

Comments:

GENERAL COMMENTS:

1. What did you like **most** about the orientation program?

2. What did you like **least** about the orientation program?

3. What suggestions do you have for improvement of the program?

Name (optional): _____ Date:_____

Fax to Staff Development: 860-706-1494

Whiting Forensic Hospital

Forensic Treatment Specialist

Whiting Building **Competency Checklist**

NAME: _____

EMPLOYEE ID#: _____

UNIT ASSIGNED: _____

ASSIGNED SHIFT: _____

Unit *dial (860)262-*	**Unit Function**	**Unit Directors** *dial (860)262-*
Unit 1 5401	Acute Admissions Diagnostic/Restoration	**Nancy Bertulis , LCSW** 5483
Unit 2 5402	Acute Admissions Diagnostic/Restoration	**Frank Valdez, LCSW** 5488
Unit 3 5403	Acute Admissions Diagnostic/Restoration	**Ninnette Rawlinitis, LCSW** 5452
Unit 4 5404	Extended Treatment Program	**Vito Iallonardo ,LCSW** 5490
Unit 6 5406	Social Learning Program	**Peter ("Burt") Henry, LCSW** 5435

Staff shifts are as follows:	
First Shift	**06: 45 am – 3:15 pm**
Second Shift	**2:45 pm – 11:15 pm**
Third Shift	**10:45 pm – 07:15 am**

- **Employees will be allowed to enter the clinical area at fifteen (15) minutes before the start of shift.**
- **Employees are expected to be on time for the assigned shift.**
- **If the employee is running late or calling out, you need to call the Nurse Supervisor.**

***You *cannot* leave a message on the answering machine**

The Nurse Supervisors office number is (860) 262- 5448

First Shift:	***Second Shift:***	***Third Shift:***
Tahisha Waugh, RNS Tracy Cummings, RNS	Brenda Bartnicki, RNS Paul Guitard, RNS	John Vallejo, RNS

If you are unable to reach the RNS in the office, have the RNS paged through the Whiting Forensic Hospital Operator by calling
(860) 262- 5000
Or
Whiting Agency Police
(860) 262-5400

SPECIFIC UNIT BASED COMPETENCIES

While on my Division-Based Orientation the orientee is expected to perform the following:

- **Each shift the orientee will bring my Division-Based Orientation packet to his/her assigned work area with them.**
- **During each orientation shift the orientee will work on completing the competency checklist items outlined by the Division-Based Checklist. The orientee's understanding and/or demonstration of each competency item will be confirmed by two sets of initials: the initials of the individual responsible for explaining the competency, along with the orientee's initials verbalizing and/or demonstrating the competency.**
- **A shift evaluation must be completed for each shift the orientee works, along with the signatures of the following individuals:**
    - **the individual responsible for orienting**
    - **the orientee (you)**
    - **the Head (Charge) Nurse for that respective shift**
    - **the RN Supervisor**

Upon beginning your orientation on the units you be provided an orientation schedule that will outline the days and times you are to report for duty. It is your responsibility to ensure that the Division-Based Orientation packet is completed in its entirety; this includes the initials/signatures of ALL required parties as outlined in this document.

You have until the end of the orientation schedule provided to complete the Division-Based Orientation packet. Be aware that failure to complete the Division-Based Orientation packet may result in progressive discipline against you.

Orientation Checklist – Must be completed during unit based orientation

TOPIC		Orientee Initials	Reviewing Staff Name & Title
Whiting Police Processing and Orientation to the Building *(Orienting Agency Police Officer to Initial)*			
• I.D. Badge • Employee Key Access • Locking of Doors • Prohibited Items • Packages/Containers • Entering & Exiting Secured Area • Main Security Gates • Emergency Responses • Incident Reports: Police Statement Taking and Investigations • Video Surveillance • Dress Code	• Patient Supervision • Tour of the Facility • Smoking Policy		
Emergency Codes: Review of Emergency Codes and Procedures **Universal Emergency Number for Medical and Fire – Call 999**			
Psychiatric Emergencies - "**Clinical Emergency"** • Identify location of Wall Code Panic buttons • Review psychiatric body alarm use			
Fire Emergencies – Call 999 • Fire Alarm Locations • Fire Extinguisher Locations • Evacuation Locations • **R.A.C.E & P.A.S.S.**			

Medical Emergencies - Call 999
• Location of crash carts
• Supervisor's office- AED only
• Crash carts & AEDs (Units1,2,3,4, 6) [Unit 5 closed]
• 2 carts in basement (gym/activity center)
  ○ AED on cart in gym
  ○ Activity center crash cart does not have an AED			

Nursing Support Review of Schedule Related Logistics (to be completed by time keeping office)			
Provide Unit Orientation Schedule to include the didactic class with Lead-FTS			
• Attendance/ Sick Call/ Call-in procedure • Late/Unscheduled absence • Request for time off • Overtime process - Voluntary/ Mandatory • Leave of absence - Jury, Military, Maternity, etc. • Mutual pass day exchange • Holiday/Comp time			

TOPIC	Orientee Initials	Reviewing Staff Name & Title
Hospital Wide and Division Specific Policy Location on T:drive		
Nursing Policy and Procedure Manual		
Operational Policy and Procedure Manual		
Location of Safety Data Sheets (chemical exposure)		
Infection Control Manual		
Knowledge of Reporting Standards		
Chain of Command		
Incident Reporting ➢ *Review of procedure, forms and documentation*		
Work Rule Violation Reporting (MHAS – 20 form) ➢ *Review of procedure, forms and documentation*		
Reporting Patient abuse allegations ➢ *Review of procedure, forms and documentation* ➢ *Review Responsibility to report abuse*		
Workplace Injury Reporting ➢ *Review of procedure, forms and documentation*		
Patient Movement Related Information		
Admission Procedures		
Discharge Procedures		
Transfer Procedures		
Charting/Documentation		
Patient Documentation Requirements • Integrated Progress notes (PNC note) o frequency (daily, weekly, monthly) & incidentals • Engagement Treatment Forms		
Treatment Planning: Interventions, Objectives, Barriers • Master Treatment Plan • Treatment Plan Reviews • Focus Treatment Plan		
Nursing 24 Hour Report		
Daily Movement Report (Census)		
Applicable Sharps Related Staff Safety Procedures		
Review of Sharp Count Procedure		
Review of Sharps List (combs, toothbrushes, razors, etc.)		
Patient Dining Room Protocol (Silverware Count)		
Random Room Checks		

TOPIC	Orientee Initials	Reviewing Staff Name & Title
Whiting Sharps Policies for Patient Use		
Razors		
Pens		
Hairdryer		
Nail Clippers		
Scissors		
Sharp precautions of patients on special observation		
Whiting Patient Wakeup/Sleeping Procedures		
Entering Patients room		
Waking Reluctant Patients		
Locking and unlocking of patient rooms		
Patient Rest Periods		
PATIENTS ON SPECIAL OBSERVATIONS *(aka "Precautions")* **Observation requirements, care of the patient, and documentation**		
Routine Observations – "*Census Checks"* (1st, 2nd, & 3rd shift)		
Fifteen minute observation		
Continuous observation **must have body alarm at all times*		
One-to-one observation **must have body alarm at all times*		
Two-to-one observation **must have body alarm at all times*		
PATIENT RESTRAINTS/SECLUSION Procedure, application, forms, and documentation		
Review of Physical Restraint		
Mechanical Restraint • Non-Ambulatory • Ambulatory		
Unlocked seclusion		
Locked seclusion		
Patient Personal Hygiene Review of Related Procedures		
Showers		
Shaves		
Activities of Daily Living (ADL's)		
Laundry		
Patient Dormitory – Maintenance Care & Cleaning		
Patient responsibilities		
Personal living space		
Staff supervision of cleaning supplies and materials		
Bed linen changes		
Telephone Procedures		
Staff use of phone		
Patient use of phone (procedure and documentation)		

TOPIC	Orientee Initials	Reviewing Staff Name & Title
Mail Packages		
Sending mail/packages		
Receiving mail/packages		
Freedom of Movement System Patient Privileges & Escorting Patients		
Unit specific steps and privileges		
Adequate staffing and coverage		
In-building Appointments (dentist, podiatrist, barber, optometrist, etc.)		
Appointments outside of Whiting • Patient Clinic – Haviland Hall • Specialist Consults • Court Appearances		
Patient Use of Activity Center		
Activity Pass		
Security Checks		
Equipment Inventory - Sharps Count		
Entering/Exiting & Escort of Patients		
Canteen		
Ordering Process/Protocol/Distribution • disbursement slips/checks • money/checks		
Dining Room & Meal Monitoring Procedures		
Utensils (distribution, count and collection at end of meal)		
Meal distribution • Verifying diets and consistencies		
Proper Meal Ticket Disposal Process		
Meal Process for Patients on Special Observations		
Courtyard		
Opening/Closing of courtyard		
Operation of portable two-way radio		
Calling in emergencies from courtyard		
Visiting Procedure		
Escorting patients to and from visiting room		
Visits with children		
Special Observation visits (continuous/one-to one)		
Review of Process for Administering Medications to Patients		
Proper Identification of Patients		
FTS assigned to med pass in escorting pt to the med room		
Mouth Checks (under tongue/sides of mouth/hands)		

TOPIC	Orientee Initials	Reviewing Staff Name & Title
Admission/Transfer/Discharge		
Triage of patient at the gate		
Police processing of patient		
Admission of patient to the unit and discipline responsibilities ➢ MD (History & Physical) ➢ Psychiatrist (Initial evaluation & observation status) ➢ RN admission/responsibilities ➢ FTS responsibilities		
Transfer of patient to another unit		
Interdivisional transfer		
Discharge		
Sharps protocol upon transfer and D/C of patient		
Shift Responsibilities for Nursing Staff (RN & FTS)		
Review 1st shift nursing routine duties		
Review 2nd shift nursing routine duties		
Review 3rd shift nursing routine duties		
Meetings		
Community Meeting		
Primary Nursing Contact (PNC) ➢ responsibility and accountability ➢ meeting with assigned patients ➢ weekly notes		
Master Treatment Plan & Focused Tx Plan Reviews (FTPR)		
Psychiatric Security Review Board (PSRB) meetings *(every other Friday for scheduled patients)*		
Nurse led groups or individual sessions w/ patient ➢ documentation in RMS		
Case Conference *(responsibilities & documentation)*		
Specimen Collection *(Forms & Proper Storage)*		
Routine/Stat blood work process		
Chain of custody (COC) urine		
Specimen Capture & Storage (Urine, Sputum, Fecal, etc.)		
Process for receiving critical values from lab		
Check to make sure that entire checklist is completed. Ensure that the individual responsible for below has done so prior to handing this document in.		
I confirm that I demonstrated competence in the above skills. **Orienting FTS:**		
I confirm this employee has demonstrated and/or understands the above competencies. **Lead FTS Preceptor:**		
I have reviewed this document and agree with this assessment. **Nurse Supervisor:**		

WHITING FORENSIC HOSPITAL

Mental Health Assistant and Forensic Treatment Specialist Performance Evaluation while in Orientation

Orientee Name: _____ Unit: ____ Shift: ____ Date: _____

	Satisfactory	Needs Improvement	Unsatisfactory	N/A
1.Reports to Change of Shift Report on time				
2.Checks Assignment Sheet for Shift duties and responsibilities				
3.Works with staff to insure that Unit assignments are carried out				
4. Documents accurately and legibly in patient's charts and according to policies & procedures				
5. Interacts therapeutically with patients				
6. Demonstrates and applies knowledge of policies and procedures evident in practice				
7. Presents a professional attitude and appearance				
8. Recognizes reportable events and notifies Head Nurse/Charge Nurse in a timely manner				
9. Demonstrates a good working attitude on the unit with staff and patients				
10. Thinks logically				
11. Works cooperatively with interdisciplinary team members				
12. Accepts direction and utilizes supervisory staff as necessary and appropriate				
13. Demonstrates initiative and motivation to perform duties within job role				
14. Voluntarily requests to do additional tasks or offers assistance with regard to unit functioning				
15. Demonstrates professional boundaries with staff and co- workers				
16. Follows work rules				

Comments: Please write a brief statement regarding this Orientee's adaptation to your unit and responsibilities. Include your suggestions, which would help this Orientee to better function with required duties.

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MHA/FTS Mentor Signature: _____Date: _____

Head Nurse/Charge Nurse Signature: _____ Date: _____

Orientee's Signature: _____ Date: _____

Send Original to Nursing Supervisor

RN Supervisor Signature: _____Date: _____

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3.Works with staff to insure that Unit assignments are carried out				
4. Documents accurately and legibly in patient's charts and according to policies & procedures				
5. Interacts therapeutically with patients				
6. Demonstrates and applies knowledge of policies and procedures evident in practice				
7. Presents a professional attitude and appearance				
8. Recognizes reportable events and notifies Head Nurse/Charge Nurse in a timely manner				
9. Demonstrates a good working attitude on the unit with staff and patients				
10. Thinks logically				
11. Works cooperatively with interdisciplinary team members				
12. Accepts direction and utilizes supervisory staff as necessary and appropriate				
13. Demonstrates initiative and motivation to perform duties within job role				
14. Voluntarily requests to do additional tasks or offers assistance with regard to unit functioning				
15. Demonstrates professional boundaries with staff and co- workers				
16. Follows work rules				

Comments: Please write a brief statement regarding this Orientee's adaptation to your unit and responsibilities. Include your suggestions, which would help this Orientee to better function with required duties.

_____

_____

MHA/FTS Mentor Signature: _____Date: _____

Head Nurse/Charge Nurse Signature: _____ Date: _____

Orientee's Signature: _____ Date: _____

Send Original to Nursing Supervisor

RN Supervisor Signature: _____Date: _____

Mental Health Assistant and Forensic Treatment Specialist
Performance Evaluation while in Orientation

Orientee Name: _____ Unit: ____ Shift: ____ Date: _____

	Satisfactory	Needs Improvement	Unsatisfactory	N/A
1.Reports to Change of Shift Report on time				
2.Checks Assignment Sheet for Shift duties and responsibilities				
3.Works with staff to insure that Unit assignments are carried out				
4. Documents accurately and legibly in patient's charts and according to policies & procedures				
5. Interacts therapeutically with patients				
6. Demonstrates and applies knowledge of policies and procedures evident in practice				
7. Presents a professional attitude and appearance				
8. Recognizes reportable events and notifies Head Nurse/Charge Nurse in a timely manner				
9. Demonstrates a good working attitude on the unit with staff and patients				
10. Thinks logically				
11. Works cooperatively with interdisciplinary team members				
12. Accepts direction and utilizes supervisory staff as necessary and appropriate				
13. Demonstrates initiative and motivation to perform duties within job role				
14. Voluntarily requests to do additional tasks or offers assistance with regard to unit functioning				
15. Demonstrates professional boundaries with staff and co- workers				
16. Follows work rules				

Comments: Please write a brief statement regarding this Orientee's adaptation to your unit and responsibilities. Include your suggestions, which would help this Orientee to better function with required duties.

_____

_____

MHA/FTS Mentor Signature: _____Date: _____

Head Nurse/Charge Nurse Signature: _____ Date: _____

Orientee's Signature: _____ Date: _____

Send Original to Nursing Supervisor

RN Supervisor Signature: _____Date: _____

Mental Health Assistant and Forensic Treatment Specialist
Performance Evaluation while in Orientation

Orientee Name: _____ Unit: ____ Shift: ____ Date: _____

	Satisfactory	Needs Improvement	Unsatisfactory	N/A
1.Reports to Change of Shift Report on time				
2.Checks Assignment Sheet for Shift duties and responsibilities				
3.Works with staff to insure that Unit assignments are carried out				
4. Documents accurately and legibly in patient's charts and according to policies & procedures				
5. Interacts therapeutically with patients				
6. Demonstrates and applies knowledge of policies and procedures evident in practice				
7. Presents a professional attitude and appearance				
8. Recognizes reportable events and notifies Head Nurse/Charge Nurse in a timely manner				
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13. Demonstrates initiative and motivation to perform duties within job role				
14. Voluntarily requests to do additional tasks or offers assistance with regard to unit functioning				
15. Demonstrates professional boundaries with staff and co- workers				
16. Follows work rules				

Comments: Please write a brief statement regarding this Orientee's adaptation to your unit and responsibilities. Include your suggestions, which would help this Orientee to better function with required duties.

_____

_____

MHA/FTS Mentor Signature: _____Date: _____

Head Nurse/Charge Nurse Signature: _____ Date: _____

Orientee's Signature: _____ Date: _____

Send Original to Nursing Supervisor

RN Supervisor Signature: _____Date: _____

Mental Health Assistant and Forensic Treatment Specialist
Performance Evaluation while in Orientation

Orientee Name: _____ Unit: ____ Shift: ____ Date: _____

	Satisfactory	Needs Improvement	Unsatisfactory	N/A
1.Reports to Change of Shift Report on time				
2.Checks Assignment Sheet for Shift duties and responsibilities				
3.Works with staff to insure that Unit assignments are carried out				
4. Documents accurately and legibly in patient's charts and according to policies & procedures				
5. Interacts therapeutically with patients				
6. Demonstrates and applies knowledge of policies and procedures evident in practice				
7. Presents a professional attitude and appearance				
8. Recognizes reportable events and notifies Head Nurse/Charge Nurse in a timely manner				
9. Demonstrates a good working attitude on the unit with staff and patients				
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14. Voluntarily requests to do additional tasks or offers assistance with regard to unit functioning				
15. Demonstrates professional boundaries with staff and co- workers				
16. Follows work rules				

Comments: Please write a brief statement regarding this Orientee's adaptation to your unit and responsibilities. Include your suggestions, which would help this Orientee to better function with required duties.

_____

_____

MHA/FTS Mentor Signature: _____Date: _____

Head Nurse/Charge Nurse Signature: _____ Date: _____

Orientee's Signature: _____ Date: _____

Send Original to Nursing Supervisor

RN Supervisor Signature: _____Date: _____

[New employee completes evaluation]

After orientation, please answer the following questions. Your responses will remain anonymous, only collated/trended data will be shared with appropriate persons for the purpose of improvement of the program; therefore, please be as honest and thorough as possible.

Use the following scale when answering the following questions:

5=Strongly Agree
4=Agree
3=Neutral
2=Disagree*
1=Strongly Disagree* *Any Score of 1 please provide a comment.

I.RN/MHA Orientation Classes

	Strongly Disagree				Strongly Agree
1. Class content was applicable to your practice.	1	2	3	4	5

Comments:

2. Class content was not redundant with general orientation content.	1	2	3	4	5

Comments:

3. The computer training class met my needs.	1	2	3	4	5

Comments:

4. The length of time in general orientation classes was sufficient.	1	2	3	4	5

Comments:

5. The instructors were knowledgeable, approachable, & able to answer questions.	1	2	3	4	5

Comments:

6. The class materials were useful.	1	2	3	4	5

Comments:

7. The audiovisuals enhanced the learning experience. 1 2 3 4 5

Comments:

II.<u>Unit Orientation</u>

1. The unit-based orientation program was well organized. 1 2 3 4 5

Comments:

2. The length of the unit-based orientation was appropriate to prepare me to function independently. 1 2 3 4 5

Comments:

3. There was ample time for discussion and follow-up. 1 2 3 4 5

Comments:

4. The transition between orientation to regular shift went well. 1 2 3 4 5

Comments:

5. The teaching tools (e.g. manuals, articles, practice equipment, quick look guides etc.) were effective. 1 2 3 4 5

Comments:

6. The skills list was effective in facilitating the orientation process. 1 2 3 4 5

Comments:

7. Expectations were realistic and minimum for my work area. 1 2 3 4 5

III.<u>Division Educator</u>

1. Introduced me to the unit resources (staff & materials). 1 2 3 4 5

Comments

2. Clearly communicated performance expectations to me. 1 2 3 4 5

Comments:

3. Assessed my learning needs and assisted me in developing weekly goals that were mutually agreed upon. 1 2 3 4 5
Comments:

4. Used a variety of education resources to meet my learning needs. 1 2 3 4 5
Comments:

5. Used effective communication techniques. 1 2 3 4 5
Comments:

6. Provided both positive and constructive feedback. 1 2 3 4 5
Comments:

7. Was approachable when questions arose. 1 2 3 4 5
Comments:

8. Was receptive and accommodating to my input. 1 2 3 4 5
Comments:

9. Provided adequate and appropriate supervision and support. 1 2 3 4 5
Comments:

10. Provided consistent information. 1 2 3 4 5
Comments:

11. Served as a positive and professional role model. 1 2 3 4 5
Comments:

IV.<u>The Unit Staff</u>

1. Assessed my learning needs and developed goals that were mutual. 1 2 3 4 5

Comments:

2. Was approachable when questions arose. 1 2 3 4 5

Comments:

3. Provided both positive and constructive feedback. 1 2 3 4 5

Comments:

4. Used effective communication techniques. 1 2 3 4 5

Comments:

5. Served as a positive and professional role model. 1 2 3 4 5

Comments:

6. Provided adequate and appropriate supervision and support. 1 2 3 4 5

Comments:

7. Provided a schedule that was coincident with my preceptor (applicable) 1 2 3 4 5

Comments:

GENERAL COMMENTS:

1. What did you like **most** about the orientation program?

2. What did you like **least** about the orientation program?

3. What suggestions do you have for improvement of the program?

Name (optional): _____ Date:_____

Fax to Staff Development: 860-706-1494

Safety Education And Training Catalog

For DMHAS State Operated Employees

July 2019 - June 2020

CT Department of Mental Health and Addiction Services

Office of the Commissioner, Division of Safety Services

Safety Education and Training Unit

Division of Safety Services
Safety Education and Training Unit

Dear Colleagues,

The Safety Education and Training Unit (SETU) is pleased to present the FY20 Annual Safety Education and Training Catalog. These courses meet training regulations established by federal, state, DMHAS policy, The Joint Commission, and the New England Healthcare Union District 1199 Contract. All of the courses offered are aligned with our mission to "promote safety, health and wellness in the DMHAS community".
All classes listed in this catalog include the class Offering Number and are also listed on line via the Saba Learning Management System.
As always, feel free to contact me for any matter pertaining to the courses.

Sincerely,

Arlene García

Arlene Garcia, LCSW, EdD
Director - Safety Education & Training Unit
Division of Safety Services

Director
Arlene Garcia
(860) 262-5341

Secretary
Valencia Johnson
(860) 262-5378

Safety Education Instructors
Michael Davis, Michael Demko
Jay Erlandson, Sterling Gatewood
Molly Malone, Nicole Mercado
Joe Monzillo, Heather Smith

Division of Safety Services
Dutton Home
Holmes Drive, P.O. Box 351
Middletown, CT 06457
Main Phone: (860) 262-5381
Fax: (860) 262-5377

960

Contents

Facility Classes

Course Descriptions

Collaborative Safety Strategies – New (3 Days)

(**Audience** – Direct care staff, new employees or anyone required by their facility)
This course, offered once a month, teaches direct care staff how to prevent angry Patient/Client behavior from escalating to physically dangerous behavior. Staff also learn how to safely intervene to manage assaultive/aggressive behaviors and avoid or escape potentially dangerous situations in the workplace. The goal is to reduce the rate and severity of injuries.

Collaborative Safety Strategies – Inpatient Review (5.50 Hours)

(**Audience** – Inpatient direct care staff or anyone required by their facility)
This course provides a comprehensive review of the knowledge and skills taught in CSS New with the focus on the inpatient environment. Staff also review the application of mechanical restraints or seclusion to protect from harm.

Collaborative Safety Strategies – Outpatient New (2.50 Hours)

(**Audience** – Outpatient direct care staff)
This module is conducted during the 3 day CSS New Employee course, on day 3, and teaches direct care staff who work in the outpatient and community setting how to avoid and escape potentially dangerous situations to reduce the risk of becoming a victim of crime.

Collaborative Safety Strategies – Outpatient Review (5.25 Hours)

(**Audience** – Outpatient direct care staff)
This course provides a comprehensive review of the knowledge and skills taught in CSS New with the focus on the Outpatient environment. Staff also review safe practices in the outpatient/community settings and how to avoid and escape potentially dangerous situations to reduce the risk of becoming a victim.

Collaborative Safety Strategies New for Professional Students (7 Hours)

(**Audience** – Professional students)
Professional students are taught DMHAS approved interventions for preventing behavior from escalating to physically dangerous behavior and should physically dangerous behavior occur, how to safely intervene to reduce the rate and severity of injuries. Course is available in review format.

CPR for the Professional Rescuer w/AED Challenge (3.50 Hours)

(**Audience** – DMHAS police personnel and lifeguards)
This ARC program includes the CPR skills for adult, child, infant, and the use of the AED. Included are First Aid skills in a challenge format.

New Employee Orientation Program (2.75 Hours)

(**Audience** – All new DMHAS employees)
This new employee orientation program covers the required topics for safety for all new employees in DMHAS. Topics include: Ergonomics Awareness, Hazardous Communication, Fire Safety and Workplace Violence Prevention.

Restraint and Seclusion Application Training New (2.50 Hours)

(**Audience** – Inpatient direct care staff & outpatient staff working inpatient overtime)
The focus of this program will be on the prevention of injury or death from restraint use. Participants will learn and demonstrate the application of restraints in accordance to manufactures guidelines and DMHAS policies

Safety Measures for Support Staff (2 Hours)

(**Audience** – Non-clinical staff, e.g., housekeeping, clerical, maintenance, etc.)
Non-clinical support staff will learn how to recognize potentially unsafe behavior, when to alert clinical staff, and use basic safety measures during patient contact..

Standard First Aid/AED – New (6 Hours)

(**Audience** – Direct care staff, new employees or anyone required by their facility)
This American Red Cross certification class combines the skills taught in Adult CPR, AED and First Aid. It provides a competency skill check of the knowledge and skills needed to assess and provide emergency care in response to respiratory and cardiac emergencies for adult victims and first aid emergencies.

Standard First Aid/AED – Challenge (2 Hours)

(**Audience** – Direct care staff, new employees or anyone required by their facility)
This American Red Cross certification class provides a competency skill check of the knowledge and skills needed to assess and provide emergency care in response to respiratory and cardiac emergencies for adult victims and first aid emergencies.

Take Charge (2 Hours)

(**Audience** – Outpatient staff, Clients living in the community)
This program is designed to provide participants information which will assist in protecting yourself and your property and reduce the potential that you will become a victim of crime.

New Employee Training Calendar for July 2019 – December 2019

July	August	September	October	November	December
19 Friday NEOP Class ID # 97227	2 Friday NEOP Class ID # 97228	4 - 6 Wed – Fri CSS Class ID # 97268	1 - 3 Tues – Thur CSS Class ID # 97309	1 Friday CPR Class ID # 97324	6 Friday NEOP Class ID # 97363
23 - 25 Tues - Thur CSS Class ID # 97209	16 Friday NEOP Class ID # 97229	6 Friday CSS - OP Class ID # 97269	3 Thursday CSS - OP Class ID # 97310	8 Friday NEOP Class ID # 97351	10 - 12 Tues - Thur CSS Class ID # 97364
Class ID #	20 - 22 Tues - Thur CSS Class ID # 97230	6 Friday RSAT Class ID # 97270	3 Thursday RSAT Class ID # 97312	13 – 15 Wed - Fri CSS Class ID # 97352	12 Thursday CSS - OP Class ID # 97365
25 Thursday CSS - OP Class ID # 97211	23 Thursday CSS - OP Class ID # 97231	9 Monday CPR Class ID # 97272	4 Friday CPR Class ID # 97313	15 Friday CSS- OP Class ID # 97353	12 Thursday RSAT Class ID # 94366
25 Thursday RSAT Class ID # 97212	23 Thursday RSAT Class ID # 97232	13 Friday NEOP Class ID # 97283	11 Friday NEOP Class ID # 97314	15 Friday RSAT Class ID # 97355	13 Friday CPR Class ID # 97367
26 Friday CPR Class ID # 97213	24 Friday CPR Class ID # 97233	17 - 19 Tues - Thur CSS Class ID # 97284	16 - 18 Wed - Fri CSS Class ID # 97315	18 Monday CPR Class ID # 97356	
	30 Friday NEOP Class ID # 97266	19 Thursday CSS - OP Class ID # 97285	18 Friday CSS - OP Class ID # 97316	22 Friday NEOP Class ID # 97361	
		19 Thursday RSAT Class ID # 97286	18 Friday RSAT Class ID # 97317		
		20 Friday CPR Class ID # 97287	21 Monday CPR Class ID # 97318		
		27 Friday NEOP Class ID # 97308	25 Friday NEOP Class ID # 97320		
			29 – 31 Tues - Thur CSS Class ID # 97321		
			31 Thursday CSS - OP Class ID # 97322		
			31 Thursday RSAT Class ID # 97323		

Contact: Valencia Johnson (860) 262 – 5378 **Location:** All Classes Conducted at CVH, Page Hall, Room 364 (*** NEOP at Processing Center)

Class Codes

CPR:	American Red Cross SFA/AED & First Aid – New	*8:30am – 2:30pm*	NEOP:	DMHAS New Employee Orientation Program	*1:15pm – 4:00pm*
CSS:	Collaborative Safety Strategies – New	*8:30am – 4:00pm*	RSAT:	Restraint – Seclusion Application Training New	*1:15pm – 4:00pm*
CSS-OP:	Collaborative Safety Strategies: Outpatient New	*1:15pm – 4:00pm*			

New Employee Training Calendar for January 2020 – June 2020

January	February	March	April	May	June
3 Friday NEOP Class ID # 97378	4 - 6 Tues - Thur CSS Class ID # 97394	3 – 5 Tues - Thur CSS Class ID # 97425	2 Thursday CSS - OP Class ID # 97441	1 Friday CPR Class ID # 97467	1 Friday CPR Class ID # 97506
7 - 9 Tues – Thur CSS Class ID # 97379	6 Thursday CSS - OP Class ID # 97395	5 Thursday CSS - OP Class ID # 97426	2 Thursday RSAT Class ID # 97442	8 Friday NEOP Class ID # 97469	5 Friday NEOP Class ID # 97513
9 Thursday CSS - OP Class ID # 97380	6 Thursday RSAT Class ID # 97396	5 Thursday RSAT Class ID # 97428	3 Friday CPR Class ID # 97443	12 - 14 Tues - Thur CSS Class ID # 97471	9 - 11 Tues - Thur CSS Class ID # 97514
9 Thursday RSAT Class ID # 97381	7 Friday CPR Class ID # 97397	6 Friday CPR Class ID # 97429	10 Friday NEOP Class ID # 97444	14 Thursday CSS - OP Class ID # 97472	11 Thursday CSS - OP Class ID # 97515
10 Friday CPR Class ID # 97382	14 Friday NEOP Class ID # 97399	13 Friday NEOP Class ID # 97433	15 – 17 Wed - Fri CSS Class ID # 97445	14 Thursday RSAT Class ID # 97473	11 Thursday RSAT Class ID # 97517
17 Friday NEOP Class ID # 97384	19 – 21 Weds - Fri CSS Class ID # 97400	17 - 19 Tues – Thur CSS Class ID # 97435	17 Friday CSS - OP Class ID # 97447	15 Friday CPR Class ID # 97474	12 Friday CPR Class ID # 97518
22 - 24 Weds - Fri CSS Class ID # 97385	21 Friday CSS - OP Class ID # 97401	19 Thursday CSS - OP Class ID # 97434	17 Friday RSAT Class ID # 97448	22 Friday NEOP Class ID # 97499	19 Friday NEOP Class ID # 97520
24 Friday CSS - OP Class ID # 97386	21 Friday RSAT Class ID # 97402	19 Thursday RSAT Class ID # 97436	20 Monday CPR Class ID # 97449	27 - 29 Wed – Fri CSS Class ID # 97501	23 - 25 Tues - Thur CSS Class ID # 97521
24 Friday RSAT Class ID # 97387	24 Monday CPR Class ID # 97403	20 Friday CPR Class ID # 97437	24 Friday NEOP Class ID # 97465	29 Friday CSS - OP Class ID # 97503	25 Thursday CSS - OP Class ID # 97522
27 Monday CPR Class ID # 97388	28 Friday NEOP Class ID # 97424	27 Friday NEOP Class ID # 97439	28 - 30 Tues - Thur CSS Class ID # 97463	29 Friday RSAT Class ID # 97504	25 Thursday RSAT Class ID # 97523
31 Friday NEOP Class ID # 97393		31 – 4/2 Tues - Thur CSS Class ID # 97440	30 Thursday CSS - OP Class ID # 97464		26 Friday CPR Class ID # 97519
			30 Thursday RSAT Class ID # 97466		

Contact: Valencia Johnson (860) 262 – 5378 **Location:** All Classes Conducted at CVH, Page Hall, Room 364 (*** NEOP at Processing Center)

Class Codes

CPR:	American Red Cross SFA/AED & First Aid – New	*8:30am – 2:30pm*	NEOP:	DMHAS New Employee Orientation Program	*1:15pm – 4:00pm*
CSS:	Collaborative Safety Strategies – New	*8:30am – 4:00pm*	RSAT:	Restraint – Seclusion Application Training New	*1:15pm – 4:00pm*
CSS-OP:	Collaborative Safety Strategies: Outpatient New	*1:15pm – 4:00pm*			

Capital Region Mental Health Center Calendar for July 2019 – June 2020

July	August	September	October	November	December
11 Thursday (3) Class ID # 96843, 96844		10 Tuesday (2) Class ID # 97784, 97796	1 Tuesday (2) Class ID # 97786, 97798	5 Tuesday (2) Class ID # 97787, 97799	17 Tuesday (2) Class ID # 98694, 97800
25 Thursday (4) Class ID # 96681, 96683		24 Tuesday (1) Class ID # 97785, 97801	17 Thursday (1) Class ID # 97789, 97802	14 Thursday (1) Class ID # 97790, 97803	
January	**February**	**March**	**April**	**May**	**June**
14 Tuesday (2) Class ID # 97805, 97817	11 Tuesday (2) Class ID # 97806, 97818	17 Tuesday (2) Class ID # 97807, 97819	7 Tuesday (2) Class ID # 97808, 97820	14 Thursday (1) Class ID # 97814, 97832	4 Thursday (1) Class ID # 97815, 97833
16 Thursday (1) Class ID # 97811, 97829	13 Thursday (1) Blue Hills Staff – Only Class ID # 97812, 97830		16 Thursday (1) Class ID # 97813, 97831	19 Tuesday (2) Class ID # 97809, 97821	18 Monday (1) Class ID # 97816, 97834

Registration Contact: Jellena Jones, Marilyn Rice
(860) 297 - 0933, (860) 293 – 6342

Location: Classes Conducted in the Auditorium

Class Codes

1. **CSS Inpatient Review & SFA/AED-C** *8:15am – 4:00pm*
   Capacity (16)

2. **CSS Outpatient Review & SFA/AED-C** *8:30am – 4:00pm*
   Capacity (16)

3. **Restraint/Seclusion Application Training** *1:30pm – 2:15pm, 2:30pm – 3:15pm*
   Capacity (16)

4. **FPR/AED/FA-C for Police Officers** *8:00am – 11:30am, 12:30pm – 4:00pm*
   Capacity (12)

Connecticut Mental Health Center Calendar for July 2019 – June 2020

July	August	September	October	November	December
11 Thursday (6) Class ID # 97550		3 Thursday (5) Class ID # 98122, 98123	8 Tuesday (1) Class ID # 98076, 98110	12 Thursday (1) Class ID # 98089, 98108	19 Thursday (2) Class ID # 98090, 98095
12 Friday (3-E) Class ID # 96647		24 Tuesday (2) Class ID # 98066, 98094	9 Wednesday (2) Class ID # 98086, 98098	21 Monday (2) Class ID # 98087, 98099	
15 Monday (3) Class ID # 96648					
18 Thursday (6) Class ID # 98079 19 Friday (7) Class ID # 96628, 96629					
January	**February**	**March**	**April**	**May**	**June**
15 Wednesday (2) Class ID # 98172, 99015	13 Thursday (1) Class ID # 98177, 98194	12 Thursday (2) Class ID # 98173, 98188	2 Thursday (1) Class ID # 98179, 98195	6 Wednesday (1) Class ID # 98181, 98196	3 Wednesday (1) Class ID # 98175, 98187
29 Wednesday (1) Class ID # 98172, 98185		25 Wednesday (2) Class ID # 98178, 98190	8 Wednesday (5) Class ID # 98279, 98282	13 Wednesday (2) Class ID # 98182, 98192	11 Thursday (2) Class ID # 98184, 98193
			22 Wednesday (2) Class ID # 98180, 98191	21 Thursday (1) Class ID # 98174, 98186	

Contact: **Allison N. Ponce, Ph.D.** (allison.ponce@yale.edu) **Location:** **Classes Conducted in W212**

Registration Contact: **Mary Mathis** (Mary.Mathis@ct.gov)

Class Codes

1. **CSS Inpatient Review & SFA/AED-C** *8:30am – 4:00pm*
   Capacity (16)

2. **CSS Outpatient Review & SFA/AED-C** *8:30am – 4:00pm*
   Capacity (16)

3. **FPR/AED/FA-C for Police Officers** *8:00am – 11:30am*
   Capacity (12)

3-E. **FPR/AED/FA-C for Police Officers** *4:30pm – 8:00pm*
   Capacity (12)

4. **SFA/AED-C** *10:30am –12:30pm, 1:30pm – 3:30pm*
   Capacity (16)

5. **CSS Review & SFA/AED-C, (Yale MD's)** *12:00pm – 4:00pm*
   Capacity (16)

6. **CSS New for Professional Students** *8:30am – 3:30pm*
   Capacity (16)

6-B. **CSS Review for Professional Students** *12:30pm – 4:00pm*
   Capacity (16)

7. **Restraint/Seclusion Application Training** *1:30pm – 2:15pm, 2:30pm – 3:15pm*
   Capacity (16)

Connecticut Valley Hospital Calendar for July 2019 – June 2020

July	August	September	October	November	December
10 Wednesday (1) Class ID # 98956, 98948		4 Wednesday (1) Class ID # 98305, 98571	3 Thursday (1) Class ID # 98315, 98574	5 Tuesday (1) Class ID # 98321, 98599	4 Wednesday (1) Class ID # 98340, 98602
16 Tuesday (5) Class ID # 96673		11 Wednesday (1) Class ID # 98307, 98572	9 Wednesday (2) Class ID # 98316, 98580	13 Wednesday (2) Class ID # 98322, 98604	12 Thursday (2) Class ID # 98347, 98609
19 Thursday (5-E) Class ID # 96675		12 Thursday (2) Class ID # 98308, 98578	10 Thursday (1) Class ID # 98317, 98575	20 Wednesday (1) Class ID # 98323, 98600	18 Wednesday (1) Class ID # 98341, 98603
24 Wednesday (4) Class ID # 97094		19 Thursday (3) Class ID # 98309, 98585	16 Wednesday (1) Class ID # 98318, 98576	20 Wednesday (3) Class ID # 98324, 98605	19 Thursday (3) Class ID # 98345, 98606
30 Tuesday (5-E) Class ID # 96676		25 Wednesday (1) Class ID # 98312, 98573	23 Wednesday (1) Class ID # 98320, 98577	26 Tuesday (1) Class ID # 98339, 98601	
30 Tuesday (6) Class ID # 98823			31 Thursday (3) Class ID # 98319, 98586		
January	**February**	**March**	**April**	**May**	**June**
8 Wednesday (2) Class ID # 98342, 98610	13 Thursday (1) Class ID # 98332, 98713	4 Wednesday (2) Class ID # 98335, 98748	1 Wednesday (2) Class ID # 98616, 98659	6 Wednesday (1) Class ID # 98621, 98665	4 Thursday (1) Class ID # 98625, 98669
15 Wednesday (1) Class ID # 98346, 98613	19 Wednesday (2) Class ID # 98333 , 98747	5 Thursday (1) Class ID # 98336, 98744	8 Wednesday (1) Class ID # 98619, 98663	20 Wednesday (1) Class ID # 98622, 98666	10 Wednesday (2) Class ID # 98618, 98661
23 Thursday (3) Class ID # 98351, 98615	26 Wednesday (1) Class ID # 98334 , 98743	11 Wednesday (1) Class ID # 98091, 98745	22 Wednesday (1) Class ID # 98620, 98664	28 Wednesday (1) Class ID # 98624, 98668	17 Wednesday (1) Class ID # 98623, 98667
29 Wednesday (1) Class ID # 98348, 98614		26 Thursday (1) Class ID # 98693, 98746	23 Thursday (3) Class ID # 98629, 98671		18 Thursday (3) Class ID # 98630, 98672
		26 Thursday (3) Class ID # 97788, 98749	29 Wednesday (2) Class ID # 98617, 98660		25 Thursday (1) Class ID # 98626, 98670

Contact: Jorge Munoz (860) 262-5117 **Registration Contact:** Nursing Support Office Scheduler **Location:** Classes Conducted in Haviland Hall

Class Codes

1. **CSS Inpatient Review & SFA/AED-C** (Days) *7:30am – 3:15pm*
   Capacity (16)
2. **CSS Inpatient Review & SFA/AED-C** (Eves) *3:30pm – 11:15pm*
   Capacity (16)
3. **CSS Inpatient Review & SFA/AED-C** (Nights) *11:30pm – 6:45pm*
   Capacity (16)
4. **CSS New for Professional Students** *8:15am – 3:15pm*
   Capacity (16)
5. **FPR/AED/FA-C for Police Officers –** (Days) *8:00am –11:30am, 12:30pm – 4:00pm*
   Capacity (12)

5-E. **FPR/AED/FA-C for Police Officers –** (Eves) *3:00pm – 6:30pm*
Capacity (12)

6. **Hearing Voices that are Distressing** *1:15pm – 3:15pm*
   Capacity (35)

River Valley Services Calendar for July 2019 – June 2020

July	August	September	October	November	December
		10 Tuesday (1) Class ID # 97754 & 97773	21 Monday (1) Class ID # 97771 & 97772	19 Tuesday (1) Class ID # 97763 & 97774	3 Tuesday (1) Class ID # 97764 & 97775
January	**February**	**March**	**April**	**May**	**June**
14 Tuesday (1) Class ID # 97765 & 97776	25 Tuesday (1) Class ID # 97766 & 97777	10 Tuesday (1) Class ID # 97767 & 97778	21 Tuesday (1) Class ID # 97768 & 97779	19 Tuesday (1) Class ID # 97769 & 97780	16 Tuesday (1) Class ID # 97770 & 97781
					19 Friday (2) Class ID # 98793

Contact: Registration Contact: Denise Learmand
(860) 262 – 5367

Location: Classes Conducted in Page Hall, Room 364

Class Codes

1. **CSS Outpatient Review & SFA/AED-C** *8:30am – 4:00pm*
   Capacity (16)

2. **Street Safe** 10:30am – 11:30am
   Capacity (25)

Southeast Mental Health Authority Calendar for July 2019 – June 2020

July	August	September	October	November	December
		23 Monday (1) Class ID # 97621 & 97624	22 Tuesday (1) Class ID # 97640 &97651	18 Monday (1) Class ID # 97622 & 97625	17 Tuesday (1) Class ID # 97641 & 97653
January	**February**	**March**	**April**	**May**	**June**
28 Tuesday (1) Class ID # 97642 & 97654	25 Tuesday (1) Class ID # 97643 & 97655		21 Tuesday (1) Class ID # 97644 & 97656	11 Monday (1) Class ID # 97623 & 97626	23 Tuesday (1) Class ID # 97645 & 97657

Contact: **Mary Beth Jordan** (860) 859 – 4500 **Location:** **Multipurpose Room**

Class Codes

1. **CSS Outpatient Review & SFA/AED-C** *8:30am – 4:00pm*
   Capacity (16)

Southwestern Connecticut Mental Health System Calendar for July 2019 – June 2020

July	August	September	October	November	December
17 Wednesday (3), (5) Class ID # 96677, 96679		11 Wednesday (1) Class ID # 97965, 97966	8 Tuesday (1) Class ID # 97974, 97976	6 Wednesday (7) Class ID # 99028, 99030	4 Wednesday (1) Class ID # 97969, 97971
31 Wednesday (5), (3-E) Class ID # 96680, 96678		16 Monday (2) Class ID # 97988, 97989	29 Tuesday (2) Class ID # 97992, 97996	25 Monday (6) Class ID # 97981, 97984	11 Wednesday (2) Class ID # 97995, 97999
		30 Monday (6) Class ID # 97980, 97983			

January	February	March	April	May	June
9 Thursday (2) Class ID # 98017, 97998	5 Wednesday (2) Class ID # 98018, 98045	3 Tuesday (1) Class ID # 97994, 98059	7 Tuesday (2) Class ID # 98019, 98046	7 Thursday (1) Class ID # 98029, 98057	24 Wednesday (1) Class ID # 98032, 98054
15 Wednesday (1) Class ID # 98025, 98051	27 Thursday (1) Class ID # 98027, 98055	25 Wednesday (1) Class ID # 98030, 98052	9 Thursday (1) Class ID # 98028, 98056	20 Wednesday (2) Class ID # 98023, 98047	
			15 Wednesday (6) Class ID # 98031, 98053	13 Wednesday (7) Class ID # 99029, 99031	

Contact: **Immacula Cann** (203) 551-7543 **Location:** **Classes Conducted at GBMCHC, Room 818 (*** 2 Classes at FSD)**

Class Codes

1. **CSS Inpatient Review & SFA/AED-C** *8:15am – 4:00pm*
   Capacity (16)

2. **CSS Outpatient Review & SFA/AED-C** *8:30am – 4:* **Review** *00pm*
   Capacity (16)

3. **FPR/AED/FA-C for Police Officers** *8:30am – 12:00pm*
   Capacity (12)

3-E. **FPR/AED/FA-C for SWCMHS Police Officers** *3:00pm – 6:30pm*
   Capacity (12)

4. **CSS New for Professional Students** *8:30am – 3:30pm*
   Capacity (16)

5. **Restraint/Seclusion Application Training** *1:30pm – 2:15pm*
   Capacity (12)

6. **CSS Inpatient Review & SFA/AED-C** (Eves) *3:30pm – 11:15pm*
   Capacity (16)

7. **CSS Outpatient Review & SFA/AED-C (At FSD)** *8:30am – 4:00pm*
   Capacity (12)

Western Connecticut Mental Health Network – Waterbury Area Calendar for July 2019 – June 2020

July	August	September	October	November	December
		6 Friday (1) Class ID # 97683, 97686	4 Friday Danbury (1) Class ID # 97691, 97692	25 Monday (1) Class ID # 97684, 97687	13 Friday (1) Class ID # 97685, 97688
		23 Monday (1-E) Class ID # 97702, 97703	28 Monday (1) Class ID # 97695, 97697		
		30 Monday Torrington (1) Class ID # 97704, 97705			

January	February	March	April	May	June
10 Friday (1) Class ID # 97734, 97738	21 Friday (1) Class ID # 97735, 97739	20 Friday (1) Class ID # 97736, 97740	20 Monday (1) Class ID # 97742, 97745	18 Monday (1) Class ID # 97743, 97746	8 Monday (1) Class ID # 97744, 97747
					26 Friday (1) Class ID # 97737, 97741

Registration Contact: Kasheene Levett
(203) 805-6422

Location: Classes Conducted in the 95 Thomaston Street Conference Room
** 9/30/19 **Class Conducted at Torrington**
** 10/4/19 **Class Conducted at Danbury**

Class Codes

1. **CSS Outpatient Review & SFA/AED-C** *8:30am – 4:00pm*
   Capacity (16)

1-E. **CSS Outpatient Review & SFA/AED-C** *3:45pm – 11:15pm*
   Capacity (16)

Whiting Forensic Hospital Calendar for July 2019 – June 2020

July	August	September	October	November	December
		3 Tuesday (2) Class ID # 98456	2 Wednesday (4) Class ID # 98395, 98396 98397, 98398, 98400	6 Wednesday (1) Class ID # 98454	5 Thursday (3) Class ID # 98492
		5 Thursday (4) Class ID # # 98366, 98388, 98389, 98390, 98394	10 Thursday (3) Class ID # 98459	7 Thursday (2) Class ID # 98458	10 Tuesday (1) Class ID # 98490
		12 Thursday (1) Class ID # 98449	15 Tuesday (1) Class ID # 98460	20 Wednesday (4) Class ID # 98401, 98402 98403, 09404, 98409	11 Wednesday (4) Class ID # 98405, 98406 98407, 98408, 98410
		25 Wednesday (1) Class ID # 98452	23 Wednesday (2) Class ID # 98457	21 Thursday (1) Class ID # 98450	18 Wednesday (1) Class ID # 98799
			30 Wednesday (1) Class ID # 98453	26 Tuesday (1) Class ID # 98451	

January	February	March	April	May	June
7 Tuesday (2) Class ID # 98503	6 Thursday (2) Class ID # 98508	10 Tuesday (1) Class ID # 98517	8 Wednesday (4) Class ID # 98427, 98428 98429, 98430, 98440	5 Tuesday (1) Class ID # 98535	3 Wednesday (1) Class ID # 98537
16 Thursday (1) Class ID # 98504	11 Tuesday (1) Class ID # 98506	11 Wednesday (2) Class ID # 98521	9 Thursday (1) Class ID # 98519	7 Thursday (3) Class ID # 98539	9 Tuesday (2) Class ID # 98541
21 Tuesday (4) Class ID # 98411, 98412 98413, 98414, 98422	18 Tuesday (4) Class ID # 98415, 98416 98417, 98418, 98423	18 Wednesday (4) Class ID # 98424, 98425 98226, 98420, 98439	14 Tuesday (2) Class ID # 98522	13 Wednesday (4) Class ID # 98431, 98432 98433, 98434, 98441	16 Tuesday (1) Class ID # 98538
28 Tuesday (1) Class ID # 98506	26 Wednesday (1) Class ID # 98507	19 Thursday (3) Class ID # 98523	22 Wednesday (1) Class ID # 98520	21 Thursday (1) Class ID # 98536	17 Wednesday (4) Class ID # 98435, 98436 98437, 98438, 98442
30 Thursday (3) Class ID # 98509		24 Tuesday (1) Class ID # 98518		21 Thursday (2) Class ID # 98540	

Registration Contacts: **Michael Coombs** (860) 262-5436, **Kyle Vontz** (860) 262- 6242

Location: **Classes Conducted in Page Hall, Rom 364**

Class Codes

1. **CSS Inpatient Review** (Days) *7:15am – 3:15pm*
   Capacity (16)
2. **CSS Inpatient Review** (Eves) *3:15pm – 11:15pm*
   Capacity (16)
3. **CSS Inpatient Review** (Nights) *11:15pm – 6:45am*
   Capacity (16)
4. **SFA/AED-C**
   Capacity (12)

Collaborative Safety Strategies

Annual Inpatient Review Training Program

Participant Handbook

State of Connecticut
Department of Mental Health and Addiction Services
Division of Safety Services
Safety Education and Training Unit
August 2018 Update

TABLE OF CONTENTS

INTRODUCTIONS and OVERVIEW

This Collaborative Safety Strategies Participant Handbook is intended exclusively for use by DMHAS employees during attendance at the CSS Inpatient Annual Review class that is taught by certified Division of Safety Services Instructors.

DMHAS employees may use it as a reference tool but because it is not all inclusive of the content and techniques that are taught during a CSS class, it should not be used exclusively to address questions related to it's content.

Program Goal

To reduce the rate and severity of patient and staff injuries related to violent behavior.

Learning Objectives

After successfully completing this class, you will be able to:

1. Create and maintain safe and therapeutic relationships and environments of care that are grounded in understanding the underlying causes of anger and related dangerous and violent behavior.
2. Use risk management strategies to prevent dangerous behavior from escalating to violence.
3. Use verbal and non-verbal communication with patients in non-emergency and emergency situations to reduce the risks to staff, patients and others that are associated with dangerous and violent behavior.
4. Use a variety of safety strategies in escalating and crisis situations to reduce the risk of physically, medically and emotionally traumatizing effects resulting from dangerous and violent behavior and the use of R/S.
5. Correctly use all of the CSS physical techniques in emergency situations and should they fail to be executed correctly, take immediate corrective action to reduce the rate and severity of injuries to staff, patients and others.
6. Use mechanical restraints and seclusion per DMHAS Restraint and Seclusion Policy's and manufacturer's instructions to prevent use related physical injury or death.

Successful Completion Requirements

- Written (**closed book)** Test Score of 80 or higher.
- 100% Physical skill demonstration of all CSS techniques and restraint application.
- 100% Active Class Participation
  - **Breaks** will be provided throughout the day.
  - **Five (5) minute or more late returns** from scheduled breaks may result in unsuccessful course completion.
  - **Cell phone use**, for any reason, is strictly prohibited during class.
- Completed Participant Evaluation

Upon successful completion of this class, your attendance and completion status will be added to your transcript in the Saba Learning Management System.

COLLABORATIVE RISK PREVENTION STRATEGIES

Strategy 1: Creating Safe and Therapeutic Relationships and Environments of Care

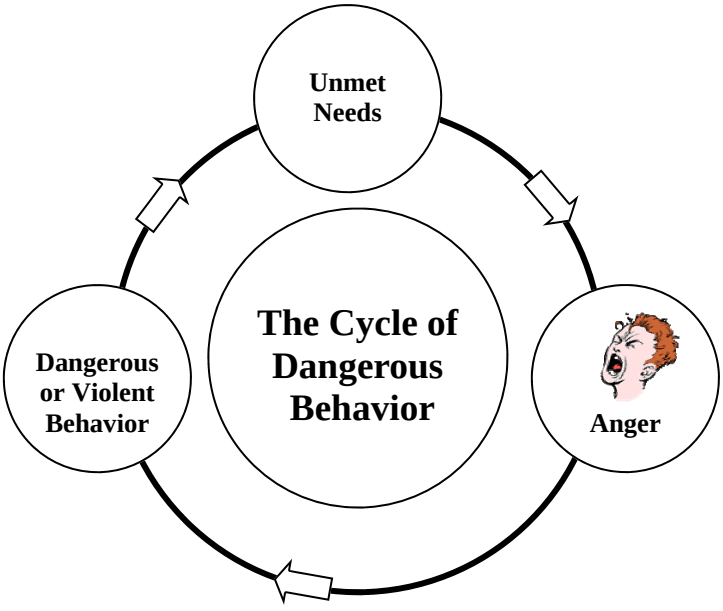
Collaborative Risk Prevention Strategies are the things that you do to minimize or eliminate the risks to prevent a behavioral crisis from occurring, or interrupt it before someone is harmed. DMHAS believes that EVERYONE, including patients, shares responsibility for safety and that dangerous behavior in any form hurts the treatment environment, patients and adds to life crisis. As caregivers, **you hold the primary responsibility** for safety.

Cycle of Dangerous Behavior

There are many reasons that dangerous and violent behavior occurs. To help you understand the cyclic nature of angry behavior, we've developed the Cycle of Dangerous Behavior model. The working assumption is that unmet needs start with a triggering event. A trigger is something that sets off emotions e.g., anger, fear, panic, despair, anxiety, that can lead to an action or series of events. The triggering event puts the "Cycle" in motion. Unmet needs may lead to anger which may lead to dangerous and/or violent behavior. This program is a review of strategies and skills needed to interrupt the cycle and restore safety.

Anger is a normal human emotion that typically prompts people to take action. For many people – they work to resolve the issue that made them angry using healthy conflict resolution skills. Others choose to ignore it and "let it go" depending on how angry they are about the issue, yet hold on to the issue – which often creates more anger over time in similar situations. **Fear** can also trigger a similar response, but when the person strikes out it's usually for self protection.

For both patients and staff, inpatient settings are complex and often high intensity settings where our patients' thinking/thoughts are compromised by their symptoms. Conflicts are an every day occurrence. You, the staff, are often in the position of not meeting needs: saying no, setting limits, etc. in effort to change their behavior– which they may not want to do. These unmet needs are at the core of most conflicts – and they often serve as the triggering event – that can escalate to dangerous behavior. What you say, how you say it, how it's perceived by the patient can often be the determining factor in your ability to resolve conflict and have safe outcomes.



Crisis Continuum

The escalation of anger to violence typically occurs in 4 phases and along a continuum called the Crisis Continuum which includes the Trigger, Escalation, Crisis and Post Crisis Phases.

- The Trigger Phase - A trigger is something that sets off emotions e.g., anger, fear, panic, that can lead to an action or series of events. The first step to interrupting the cycle of Dangerous Behavior is identifying the triggers- we'll be focusing a lot on triggers throughout the training.
- The Escalation Phase: Is when these behaviors are increasing in intensity.
- The Crisis Phase: Is when the behavior presents an immediate risk of physical harm.
- The Post Crisis Phase: Occurs immediately following the crisis – which is when the person is calming down.

Acting in a caring, compassionate and respectful way – not taking things that patients say personally – can be difficult. The most significant thing that you can do to prevent dangerous behavior is to create an environment that feels safe for both you -the staff - and your patients. "**The best way for you to be safe, is to make your patients feel safe**" Dvoskin.

Dr. Sandra Bloom, who created the Sanctuary Model has written extensively on safety in psychiatric treatment settings. She identifies 4 aspects of safety: physical, psychological, social and moral.

Four Aspects of Safety

Physical Safety is the easiest to describe – it includes all aspects of the environment that keep you physically safe – i.e., equipment and policies. Physical safety is a critical aspect of safety - without it, other forms of safety are hard to achieve.

Psychological Safety refers to the ability to be safe with oneself, specifically, the ability to self-protect against destructive impulses from within, or from others threat to self (keeping out of harms way). Examples of threats to psychological safety include being talked to sarcastically, lectured at, put down, humiliated, talked to in a negative tone, infantilized, blamed or shamed. Most of us think about this as emotional abuse.

Social Safety is the trust that exists in the environment between everyone that is in it. In a safe social setting, people feel cared for, trusted, free to express feelings, unafraid of being abandoned or misjudged. And, they feel connected to each other and not isolated. Rules exist for safety and structure, they make clear what is socially acceptable (and not) and are flexible when safety is not compromised.

In a socially safe setting, there is a high level of awareness about group and individual dynamics. Staff recognizes that behavioral change is hard and works collaboratively with patients to help change behavioral patterns that are destructive.

Moral Safety encompasses honesty, integrity and doing the right thing. It refers to clear social norms that are not hypocritical. It answers the questions:

- What do we believe in, what are we trying to achieve, will the means get us to the ends and are they justified?
- Do the therapeutic activities we use lead to autonomy, connectedness, empowerment, or dependence, alienation and helplessness?

Therapeutic Relationships

In behavioral health, medications and other therapies are very important elements, but the vast majority of work that you do is to help people change their behavior (since the symptoms of Mental Illness and Substance Use are mostly behavioral). The primary way that you prevent a crisis from occurring and help people recover takes place in the context of the relationship between you and the patient. Therapeutic relationships provide psychological, social and moral safety. Therapeutic use of self is defined as the ability to use one's personality consciously and in full awareness. This will allow you to relate to the patient and structure your interventions in a way that is beneficial to the patient.

Therapeutic relationships differ from personal relationships in that they are goal oriented and directed to helping the patient learn how to cope in healthy adaptive ways – and develop safe and socially appropriate behaviors.

Treating people with respect and dignity is the foundation of a therapeutic relationships and using yourself as the TOOL to recovery. In order to be the most effective in using yourself as a tool, you need be aware of how your values, attitudes, beliefs, culture, religion, social status, gender, age, affect how you interact, perceive, interpret, and ultimately respond in every interaction with your patients.

Patient Rights

DMHAS believes that patients have the **right to be free from seclusion and restraints** and cannot be imposed as a means of coercion, discipline, convenience or retaliation by staff. Restraints and seclusion may only be used when there is immediate risk and non-restrictive measures have been determined to be ineffective in protecting the patient, staff members, or others from harm. The type or technique of restraint (physical or mechanical) or seclusion used **must be the least restrictive to protect the patient, staff or others from harm**. The decision on which approved restrictive interventions to use is based on the circumstances and considers all of the risk factors at the time. Therapeutic and non-restrictive interventions are preferred as the first intervention, unless they have been determined to be ineffective or when safety issues require a restrictive response.

Patient Abuse, Neglect, or Exploitation
DMHAS has a zero tolerance policy for the abuse, neglect or exploitation of patients. Every patient has a right to be free from verbal, physical, sexual, and emotional abuse, neglect and exploitation. All employees are expected to report witnessed or suspected incidents of abuse, neglect, or exploitation of any DMHAS patient. Immediate reporting is crucial to ensure protection of our patients, and the timely investigation of events leading to the report. Failure to report incidents of abuse, neglect or exploitation may result in disciplinary action and legal penalty.

Employee Rights
STATEMENT OR PURPOSE: The State of Connecticut has adopted through Executive Order No. 16, a statewide zero tolerance policy for workplace violence (WPV). DMHAS supports this policy and recognizes the right of its employees to work in a safe and secure environment that is characterized by respect and professionalism.

> **Workplace violence** is defined by the state of CT as any physical assault, threatening behavior, or verbal abuse occurring in the work setting.
>
> A **workplace** may be any location either permanent or temporary where an employee performs any work-related duty. This includes, but is not limited to, the buildings and the surrounding perimeters, including the parking lots, field locations, clients' homes and traveling to and from work assignments.

One of the major tenets of the WVP Executive Order is the concept of zero tolerance for violence. **Zero Tolerance** for workplace violence means that the State will not tolerate violence in the workplace and will make every reasonable effort to prevent violence or threats of violence from occurring.

Importantly, zero tolerance is sometimes misunderstood to imply that if a person, employee, patient, or others becomes violent, they will be discharged, punished, or fired. This is not necessarily true, every instance of WPV is evaluated based on the circumstances and the responses can vary based on those circumstances.

It is not possible to prevent all inpatient violence. "Reducing violence enhances the therapeutic milieu and a therapeutic milieu reduces violence" .Dvoskin

It's important to practice OSHA's Universal Precautions for Violence in Healthcare Settings:
Violence should be expected but can be avoided or mitigated through preparation.

COLLABORATIVE RISK PREVENTION STRATEGIES

Strategy 2: Assessing and Analyzing the Risk for Violence

Even when using learned evidence-based strategies to establish and maintain therapeutic relationships and safe recovery orientated treatment environments, the risk for dangerous or violent behavior still exists. This module is a review of how to assess the risk for violence.

Risk Management

The way that you manage the risk of dangerous/violent behavior is by continuously assessing, analyzing, then selecting and implementing interventions and evaluating whether or not your interventions were successful in reducing the risk that you identified:

Assess: *this is when you identify the problem and its severity.*

Analyze: *this is when you consider the possible options of interventions to address the problem in the context of the person (s) involved, the environment that you are in, and who is available to help.*

Select: *based on the analysis - select the intervention/s and develop a plan that will best eliminate or minimize the impact of the problem based on your consideration that* ***the benefits of your selected intervention outweighs the risks****, since there will always be risks.*

Act: *put the plan into action*

Evaluate: *the patient's response to the intervention/s.*

Clinical Risk Assessment and Analysis

Risk Assessment and analysis are key to determining whether potential or actual danger exists. There are many factors that increase and decrease the potential for dangerous behavior. Factors that increase the risk potential for dangerous/violent behavior are called Risk Factors (RF's). Factors that decrease the risk are called Protective Factors (PF's) . The patients at risk have more RF's than PF's. The goal of inpatient treatment is to tip the scale so that the Protective Factors outweigh the risk factors.

Dangerous behavior always occurs in context to a situation that is occurring. The triggering event is not always easily seen and is typically a result of an unmet need. It can be as simple as someone wanting to go for a walk who is told no…to someone who wants to be discharged immediately. The B= P x S equation is a quick way to focus on the 3 key risk factor categories (Behavior, Person, Situation).

CSS focuses on triggers because triggering events are what put the Cycle of Dangerous Behavior in motion. At the triggering point - you need to take **immediate action** and provide more intensive care. The intensity of care will depend on all the risk and protective factors. Typically, when triggered, we see a response that indicates whether or not they are able to self control their behavior. Waiting until the person's behavior has escalated to dangerous levels is too late – you must immediately intervene to provide more intensive care and the assessment will tell you what kind of care to provide.

Triggers

Typical situations that trigger anger include:

- Hearing bad news (e.g., laid off, divorce, loss of Level, being told no)
- Lack of Privacy
- Being stared at, touched, isolated
- Being teased, shamed, humiliated
- Particular time of day, night or year
- Contact with people e.g., family, friend…staff with whom they have issues.
- Access to his/her money
- Access to own bedroom
- Smoking ban
- Patient contraband and bartering
- Required attendance at programs/activities
- Medication administration time
- Access to telephones

[2] www.clevelandclinicmeded.com; Psychiatric Emergencies, George E. Tesar Published 8/1/10

Cultural Factors that affect Responses to Situational Triggers

One of the reasons people can misperceive your words or actions is related to cultural differences. There are many cultural norms for human behavior and we will address eye contact, speaking volume and touch. Most information on cultural differences is generalized, it's dangerous to generalize because so much of how we behave is influenced by more than just our culture. So, these are just general tips – as always, learn what triggers individual(s).

Eye Contact

The duration and frequency of eye contact communicates a great deal—honesty, respect, shame, interest—but the norms can differ widely among cultures.

- African-Americans use more eye contact when talking and less when listening with reverse true for Anglo Americans.
- Among Latinos, it is respectful to avoid direct eye contact with authority figures.
- Among Asians, direct eye contact is very brief, with the gaze then sliding away to the side, especially with superiors or members of the opposite sex.

Speaking Volume

White Americans typically interpret raised voices as a sign of anger or hostility. Among non-white Americans and other ethnic groups such as Latin Americans or Africans, raised voices may simply signify an exciting conversation.

Touch

Compared to other cultures, Americans rarely touch each other, limiting ourselves to handshakes and occasional pats or hugs in closer friendships.

- Latin Americans and Middle Easterners touch with much greater frequency. In these cultures, it is not uncommon for two men to hold hands, signifying nothing more than friendship.
- Japanese, touch less than Americans and may be uncomfortable being touched in a casual relationship. Touching someone on the head is offensive to most Asians.
- People from cultures with conservative customs regulating inter-gender relationships may be extremely uncomfortable being touched by someone of the opposite sex.

Diversity Tip Sheet, The Diversity Council – DMHAS 2008

Other Risk Factors that affect Responses to Situational Triggers

- Poor impulse control
- Poor coping skills or ability to self manage angry behavior
- Don't care and/or anger is used as part of intimidation.
- Fatigue
- Being overstimulated/over-activity
- Being medically sick/ill
- Adverse medication reaction

Assessing the Risk of Danger/Violence

Risk and Protective Factors

There are many factors that increase or decrease the potential for dangerous or violent behavior. Risk factors increase the risk/chance and protective factors decrease the risk that something will occur. Patients at risk typically have more risk than protective factors and vice versa. The goal of inpatient treatment is to tip the scale so that the protective factors outweigh the risk factors.

Protective factors work to protect the person against the risk factors by either reducing the risk itself or by providing an alternative. Typical patient **protective factors** include:

- Religiosity – faith and a belief in a higher power provides comfort to many
- Reality testing ability, Life Satisfaction
- Engagement in treatment
- Demonstrated internal ability to cope with feelings e.g., hobbies, problem solving skills
- Positive social support (family and friends)
- **Positive relationships**: Service providers e.g., primary clinician, case manager, etc. Other supports e.g., family, friends, etc.

A trusting relationships is one of THE most important protective factors.

Risk Assessment (RA)

An extensive admission risk assessment is conducted on admission to identify person specific risk factors and develop a plan of care. It provides information about:

- What type of violence the person is capable of?
- When: How frequently the violence is likely to occur?
- Where: What conditions make the subject more likely to be violent?
- Who the likely targets is likely to be?
- How severe the damage is likely to be?

These **categories are typically assessed**:

M**edical conditions:** people with brain injuries or other conditions that reduce impulse control e.g., dementia, can be at higher risk. People with high fevers or whom are delirious can also become violent. Also, people in chronic and persistent pain often become increasingly irritable and may strike out in frustration. People can sometimes be violent immediately before or during a seizure as a result of the neurological misfiring that is occurring. People who **use/abuse substances** are at greater risk for violence especially when using or during withdrawal. Alcohol use is the substance that is MOST often associated with violence. Many people with mental illness (MI) also abuse substances. This also increases the risk of violence.

Generally, people with MI are no more likely to be violent that people without mental illness. However, there is a sub-category of people with MI that are at higher risk. We do know that as a result of mental illness, sometimes the violent behavior is not intentional and is related to their symptoms which affect their view of the world. For example, if someone is deeply depressed and hopeless, they are at greater risk for being a danger to themselves/suicidal.

Other

- People who were involved in or witnessed **direct military combat** have at the very least, experienced violence in a very different way than most of us. And, these experiences may have resulted in PTSD and may be easily triggered by environmental sounds (e.g., helicopters, loud sudden noises). This can result in higher levels of violence, but at the same time, their military experience related to self control/disciple can also be a protective factor.

- **Trauma** – People with a history of trauma may be at greater risk in response to self protecting against perceived threats.
- Young males have a higher risk of violence.

Extreme Emotional Stress

People who have experienced a recent lack or **loss** of social support; unemployment, loss of therapist can feel hopeless or angry.

Ultimately, there are many underlying risk factors that contribute to violence, but violence always occurs in context to the situation occurring at the time.

The greatest predictor of future violence is knowing the specific situations when the person was violent in the past. All of the information learned on admission is used to develop the plan of care including what interventions are likely to reduce the risks.

B=P X S

We've adopted this equation: B (behavior) = P (person) X S (situation), to help you quickly and systematically **assess** the risk factors present in a specific situation.

B = P X S describes the major categories of risk factors and shows that the behavior occurs as the result of the dynamic interaction between the **P**erson or people in a **S**ituation. It shows you that violence never occurs in a vacuum – it ALWAYS occurs in context to what is happening in a specific situation. This equation was developed by Dr. Joel Dvoskin, a leading authority in risk assessment of violent behavior.

The 3 major categories that you will assess include the:

1. Behavior of the people involved
2. Persons involved in the situation
3. Situational factors that are present at the time.

Of all of these parts of the equation, the SITUATION is the thing that you have the most control over changing and is the one thing you can do to prevent violence from happening.

Affective Violence

The vast majority of violence that occurs in our settings is a result of affective violence. It is violence that is reactive to a perceived threat that is experienced internally or externally. Earlier, you learned about the physiological affects caused by the Fight/flight response. In affective violence, the autonomic nervous system is stimulated.

Internal Threats: Typically the result of psychotic symptoms – auditory hallucinations, delusions – especially paranoia- or can be related to extreme anxiety e.g., phobia's, or chronic or extreme pain, or substance abuse.

External Threats: Result of a direct verbal or implied threat. Because of the intense autonomic nervous system arousal, the violence is typically rapid and over quickly.

The goal of violent behavior in these circumstances is to reduce or eliminate the threat.

Risk Analysis: B= P X S

Risk analysis is when you have identified all the risk and protective factors in- context - to determine **IF** violence will occur, **how serious** it might be and **WHEN** it will occur.

Determining IF violence will occur and HOW Serious it might be:

1. **Use B = P X S to assess all the risk and protective factors for everyone involved – where is the scale? Is it tipped to the risk factors?** A past history of violence doesn't necessarily mean the person will be violent now, but if the situation is similar, the likelihood is higher.

2. **Seriousness is determined by considering what the** thoughts, feelings and images of violence (Intent) are, AND the plan and means to carry out the plan. Looking back at patterns and types of violent behaviors will help. Consider all the risk factors in the context of the situation that is occurring. Remember to always consider the 3 highest risk actors: history of violence, active psychosis and active substance abuse.

   What's critical about this assessment process (B=P X S) is that it happens very quickly. If you miss any of the important pieces of information, your decisions and actions will be made based on missed information and will have a direct impact on what happens.

To determine **WHEN** you think the person might become violent, use these timelines:

- **Immediate – is about to happen or is happening right now.**

  This is a suddenly erupting high intensity situation and display of behaviors – often begins without a trigger being known or displayed – the intense response can be related to the person's internal thought process – may be described as unpredictable. If the trigger was known, the patient's response is often greater than expected. If the trigger was unknown, or the patient's response was unexpected, these situations are highly unpredictable. These are typically more dangerous and call for an immediate response however, they are often short and end quickly.

- **Short Term – high likelihood within 24 hours.**

  This can be a smoldering situation that is known and where there's a moderate level of intensity – over a longer period of time. These situations are unpredictable in that it is unclear where the situation is heading. They require constant monitoring and interventions. Or, it can be a bubbling up situation where the level of intensity goes up and down repeatedly, usually by mild increases and the ups never reach the highly intense level of a sudden eruption. This can involve only one person, or at times, it can have a contagious effect involving others – with behavior that is interconnected in a negative way. These are situations where staff often feel like you are "putting out fires".

- **Chronic Long-Term risk means that it can happen in the future.** People who are a chronic risk may become aggressive in a specific situation e.g., an anniversary date… or a court hearing. This is especially true if they are relapsing or under significant stress e.g., stopped taking their medications.

Patient: B (behavior)

- **Irritability:** easily annoyed or angered, unable to tolerate others presence.
- **Impulsivity:** behavioral and affective instability, inability to remain composed.
- **Unwillingness to follow directions** and becomes angry and/or aggressive when asked to adhere to rules, treatment, etc.
- **Sensitivity to Perceived Provocation:** sees others actions as deliberate and harmful, may misinterpret others behavior or respond disproportionately to the provocation.
- **Negative attitudes:** antisocial and negative attitude /beliefs may relate to violence and aggression.
- **Verbal Threats:** threatening, loud or profane and may include ideation or a plan. Intent is to intimidate or threaten.
- **May be unseen or related to thoughts.** Pay special attention to what the patient is thinking and talking about, because sometimes people don't act how they are feel, thus you won't have behavioral cues to observe.

Patient: P (person)

The 3 highest risk factors for violence are:

- **History of Violence:** people with a past H/O violence are more likely to commit violence in the future.
- **Active Psychosis** – people with untreated/active; especially paranoia, command hallucinations and the belief that thoughts are controlled externally are at high risk especially if they have:

  Paranoid Delusions – thoughts that others are out to harm them.

  Can lead to dangerous behavior because they cause a great amount of imagined fear.
  - This is especially true if the delusion includes a belief that one's thoughts are controlled by external forces. This belief can lead to dangerous behavior because the patient feels that they have no control over their own actions – thus, they are acting in self-defense.

  Command Hallucinations – Can lead to dangerous behavior because patients are more likely to obey the command especially when the hallucination is related to a delusional belief, and when the voice is familiar to the person.
- **Active Substance Abuse or withdrawal.**

Patient: S (situation)

Violence does not occur in a vacuum – it always occurs in the context of a situation. Importantly, something occurs that TRIGGERS violent behavior: Unmet needs is the typical trigger (cycle of dangerous behavior). Typically people are triggered when they feel betrayed, treated unfairly, threatened, disrespected, wrongly accused.

Staff Behaviors that Increase the Risk of Becoming a Victim of Violence

Staff are also part of the Risk equation and must be assessed. These behaviors increase the risk that you will become the victim of violent behavior.

- Poorly managed anger or fear
- Irritability, Negative attitudes
- Impulsivity, Authoritarian Approach
- Not using Active Listening
- Sensitivity to Perceived Provocation

Key Staff Risk Factors

These are the most common (among many) risk factors that increase the risk that you will become the victim of violent behavior:

- Youth and inexperience,
- Lack of training, knowledge and skills
- History of trauma make you more vulnerable.
- You may be an identified target.

Situations that increase the risk of Staff becoming a victim of Violence

Always pay attention to the situational context.

- If you are in a **similar situation** with a patient when violence occurred in the past. The likelihood increases that they will be violent again – if there hasn't been a substantial change in their risk and protective factors.
- Fatigue and letting you guard down.
- Setting limits & Unfamiliarity with patients

Staff Protective Factors

These have been found to reduce the risk that you will become a victim of violence:

- Experience and Training
- Ability to manage anger/fear
- Positive problem solving skills
- Positive work relationships
- Treating people with respect, dignity and compassion
- Job satisfaction

Other patients, like roommates – can also be victimized when the patient is angry. In our inpatient settings, while not a common occurrence, there are patient on patient assaults. Know who is getting along and who is not and closely monitor their interactions. And, work with both to resolve the conflicts. Sometimes, a room change will help.

Regardless of the relationship, anyone can **trigger a** patient – remember, pay close attention to the situational context and WHO's in it – what role do they play in escalating or calming a situation.

NOTES—Learning Activity (Risk Management)

1. **For staff, what is your immediate concern**

2. **Is there risk? Who is at risk?**

3. **What are the factors that contribute/minimize the risk?**

4. **What additional information would you like to know about the patient/staff or situation?**

5. **Select a staff response to manage the risk.**
   - Please describe?

Assess/Analyze Select Act Evaluate

Risk Factor– Staff Burnout (Mental Health Providers)
Staff Burnout is a serious risk factor for mental health providers
Burnout is a psychological syndrome developing over time as a result of difficulty managing chronic job related stressors. Christina Maslach, social psychologist, a leading authority and researcher on staff burnout, describes burnout as consisting of the following components:

- Emotional Exhaustion
  - Compassion Fatigue
  - Vicarious Traumatization
- Depersonalization/Cynicism
  - Negative and Cynical Attitude towards patients, co-workers and management
- Reduced Personal Accomplishment
  - Negative self-evaluation of job effectiveness, self worth

Staff burnout will get progressively worse if steps are not taken to address the problem. Several studies highlight the increasing scope and prevalence of burnout with mental health workers and it's impact on staff on emotional and physical health. Burnout, if untreated, often becomes a chronic condition.

- 21%-67% of mental health workers may be experiencing high levels of burnout. Morse, 2012
- 54% of mental health workers had high emotional exhaustion, 38% reported depersonalization. Webster & Hackett, 2008
- Burnout often increases feelings of being powerless, ineffective, lack of personal achievement, and job dissatisfaction. Maslach & Leiter, 2001

Burnout is associated with a large number of negative conditions that impact employees, organizations, and the patients they serve.

- Burned out employees may be less able to be empathetic, collaborative, and attentive. Corrigan, 1990
- Burnout is associated with reduced commitment to the organization and negative attitudes towards their patients. Holmqvist & Jeanneau, 2006
- Burnout is associated with decreased patient satisfaction and is linked to poor outcomes. Halbesleben & Rathert, 2008
- Burnout may also damage morale of other employees. Stalker & Harvey, 2002

Risk Assessment– Staff Burnout
Burnout can be prevented and burnout reduction is possible. The first step is recognition**.** The following Burnout Self Assessment Questionnaire can help staff identify feelings about their job and if they are at risk for burnout.

- Am I enjoying my work?
- How do I feel when I arrive at work?
- Am I prone to negative thoughts about the job?
- Do I dream about work-related things?
- Do I distance myself from certain clients?
- I feel the organizational structure is frustrating my ability to do a good job?
- Am I drinking, overeating, getting enough sleep?
- Do I feel worthwhile?
- Am I under stress?

Risk Management—Staff Burnout
Regardless of whether organizational measures and support structures are in place, each staff member must take responsibility for their health and wellness by following these recommendations:

- Acknowledge the problem, know your red flags
- Maintain awareness of your limits, avoid excessive overtime and avoid unnecessary stress
- Alter the situation and Adapt to the stressor
- Know when to say “No”
- Debrief stressful events, know when and how to ask for help when needed.
- Engage in Self-care (ex. Regular Cardiovascular Exercise, Burnout/ Stress Reduction Activities/Programs, Relaxation Activities, e.g. Yoga, Mindfulness Meditation)

NOTES

17

PROTECTIVE PHYSICAL TECHNIQUES

Protective Physical Techniques

Personal Space

Ready Stance

Protective Stance

Step Slide

Pivot and Parry

Blocks (Inner, Outer, Lower, Leg)

Choke Escapes

READY STANCE

- Turn to the side (45 degree angle)
- Feet shoulder width apart
- Knees slightly bent
- Hands above waist level

PROTECTIVE STANCE
"The Fence Concept"

- Assume Ready Stance and extend your arms in front of your body in a relaxed, natural, and non-aggressive posture. This allows you to control the space between you and a potential aggressor without escalating the situation.

BLOCKS - Upper

- Extend your forearm above and out from the front of your head

BLOCKS - Inner

- Bring forearm across the front of your chest, slightly past your centerline

BLOCKS - Outer

- Extend your forearm away from your centerline

BLOCKS - Lower

- Bring your forearm down across your centerline

BLOCKS - Leg

- Lift the heel of your front foot
- Pivot and turn your body to the side
- Absorb impact on the back or out-side part of the thigh

Two Handed FRONT CHOKE

- Tuck chin and raise both arms
- Place one foot back
- Pivot your body towards your back foot

Two Handed REAR CHOKE

- Tuck chin and raise both arms
- Place one foot forward
- Pivot your body towards your back foot

Rear Arm CHOKE

- Tuck your chin, pull down on arm & forearm,
- Widen your stance & lower you hips, turn your face away from the Pt's elbow

- Pivot your hips and turn your upper body towards the Patient, then place your foot behind the Pt's foot

- Release the grip on the wrist then,
- Place your inside hand on top of Pt's wrist

As you push forward on elbow—push down on the wrist; slide your head out

21

COLLABORATIVE RISK PREVENTION STRATEGIES

Strategy 3: Therapeutic Interventions for Enhancing Safety and Interrupting the Cycle

Communication Strategies

Consistent with the recovery model and DMHAS philosophy, the focus is on using the **most therapeutic – person centered** interventions. With this perspective, this module is a review of communication strategies that will minimize the risk of behavior escalating to a level of dangerousness or violence. "For people working in Human Services and those providing services to the public, effective communication skills are one of the most crucial components of your job." *National Organization for Human Services*

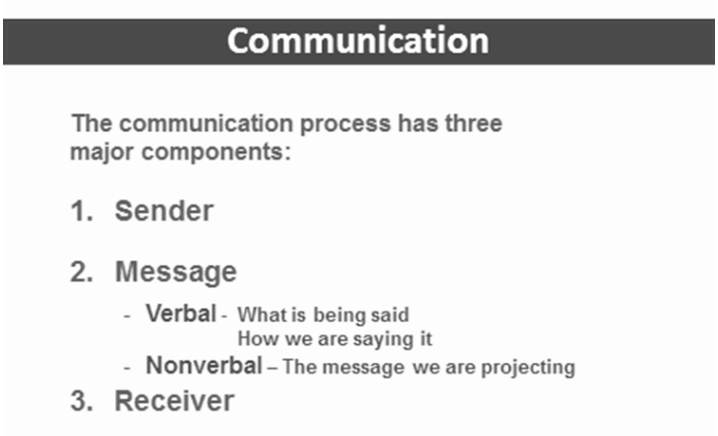
Verbal De-escalation—Using a Conflict Resolution Approach

Reasoning with an highly agitated person is usually not possible.
The goal of Verbal De-escalation is to decrease agitation and reduce the potential for violence. The primary objective in Verbal De-escalation is to reduce the level of arousal so that discussion becomes possible.

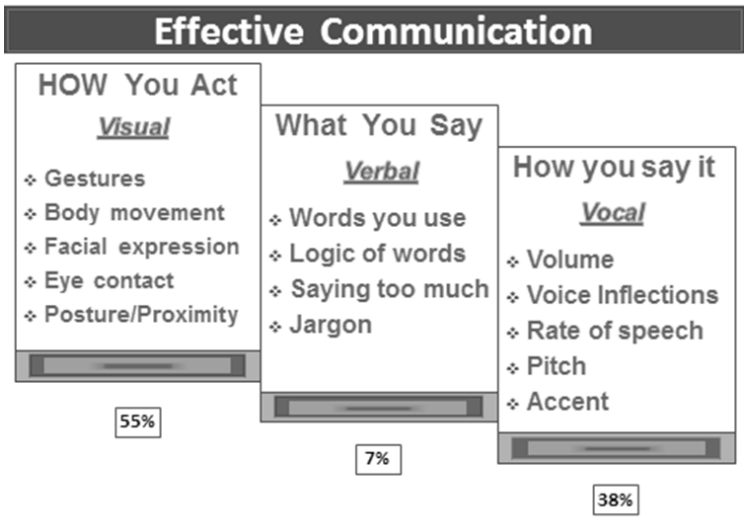
Remember, challenging behaviors serve a purpose, a function - to change the current situation . As we review how to verbally de-escalate agitated and angry individuals, we need to remember the Cycle of Dangerous Behavior and the contextual framework that provides a better understanding of the cyclic nature of angry behavior. Unmet needs can generate strong emotional responses. During the de-escalation process it is critical to identify what is the unmet need and how can we change the situation to avoid further escalation. Can we help the patient to get their needs met or help them cope with an unmet need?

There are many factors that can have a negative impact on this interactional dynamic and a patient's response, such as poor coping skills, or being cognitively compromised by the symptoms of their diagnosis. Additional factors include staff's inability to acknowledge and demonstrate responsiveness to the patient's needs. Remember, how you respond to patient in a heightened state of emotional arousal, your verbal and non-verbal communication, and how it is perceived by the patient can often be the determining factor in your ability to resolve conflict and have safe outcomes. Our best chance at achieving safe outcomes requires early intervention before the behavior increases in intensity to the Crisis Phase.
Let's review the basics of effective communication applied to Verbal De-escalation skills.

Communication is the process of sending a message, whether it is verbal or nonverbal. This process requires a variety of skills including processing, listening, observing, speaking, questioning, analyzing, and evaluating. It is through communication that collaboration and cooperation occur. Communication consists of these 3 major components:



With face to face communication, the message is both **Verbal** & **Non-verbal**.

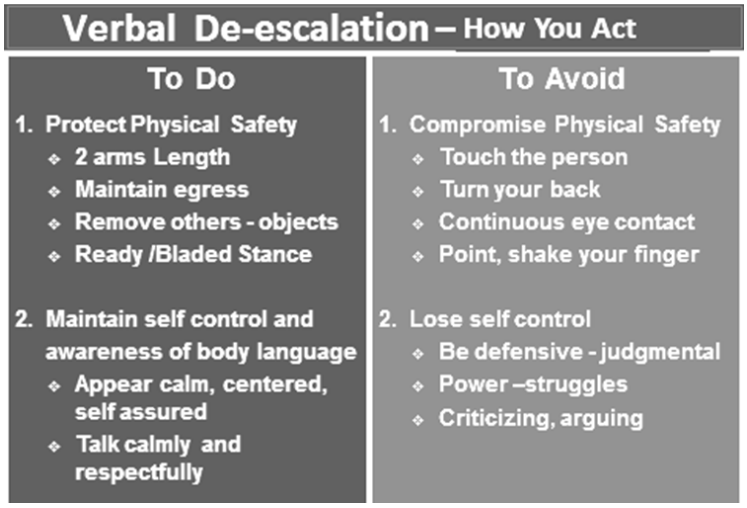


Effective communication can be a very challenging process. There are numerous barriers to effective communication, especially when interacting with individuals struggling with the symptoms of mental illness. It is essential that we know how to overcome common barriers and how to create bridging statements and strategies that allow us to connect and build rapport with our patients to ensure they are receiving the messages we intend.

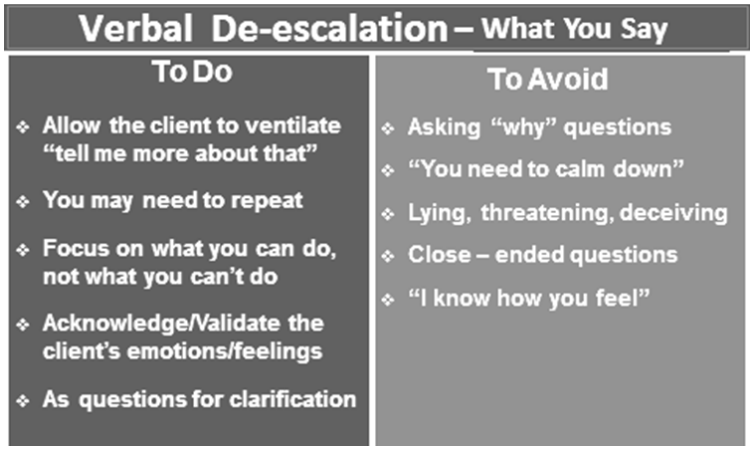
In face to face communication, messages are communicated in 3 ways:
How you act — The message is our posture and body language communicating.
What you say — The spoken words used to communicate.
How you say it — the tone of voice, volume, inflections, etc.

Is verbal content only 7% of how we communicate? Of course not. These numbers, originating from two research studies by Albert Mehrabian, are controversial and often misunderstood. In face to face communication, where there is inconsistent or contradicting communication, body language and tonality may be more accurate indicators of meaning and emotions than the spoken words. This is important to remember, especially when attempting to communicate with someone is heightened state of emotional arousal. For many of our patients, the ability to effectively communicate their needs can be a challenge.

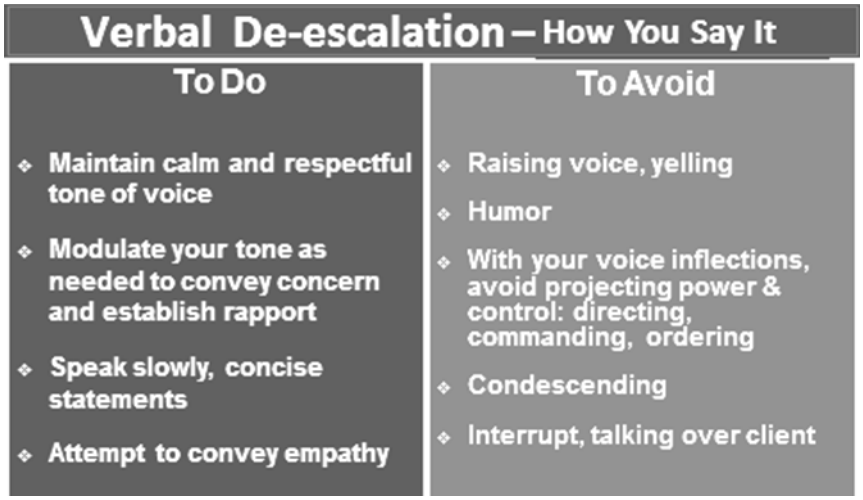
As previously stated, **How you act, What you say, How you say it,** and more importantly, how it's perceived by the patient can make the difference in your ability to effect safe outcomes. Let's start our review of **To Do** - Bridges to effective communication and **To Avoid** - Barriers to effective communication for "**How you Act**".



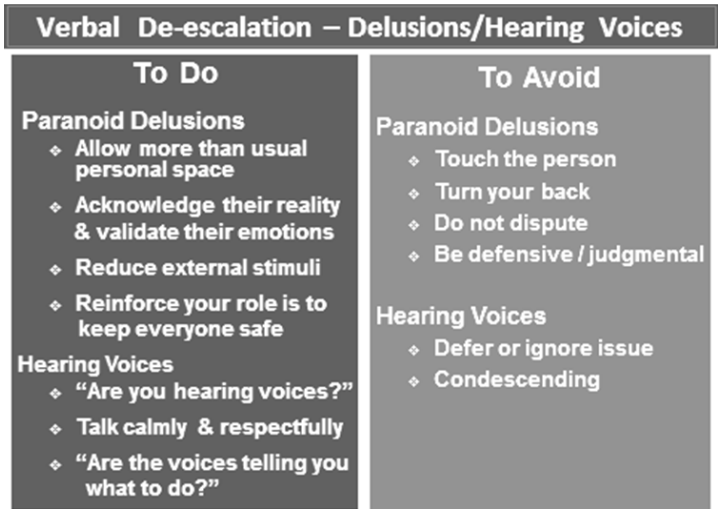
Maintain awareness of the message your facial expressions, posture, and overall body language may be communicating. Your verbal and non-verbal should be congruent.
Physical safety is a priority and should never be compromised. Addressing physical safety for yourself and the patient makes successful de-escalation possible. Maintain personal space appropriate for the situation. By maintaining appropriate personal space, you are less likely to trigger the fight, flight, and freeze response in yourself or the patient.
Avoid touching or turning your back to an agitated patient. Whenever possible, remove an audience and reduce stimuli. It is natural for staff to experience an emotional response such as anxiety, anger, or fear. However, effective verbal de-escalation is not possible if our responses are driven by emotion. The key to managing your emotions is knowing what your personal triggers are and the warning signs of those triggers. Project calmness and be respectful. Avoid being judgmental or making statements that might trigger a power-struggle.



What you Say—Remember, allow the patient to ventilate their feelings, it's better to talk it out than act out. Validate their feelings and emotions, this will help to reduce their level of emotional arousal. Focus on the positives, what you can do to help, avoid talking about what you cannot do. Avoid making promise, even though well intentioned, making promises can backfire if you are unable to follow-through. Avoid saying anything that reduces dialogue such as closed-ended questions.



How you Say It - Your tone of voice should project respect, empathy, and a calming effect. With your voice inflections, avoid projecting power and control, or being condescending. Maintain awareness of your emotions and the possible effect on your vocal tonality. Remember, the use of humor is a high gain, high risk tactic. Humor should be used sparingly and never at the expense of the patient.



Attempting to verbally de-escalate someone that is delusional or hearing voices can be very challenging. With a patient that is experiencing paranoid delusions, you need to be cognizant of their safety needs as well as your own. Allow for more personal space than usual. Means of egress should be available for you and your patient; avoid being isolated. Acknowledge their reality and validate their feelings/ and emotions. Address their safety needs and reinforce your role is to keep everyone safe. Redirect when opportunity allows. Avoid disputing their perception of reality and being defensive or judgmental, especially if you are the focus of their delusions.

With a patient you believe is Hearing Voices, it's important to identify the content of the voices and how the patient feels about the voices. "Are you hearing something that I am not hearing?" "Are the voices telling you what to do?" With an agitated person hearing voices, avoid deferring or ignoring their experience.

The NEAR verbal de-escalation approach is a 4-step process that can be very effective when responding to challenging behaviors.

NEAR - Verbal De-escalation Process

N Neutralize
Intervene without escalating the situation by your approach; Assess for safety, maintain adequate person space, introduce yourself and communicate to patient that you are there to help. Control your emotions, Remain Calm.

E Empathize
Primary objective – reduce level of emotional arousal
Acknowledgement, try to see the Patient's Perspective
Validate person's feelings/emotions i.e., "it's ok to be angry …"
Convey concern, interest using verbal and non-verbal
Take focus off of you, focus on their feelings/emotions
Identify things that allow you to agree with the patient

A Active Listening
Identify the Issue (what is the key unmet need—the triggering factor?)
Ask Open-Ended Questions i.e.., Can you tell me what is upsetting you right now? Is there <u>one thing</u> that would be good to have changed (different)?
Use paraphrasing - i.e., "What I hear you saying is…Let me see if I understand you... "

R = Resolve
Attempt to build collaboration, explore/explain options
Empower the individual to choose i.e., "Do you have any ideas that would help you"?
Explain natural consequences of their choices/actions
Use checking-in statements " Is that OK?" "Does that sound like a good plan?"

Remember, there are 3 ways to agree :

a. Agree with **the truth** *"Yes, I can see that you are angry"*;

b. Agree **in principle** – if patient feels disrespected by someone, "*I believe everyone should be treated with respect."*

c. **Agree with the odds** *e.g., if patient is angry about waiting, "others would be too."*

Respond selectively; answer all informational questions no matter how rudely asked, (e.g. *"Why do I have to take these meds?"* This is a real information-seeking question). **DO NOT answer abusive or provocative questions** .

- Explain limits and rules . Remember, weigh the consequences of inappropriate behavior without threats or anger

Empathize with feelings but **not with the behavior** (e.g. "*I understand that you have every right to feel angry, but it is not okay for you to threaten me or other staff.)*

- Do not ask how they are feeling or interpret feelings in an analytic way.
- Suggest alternative behaviors where appropriate e.g. *"Would you like to take a break and have a cup of juice or some water?*

Offer something to drink, snack. This shows you are listening, making the time and as a nice gesture, in and of itself can help to defuse the anger. Timing is everything on this…don't do this in the heat of escalation, but may work as the person is beginning to de-escalate.

Trust your gut: If you assess or feel that de-escalation is not working, STOP! You will know within a couple of minutes if it's beginning to work. If it's not, or you determine that it won't be effective to continue, reassess and consider next steps.

Additional communication strategies include the following:

Limit Setting

Verbal limit setting can be either directive or you can use wondering reflective statements. Limit setting is used to obtain a desired outcome that is pre-determined by the staff. The 4 step process for setting limits include:

1. *Pointing out the maladaptive BEHAVIOR*
2. *State the desired behavior*
3. *Provide reasonable choices and explain the consequences (without being threat-ening)* and if you think stating the consequences will be a trigger, don't say it.
4. Follow through with the consequences

Sometimes, explaining the consequences will be perceived as a threat or challenge, despite a helpful tone of voice. You should only do so when you've assessed that there is therapeutic value in stating the consequence.

Wondering Reflective Limit setting statement:
Statement acknowledges behavior and directs them to think about consequences.
"Tim, I know you are soon to be discharged, I am wondering what will happen if you continue to verbally threaten your roommate?"

A wondering reflective limit setting statement is typically used to gain cooperation by acknowledging the behavior and works best with people who are more able to self regulate their behavior:

Saying No or "Wait" (can't do it now) and **sharing bad news** (loss of status/level, family emergency, etc.) often serve as triggering events and can happen pretty routinely with your patients. They may be asking to go out for a walk and you can't take them right now…or you might be the staff telling them that they are not getting a level/status change.

It you don't already do this, ALWAYS consider ahead of time what the response/impact will be and if it will be a triggering event. Consider the following:

1. How likely is it that no, wait or sharing bad news will be a trigger?
   - How important is it to the patient?
   - Have they asked repeatedly?
   - Are they expecting a yes?
   - Are they expecting bad news?
2. How soon after hearing this is it likely to occur (immediate or short term risk)?
3. How severe will the outcome be if it does occur?
4. What do we need to do to reduce the risks starting NOW?

Just because it's a minor request doesn't mean that it's not a big deal to the patient.
To interrupt the cycle when you think the patient might be triggered by hearing no, wait or bad news, plan ahead and consider these things:

WHY: Sometimes, these responses are related to staff convenience rather that how these responses should have therapeutic value (not necessarily mutually exclusive) – so think about WHY you are saying no. wait or giving bad news and if it could be a "yes".

WHEN: Timing can be everything – consider time of day, weekday vs. weekend or Holiday and your availability e.g., don't "drop the bomb" at end of shift or prior to your being unavailable if you are the primary clinician.

WHERE: Public vs. private space depending on anticipated reaction. Always make sure co-workers know where you are.

WHO: The greater the response or impact, the more familiar and trusting the staff should be that's saying no- BUT, sometimes it's better for a neutral person to give the news.

HOW: Choose your words carefully – so that they lessen the potential impact.

Remember, you are creating a situation in all of these, so situational awareness is critical. Whatever verbal technique you decide to use:

Avoid power struggles. Always consider how you request or respond to a patient. Remember that it is not about power and control, rather every interaction you have has therapeutic value.

Consider focusing on the positive versus the negative. For example if you want someone to stop doing something, consider phrasing it with what you *want them to do* rather than what you don't want them to do.

Distraction and other therapeutic interventions:

There are situations with patients for whom verbal interventions don't work and/or are contraindicated, thus they can't engage in verbally. Generally, people who are profoundly impaired by psychosis, delirium or cognitive deficits – may not respond or benefit from verbal interventions. In fact, **less interpersonal stimulation, not more**, may help.

At these times, distraction is a good technique. The type of activity you select to distract the person, that will work best is one that they prefer i.e., alone time with music, being left alone quietly, doing a physical activity or writing in a journal. There are times when the your best option may be stop trying to engage the person and see if after a few minutes you can re-approach them.

- Comfort Room
- Sensory Modulation devices e.g., Weighted Blanket
- PRN Medications: To treat the underlying symptoms of specific diagnoses
- Personal Preferences
- Other:

Staff to Staff Communication—3 Ws

The 3 Ws is an easy, simple, direct & focused way to communicate safety concerns with members of your team.

What I see – Share clinical information that you see e.g., *I just noticed that Bill is pacing more, is talking more to self -looks angry and preoccupied.*

What I am concerned about – *I'm concerned that this can escalate quickly because he has been refusing his meds and has a history of violence.*

What I Want/Need – *I believe he needs to be evaluated. I don't think he should be alone, I can stay with him until you come.*

The 3 W's are also a great way to communicate with the patients you are concerned about. What you change is the last W and the patient is asked: *What can I/we do to HELP?* This model structures the discussion for you and the patient and is a great way to discuss non-emergency planning with the patients who are a short term risk for dangerous behavior.

Collaborative Crisis Management:

Strategy 4:
Safety Strategies in Escalating and Crisis Situations

Consistent with DMHAS policy, the use of restraint or seclusion is based on the use of least to most restrictive interventions. This phrase represents the continuum of increasingly restrictive interventions including the use or mechanical restraints and seclusion (R/S), which are considered the last resort and most restrictive interventions. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm.

Underlying Principles for the Use of Restraints or Seclusion

These underlying principles are important in your decision making process and always must be considered:

- They are only used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff or others.
- They are not used for coercion, discipline, convenience, retaliation or as physical or mental abuse or corporal punishment.
- All patients have the right be treated in a safe environment and to be free from all forms of abuse or harassment.
- All employees have the right to work in a safe environment.
- The risks of not intervening are greater than the risks of intervening.
- Choice of intervention is least restrictive.

Crisis situations require an immediate response. The first action you take in an emergency is to alert staff/get help, ensure you have adequate human and material resources. Follow your facility policy regarding calling a Code. From that point on, the decisions about if a restrictive intervention is warranted and what restrictive intervention is appropriate to take depends on your assessment/analysis of your ability to contain the violence using the least restrictive intervention. So, for example, if you determine that you are able to contain using the secure guide escort, then you'd use it. If not, you'd pick the technique that you determine will work. You don't have to try each in the order they are listed- your assessment will determine what technique is most likely to work to contain the violent behavior. Remember, the use of restrictive interventions, Restraints or Seclusion, require that the patient's behavior presents an immediate risk to themselves or others.

Restraint Use

There may be times when non-restrictive interventions have failed or are contraindicated, and the use of physical /mechanical restraints are warranted. Restraints is defined as: *Any mechanical device or physical/manual hold, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.*

Use a team approach and CSS authorized techniques. Remember, face down restraints and pain compliance are prohibited.

Seclusion Use

Seclusion may be an option if it is preferred by the person and is safe. Individuals should not be in seclusion, for example, if they are actively suicidal or self-injurious, are unable to contain their outward physical dangerous behavior (physically unsafe), need to be closely medically monitored (medically safe) or traumatized (psychologically safe) by being alone in the seclusion room. Once you've determined that seclusion use is safe, reassess their physical status before leaving them alone and then continue to monitor them closely. Seclusion is defined as: *The involuntary confinement of a patient alone in a room or an area from which s/he is physically prevented from leaving*.

Managing a Crisis using the Team Approach

The Team Leader Role and Responsibilities

The Team Leader can be the staff member that is:

- Most directly involved in the trigger or escalating phases
- Most familiar to the individual
- Self-appointed: volunteers to lead
- Pre-determined – per policy, or based on earlier Risk Assessment that determined an individual is a Short Term Risk for dangerous/violent behavior.

The Team Leader is responsible for determining the plan and directing the intervene tins. Tasks include:

1. **Identifying self** *as the Team Leader and communicating it verbally. If you are called to a crisis and can not determine who the leader is – ask.*
2. *Assigning someone to* **Call a code.**
3. **Assigning limbs** (*arms-arms-ankle-leg-head, if needed extra arms-arms). Be prepared to provide the verbal countdown (1-2, technique, go) when directing a physical intervention.*
4. **Assigning someone to secure the scene by** *removing other patients from the immediate area and removing items that present a risk.*
5. **Assign an Observer.**
6. **Assigning someone to the door** *of the unit to inform code responders of the situation and instruct them as needed*
7. **Assigning someone to get the MD, a nurse to get PRNs if applicable.**
8. Assigning **someone to get the restraints** *& bed/stretcher or prepare the* **seclusion room**
9. **Manage the emergency** *through to the end, including organizing the post-crisis staff*

If you decide to turn over the Team Leader role, verbalize it clearly and formally so that everyone knows it changed. Communicate what's happened to the point of handoff. Typically, there should be at least five members for the takedown. As the team leader you may have to physically participate as needed, while directing the interventions.

Selecting Team Members. When selecting team members, consider assigning staff that are the most appropriate and for what role for the safest possible outcome.
Make assignments based on their strengths/abilities as related to the specific patient and the role assigned to them as well as patient related factors including:

- **Trauma issues**. Consider the individual's response to gender of team members (especially in situations where there is a history of sexual assault). When possible have both men and women as part of the team. Give consideration to the placement of team members during the physical intervention.
- The **age and/or physical condition** of the patient. Give special consideration to the elderly as well as those with medical complications. Evaluate the person's strength and physical abilities i.e., some people have skills to defend themselves if they feel threatened.
- **Developmental or cognitive disabilities** should also be evaluated. People with Traumatic Brain Injuries (TBI) or Acquired Brain Injuries (ABI) and individual's in the Young Adult Services (YAS) program should be evaluated for reactions to touch and the need for space. These individual's often feel threatened and have a need for greater personal space and are sensitive to being touched.
- The **patient's relationship with potential members**. Be sensitive to known transference or counter-transference issues when selecting team members, especially in roles where they would be in view of the patient.
- **Ethnicity**. If a patient has identified a preference for speaking with someone in their native language all efforts should be made to accommodate that. If there is a known trigger related to an ethnic sensitivity, staff should make every effort to reduce the presence of that trigger during the crisis intervention. Cultural differences are unique to each individual. Staff should explore any observed or noted ethic preferences and incorporate them into the person's treatment plan.

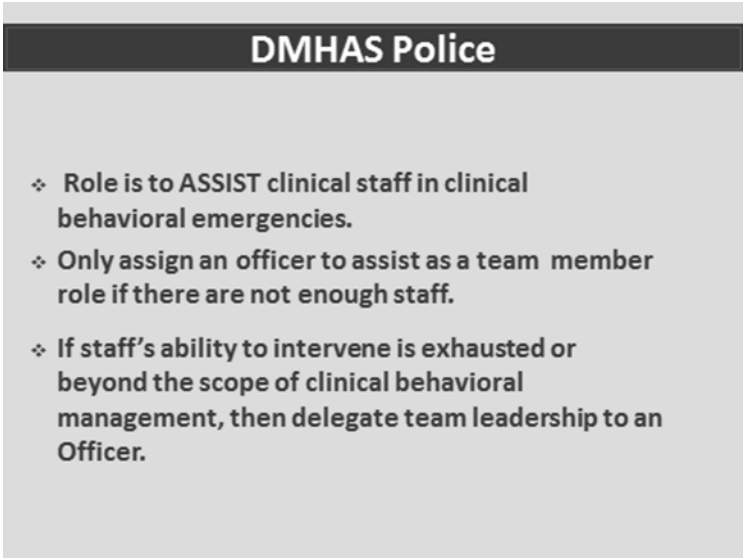
In a suddenly erupting crisis, you may not have time or the resources to select the best staff for the best roles. Remember, you can change assignments when it is safe to do so.

The Team Member Role/Responsibilities

Once selected and assigned as a Team Member, always:

- Follow the Team Leader's instructions.
- Monitor the patient's physical and emotional status.
- Continue instructions until told otherwise.
- Never physically intervene alone.
- If you don't know who is the Team Leader, ASK .

The Role of DMHAS Police



The following policy statement speaks to the role of the DMHAS agency police officers in the management of patient behavioral emergencies:

"*Behavioral emergencies are clinical situations that are typically managed by clinical staff. However, officers are expected to respond and provide assistance, if there is not adequate clinical resources to intervene and manage the situation. In this role, they function as a team member, directed by the "Team Leader".*

When clinical staff determine that all preventive and emergency safety interventions have failed or are determined to be ineffective, the Clinical Team Leader will delegate primary responsibility for managing dangerous patient behavior to the DMHAS Police.
In situations that require an immediate police response, e.g. presence of a weapon and/or dangerous instrument, hostage, barricaded individual, the DMHAS Police will assume primary responsibility for protecting the patient and/or others from harm.
Police management of these situations is not considered a healthcare intervention, but rather, a law enforcement intervention. Law enforcement interventions as a means of coercion, discipline, convenience, or retaliation shall not be tolerated.

The decision to arrest the patient, following the use of less than lethal weapons, e.g. chemical spray, baton, and techniques by police to contain the dangerous behavior shall be made consistent with the Commissioner's Policy 6.23 "Arrest of Clients" and PSD's applicable Administrative Directives."

Preventing Restraint related Injury or Death: A-F Assessment

This patient assessment can be utilized in managing the risk of physical intervention. Starting at the head/neck….you will check the airway and proceed anatomically down the body:

Airway	Can they get air in? Is there any pressure to their neck? Is there or other item blocking their airway Is their mouth or throat free from vomit? Are there any signs of airway obstruction? i.e., gurgling/gasping sounds; verbal complaints or difficulty speaking
Breathing	Are they able to breathe? Is their chest free to move? Is their abdomen free from pressure? Are there signs they are having difficulty breathing? i.e., an increased effort to struggle or heightened distress/anxiety (Excited Delirium)
Circulation	Can blood be circulated efficiently? Are their limbs free from pressure Are there any signs of tissue hypoxia? i.e., pale/grey/blue skin coloring to the lips, nail beds or earlobes Are there reported symptoms of compartment syndrome? i.e., pain, pins and needles, pulselessness and/or paralysis
Deformity?	Is there a risk of injury to any joints, limbs, or other skeletal/muscular structures? Is the spine in correct alignment? Are the joints of the upper and lower limbs free from end-of-range stress? Is the patient complaining of discomfort or pain to any party of their body? In addition to the risk of respiratory and cardiac risk factors, remember, that the elderly pose risks associated with poor skin integrity and that their bones tend to be weaker / brittle, so there is a greater risk for injury.
Existing medical condition or injury?	Is there anything known about this patients medical history that influences risk? Any known respiratory disease? Any known cardiac or vascular disease? Any other relevant pathology or injury?
Fear	Regardless of the type of restraint or seclusion you use, fear can be a major factor. It may be related to past trauma or the current situation. Despite the fact that you've determined that the use of R/S are justified, your assessment should include any signs of emotional distress. Specifically, listen and look for signs of fear, emotional detachment, tearfulness, or any other emotion related to your use of R/S. This is especially important in determining which intervention to use: restraints or seclusion.

Hollins L: Managing the risks of physical intervention: developing a more inclusive approach.
Journal of Psychiatric and Mental Health Nursing, 2010 17, 369-376

Preventing Restraint Related Injury and Death

The 5 step process for **WHEN** to assess when using restrictive interventions:

Step 1: Done on admission *and findings included in treatment plan with plan for reducing risks*

Step 2: Done immediately prior to use *to determine whether R/S use is safe.*

Step 3: Done during application *to determine whether to modify your intervention or whether it's safe to proceed.*

Step 4: Done during use *to determine whether it's safe to proceed as well as when it's safe to discontinue.*

Step 5: Done immediately prior to release *to ensure that it's in fact safe to do so and to determine if any specific monitoring should occur following discontinuation (in addition to the standard monitoring).*

Intensive Care for the Patient in R/S

The use of restraints or seclusion doesn't end the crisis, it's only the point at which the violence is contained. In fact, the interventions that you have to use until the patient is behaviorally safe (out of R/S) are much like an intensive care unit in a medical hospital. That means that you must provide a high level of care and monitor the patient closely per individualized assessment and R/S Policy – constant observation is typical.

While monitoring, you must minimally:

- Continuously reassess physical, medical, emotional and behavioral condition i.e.,
  - Signs of injury associated with R/S use
  - Nutrition and hydration
  - Circulation and ROM
  - Vital Signs
  - Hygiene and elimination
  - Physical and psychological status and comfort
  - Patient specific concerns
- Use your facility specific flow sheets and policy's for other monitoring requirements.

Communicate concerns immediately to licensed medical staff. Take all complaints of pain, discomfort seriously – and have them immediately medically evaluated.

Debrief with the patient about what just happened. Provide reassurance and the specific criteria for discontinuing R/S; then work with the patient to meet the criteria based on your assessment e.g., in an extremely agitated or psychotic patient, some quiet time or music or other calming activity may be helpful. Find out from the patient, what would help them calm down and regain behavioral control.

Release from R/S

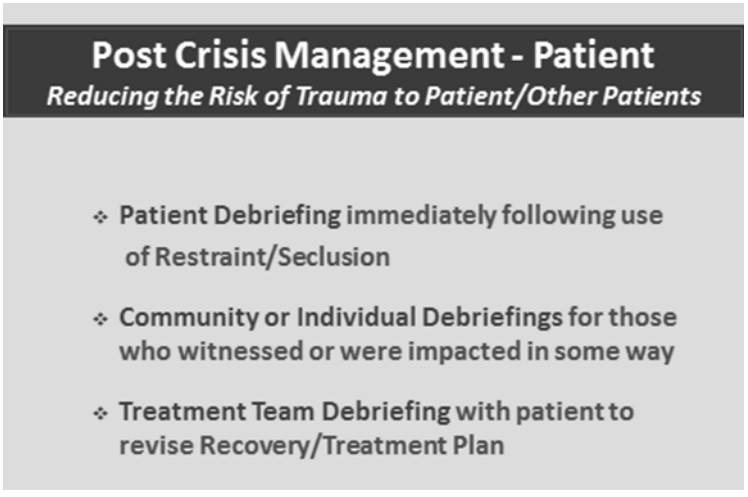
The main criteria for release from R/S is that the patient no longer poses an immediate risk of violence –again, think about the scale – the risks of remaining in either R/S now would outweigh the risks of release from R/S. Typically, you will observe that:

- Cognitively, there is a decrease in their focus, hostility and suspicion related to what triggered the behavior.
- They will be less aroused - irritability and intensity of emotions should be decreased.
- Impulsivity, verbal aggression, physical aggression, physical tension should be decreased. If they have had medications or used other methods to become calm, you should see fewer or decreased diagnostic symptoms e.g., agitation from psychosis.

When you are able to talk with a patient who is in R/S to debrief and help them meet criteria for discontinuing, the focus of the conversation is on the specific criteria. This is not the time for more in-depth, insight gaining discussions. That can and should occur after R/S discontinued. Remember that waiting too long to use R/S can have negative outcomes, so can releasing too early. Make sure that the criteria are met. There's always a risk or reoccurring dangerous behavior, but if the criteria is met and there's a plan in place, the risks should decrease.

After Care of the Person who has been released from R/S

Using the intensive care medical model, after a patient has been released from R or S, they should still be monitored closely. You should be viewing the patient as a short term continued risk and put a plan in place that reduces the likelihood that they will re-escalate. The patient should be aware of the plan – and whenever possible, should participate in developing it. It should address all the elements of the non-emergency plan that were received earlier e.g., interventions, activity, structure, etc.



Patient Debriefing
As required by DMHAS policy, a staff member should also immediately debrief the patient depending on their mental status and willingness to debrief. Similar to the staff debriefing, this debriefing should focus on immediate emotional/psychological needs. Supportive, reality based comments, such as "*we are here to keep you and everyone here safe*" are helpful. This conversation is typically held in the context of getting the patient's perspective on what occurred. Is there any thing that could have been done differently to avoid a restrictive intervention? Does the patient have any insight into what occurred?

Treatment Team Debriefing
As required by DMHAS policy, a treatment team debriefing should take place in which includes a detailed review of the incident and changes are made to the patient's recovery Plan if needed. The review includes information detailing what happened, what worked or didn't, the patient's perspective, and any new information about the patient that would help revise the plan.

Community Debriefing
A community debriefing is not required by policy, however, we should always consider the impact of these emergencies on others who may have witnessed the violent behavior, or who know about it and may be impacted in some way. In a 24 hour care setting, this is an excellent time to call an emergency Community Meeting to address the concerns of others and to reassure them that they are safe. Pay special attention to the patient's roommate(s) and meet with them as needed to provide reassurance. The community meeting may also provide information about what was happening prior to the crisis that you didn't know about.

Post Crisis Management : For the Staff
For staff, being involved either directly or witnessing a restraint or secluded related emergency may be traumatizing. Staff that are victims of workplace violence could suffer a variety of consequences, in addition to their actual physical injuries. These may include:

- Short and long term psychological trauma
- Fear of returning to work
- Changes in relationships with co-workers and family
- Feelings of incompetence, guilt, powerlessness
- Fear of criticism by peers, supervisors, managers

Post Crisis Management : Intensive Care for the Staff

Trauma

Signs and symptoms of trauma include the following:

- Difficulty managing your emotions; e.g.: depressive symptoms, pessimism, cynicism, fatigue, specific somatic problems, Irritability, anxiety, guilt,
- Difficulty accepting or feeling okay about yourself;
- Difficulty making good decisions;
- Problems managing the boundaries between yourself and others (e.g., taking on too much responsibility, having difficulty leaving work at the end of the day, trying to step in and control other's lives);
- Problems in relationships;
- Physical problems such as aches & pains, illnesses, accidents;
- Difficulty feeling connected to what's going on around and within you; and
- Loss of meaning and hope.
- Poor performance at work, absenteeism, avoiding restrictive interventions.

Staff Debriefing

Debrief immediately following emergency situation. The Team Leader is responsible for making sure it happens and may lead the debriefing, or have another person who is aware of what happened conduct the staff debriefing. Everyone that was immediately involved in the Crisis should attend.

- Immediately assess if there are any physical injuries.
- Immediately assess the emotional status of all involved.
- Briefly discuss what worked - in terms of the roles, responsibilities and mechanics of techniques used, what didn't work, and why.
- Make sure to share your feelings, to be heard, and validated.
- What can we do better next time? Can we avoid a restrictive response? Can we function better as a team?
- Make sure the information is incorporated into the plan that's developed for the patient upon release from R/S.

Support each other and use additional supports to decrease the risk or signs of trauma: talking helps reduce a sense of isolation, and rebuild trust in others, and may also enable you to contribute to the recovery of others. Accept that reoccurring thoughts will decrease over time. Use EAP and CISM as needed.

Documentation

Make sure that the following information is documented in the patient's medical record:

What happened **prior** to the use of R/S?

- The condition or symptoms) that warranted the use of R/S
- The response to all of the interventions) attempted, including the rationale for continued use of the intervention
- The rationale for the type of restraint or seclusion used

What happened **during or immediately after** R/S use?

- The 1 hour and any other face to face medical and behavioral evaluation;
- Notification of the individual's family/conservator/legal advocate, when appropriate
- Written orders and telephone orders for use
- 15-minute assessments of the individual's status
- Assistance provided to help patient meet the behavioral criteria that was identified for discontinuation of R/S
- Continuous monitoring
- Debriefing of the individual with staff
- Death or injuries that are sustained and treatment received for these injuries

Staff injuries are documented using the Worker's Compensation Injury Forms. Follow your facility policy for any other specific forms that are used.

NOTES:

40

PHYSICAL CRISIS TECHNIQUES

SECURE GUIDE ESCORT

- Your outside hand holds slightly above the patient's wrist
- Place your inside arm underneath patient's armpit and grab your other wrist
- Extend patient's arm across your body

Alternate Secure Guide Hold

- From Secure Guide Escort, reposition inside hand to secure the upper arm
- Bend knees, widen/lengthen stance

Third Person Assist

- From the Secure Guide, third staff member approaches patient from behind
- Use both hands to secure patient by holding their waistband

Fourth Person Assist

- From the Third Person Assist
- Staff in the Secure Guide Escort place their inside leg across and in front of the patient's leg
- Staff in the Third Person shifts over, Fourth Person slides in
- Fourth Person and Third Person help secure the patient, they are in a side stance, back to back

OPEN APPROACH TAKEDOWN

- Two staff approach the patient from the front, at a 45 degree angle
- Outside Hand holds the patient's wrist
- Simultaneously step forward and place Inside Foot behind patient's heel, heel to heel
- Inside Arm hooks under patient's armpit
- Take two steps and kneel on inside knee
- Remain hip to hip, feet shoulder width apart

Head:

- Place knees on opposite sides of the head
- Overlap open hands and place on patient's forehead

FLOOR CONTAINMENT POSITIONING
Following a Takedown

- The patient is always (**Face Up) Supine**, the prone (Face Down) is prohibited
- All staff are positioned facing the patient
- Never apply pressure to the chest or joints, pain compliance is prohibited
- Nothing obstructing patient's airway (Use face shield if needed)
- Remain hip to hip, feet shoulder width apart

Arms:

- Pt's arms at a 45% angle, palms down
- Hold the patient's upper arm and just above the wrist

Additional Support: Facing staff securing arms, two additional staff can kneel and hold arms above and below the elbow

Ankles & Legs:

- Cross closest leg over furthest leg
- Wrap your arm around & under patient's Ankles
- Place other hand on shins close to your chest and lean back
- Leg staff are on the opposite side, above or below the knees, hand positions same as Ankle staff

THIRD PERSON TRANSITION TAKEDOWN

- Staff in Secure Guide will step forward and away from the patient
- Pivot 180 degrees, facing patient
- Release your inside hand from holding your wrist and use this hand to secure patient's wrist
- Step forward, heel to heel, your heel behind patient's heel
- Place your inside arm, palm open, underneath patient's armpit
- Third person disengages as staff take two steps, kneeling on outside knee as the patient is lowered to the floor

FOURTH PERSON TRANSITION TAKEDOWN

- Two additional staff (5 & 6) approach patient from opposite sides, at 45 degree angle
- Staff 5 & 6 will grip patient's arm closest to them, above the wrist and above the elbow
- Upon verbal cue, staff in Secure Guide will move their Inside leg from in front of patient, pivot to the side while maintaining grip of patient's wrist
- Simultaneously, staff in 3rd and 4th positions will disengage and become Safety Spotters

Collaborative Safety Strategy Physical Techniques
Descriptions for Documentation

When documenting in the medical record, correct use of the technique name) used is critical to accurate documentation.

Technique Name	**Describes methods for:**
Personal Space:	Creating and maintaining a safe physical space around you that separates you from another person.
Ready Stance:	Standing in a non-aggressive position to minimize injury to major body organs/parts.
Protective Stance:	Standing in a non-aggressive position to minimize injury to major body organs/parts when faced with a perceived or immediate physical threat of harm.
Step Slide:	Moving away or towards person in a manner that maintains stability and prevents falling.
Pivot and Parry:	Moving out of the way and redirecting a person lunging aggressively attempting to punch or grab.
Blocks:	Using arms or leg, to protect against strikes.
Wrist Release:	Escaping from a single or double wrist grab.
Choke Escapes:	Escaping or surviving a front, back or side arm choke hold.
Bear Hug Escapes	Escaping bear hugs – arms trapped or arms free.
Hair Pulls:	Protecting scalp area and neck from a hair pull.
Bite Escapes:	Protecting against further injury from bites.
Guide Escort:	Escorting a patient (physically or medically unstable) with 2 staff. **This is Not a restraint**.
Secure Guide Escort:	Escorting a person with 2 staff using a more secure holding technique. **This is a restraint**.
Alternate Secure Guide Hold:	Used to regain containment if losing control of the Secure Guide Escort. This holding technique not an escort. **This is a restraint.**
3rd or 4th Person staff Assist:	Immobilizing and stabilizing a person by adding a third or fourth member who holds the person from behind.
Take Down:	Taking a person to the floor in the supine position typically using 5 or more staff members.
Verbal Altercation Separation:	Separating patients involved in a verbal altercation by using re-directionality.
Physical Altercation Separation:	Separating patients involved in a physical altercation by using the secure guide escort to separate one person from another.

NOTES:

Annual Competency Requirements by Function (Discipline)

Every Staff is assigned a FUNCTION FIELD which is utilized to assign Mandatory Competencies and provide Competency Compliance Reports. Look at the list below and determine which function field applies to you.

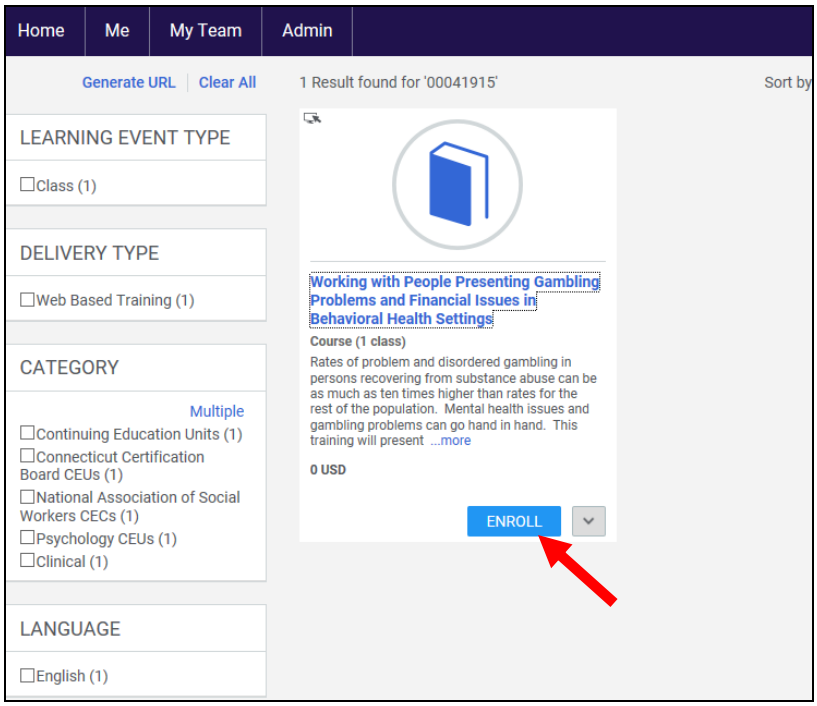
CMS: Clinical Medical Staff	**CSW: Clinical Social Worker**
CRN: Clinical Registered Nurse	**CRT: Clinical Rehab Therapies**
CLPN: Clinical Licensed Practical Nurse	**COSP: Clinical Occupational, Speech, Physical Therapist**
CPPN: Clinical Para-Professional Nursing Staff (MHA/FTS)	**CCAC: Clinical Certified Addictions Counselor**
CPSY: Clinical Psychologist	**COTH: Dieticians and Clinical Other (i.e. State School Teacher, etc.)**
	Non-Direct: Non-Clinical (Administrative Support Services Division)

Function →	CRN CLPN	CMS	CCAC CRT COSP COTH	CPPN	CSW CPSY	Non-Direct
WEB-BASED TRAINING (*Online using the LMS*)						
Computer Use Policy Class ID# 00060946	X	X	X	X	X	X
Fire Safety Annual Training (CVH) Class ID# 00087423	X	X	X	X	X	X
Agency Compliance and Integrity Training Class ID # 00037420	X	X	X	X	X	X
Reporting Abuse and Neglect- Code of Conduct Class ID # 00077573	X	X	X	X	X	X
Infection Control Annual Update Class ID # 00077860			X	X	X	X
Infection Control Annual Update PLUS Class ID # 00089471	X	X	**Special Edition for Medical Staff, RNs, and Pharmacists*			
Environment of Care Annual Training (CVH) Class ID # 00059688	X	X	X	X	X	X
Medical Emergency Response Competency Class ID # 00059690	X	X	X	X	X	X
Assessing and Managing Suicide Risk - Annual Review for Clinical Staff Class ID # 00055807	X	X	X	X	X	
Emergency Cart Competency Class ID # 00092870	X	X	X	X		
Understanding Diet Consistencies Class ID # 00066042	X			X		
INSTRUCTOR LED TRAINING (*Live- registered by your Division/Department scheduler*)						
Collaborative Safety Strategies (CSS) (5.5 hrs)	X	X	X	X	X	
CPR: Standard First Aid/AED- Challenge (1.5hrs)	X	X	X	X	X	
Oxygen Policy/Tank Use Competency (0.75 hrs)	X	X				
Glucometer Competency (0.5 hrs)	X					

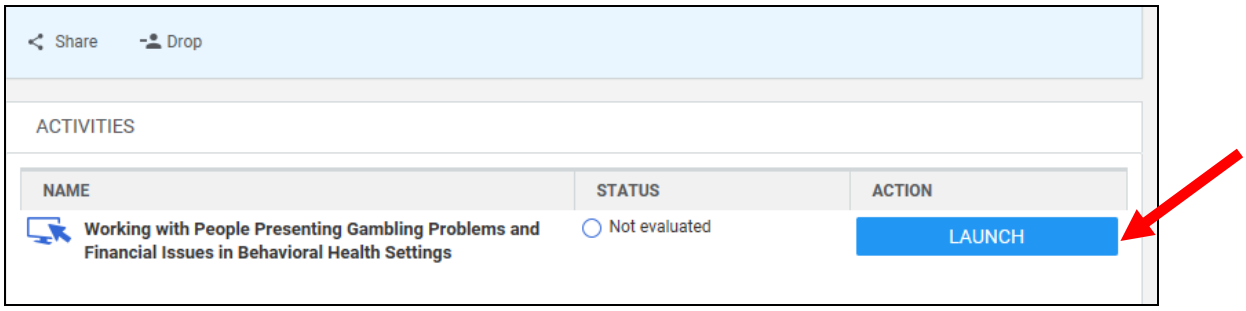
To Access the Web-Based Trainings:

- Login to LMS at https://ctlms.ct.gov (your username is your 6-digit employee #)
- Once you are in your home page, on the right side of the screen will be a **Catalog Search** box.
- Enter the class ID number in **Search** box.
- Next click **Enter** on your keyboard or click on the *magnifying glass* to search

- The page will refresh and the course will appear on the bottom of your screen (you may need to scroll down on the page). You will need to click on the ENROLL button.



- The page will refresh a second time and you will click on the right side select **Launch** and follow the instructions.



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	Non-Direct: Non-Clinical (Administrative Support Services Division)

CVH – OPTIONAL (One Time) WEB-BASED TRAINING

WEB-BASED TRAINING	COURSE ID#	CLASS #	STATUS	FUNCTION FIELDS
The Use of Weighted Modalities with Adult Psychiatric Populations	DMHAS_N9763	00036234	Web- based	***Optional***
Donning and Doffing PPE (10/14)	DMHAS_N9662	00048920	Web-Based	CRN, CLPN, CMS & CPPN ***Optional***
Importance of Wheelchair Seat Belts (2-11-16)	DMHAS_N9609	00058668	Web- based	CPPN, CRN & CLPN ***Optional***
Dysphagia	DMHAS_N2536	00059291	Web-Based	CPPN, CRN, CLPN ***Optional***
NP & P 13.3.5 Shaving (7/12/16)	DMHAS_N9560	00061696	Web Based	CPPN ***Optional***
Basics of Motivational Interviewing	DMHAS_N9802	00063350	Web Based	***Optional***
Legionnaires' Disease (10/14/16)	DMHAS_N9547	00063692	Web Based	***Optional***
Computerized Pre-book Overtime Training (11/10/16)	DMHAS_N9539	00064201	Web Based	CRN, CLPN, CPPN Middletown Campus ***Optional***
Incident Management	DMHAS_N9546	00064029	Web-based	All Staff ***Optional***
Diet & Meal Monitoring	DMHAS_N9533	00065138	Web Based	CRN, CLPN, CPPN ***Optional***
Prevention of Tubing Misconnections OP&P 2.30	DMHAS_N9629	00065972	Web Based	Clinical Staff ***Optional***
Temporary Exception for Special Observation- Privileged Conversation	DMHAS_N9503	00067037	Web Based	Clinical Staff ***Optional***

(Updated 3/7/19)

Professional Development:

Staff Development has started using National Seminars Training. Their mission is to provide the highest-quality training for organizations.

Staff Development provides Live Webinars for Middletown and Hartford Campuses once a month. Staff Development also provides remediation on the below topics for staff.

National Seminars Training

Topics included:

Assertive communication
Dealing with difficult people
Managing chaos and pressure at work
Dealing with toxic employees
Defeating negativity in the workplace
Extinguishing burnout and eliminating job overload
How to handle emotionally charged situations in the workplace
How to handle emotions under pressure
Building trust and cooperation across organizational lines
Clear and confident communication skills
How to handle conflict and confrontation
Create Better Understanding Through Active Listening
Handling Personality Clashes in the Workplace
The Essentials of Collaborative Communication
The Keys to Delegating Effectively
Must Know Secrets for New Team Leaders
Managing Millennials and a Younger Workforce
Leadership Solutions for when you are the Boss But You Have Limited Control

DMHAS
WORKFORCE DEVELOPMENT

INSTRUCTOR-LED TRAINING

Fall 2019 Catalog

www.ct.gov/dmhas/workforcedevelopment

10 New Trainings

DMHAS WORKFORCE DEVELOPMENT PERSONNEL

Main Telephone Number/Staff Phone Directory: (860) 262-5061, Fax Number: (860) 262-5073
Richard Fisher, LCSW, Director
CVH, 1st Floor, P.O. Box 351, Middletown, CT 06457
www.ct.gov/dmhas/workforcedevelopment
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RICHARD FISHER, LCSW	richard.fisher@ct.gov
KIMBERLY PLATT, LCSW, LADC	kimberly.platt@ct.gov
ANTHONY CRETELLA, RN	anthony.cretella@ct.gov

CONTINUING EDUCATION UNITS (CEU) INFORMATION

These instructor-led trainings offer continuing education contact hours approved by the Connecticut Certification Board for Counselors. Participants MUST ATTEND 100% of the class to be eligible to receive this certificate. Please retain your certificate of completion for your records.

The trainings listed in this catalog are open to DMHAS Operated staff and DMHAS Funded staff.

REGISTRATION INFORMATION

Please only register for trainings that have been pre-approved by your supervisor. Do not enroll in multiple trainings with plans to cancel them later; this will help us to keep wait lists more manageable.

- To register for training, you must go through our Learning Management System (LMS) https://ctlms-dmhas.ct.gov. You will not be able to login unless you have a valid username and password.
- If you do not have a username, or to update your email or other profile information, fill out and return the My Profile Information Form. You will receive an email with your login information.
- For help registering, searching the catalog, transcripts, and more, check out our interactive tutorial, Introduction to the LMS.
- For information on available web-based trainings, please see our Web-based Training Offerings List on our website: www.ct.gov/dmhas/workforcedevelopment.
- Upon registering for a training, you will receive an email from Workforce.Development@ct.gov regarding your enrollment status (confirmed or waitlisted), room assignments, and session information. Please read your emails completely and mark your calendar!
- Check your SPAM filter to mark Workforce.Development@ct.gov as SAFE. Contact your IT (Information Technology) person if you have questions.
- If you are on a waitlist and a seat becomes available, you will receive an email, offering you the seat. You must ACCEPT the offered seat through the LMS within five calendar days.
- Directions and instructor biographies, as well as other training resources and links, are on our website: www.ct.gov/dmhas/workforcedevelopment.

AMERICANS WITH DISABILITIES ACT (A.D.A.)

If you need an accommodation based on the impact of a disability or medical condition, make the request **immediately upon registering for training** by contacting Workforce.Development@ct.gov.

FREQUENTLY ASKED REGISTRATION QUESTIONS

Q: **What do I do if I forgot my password?**

A: On the log in page of the LMS, click the "Forgot Password?" link. The system will prompt you to enter the email address that is associated with your LMS account. When you've entered the information, the system will send you an email with a temporary password.

Q: **How do I get a certificate with Continuing Education Units (CEUs) for an instructor-led training?**

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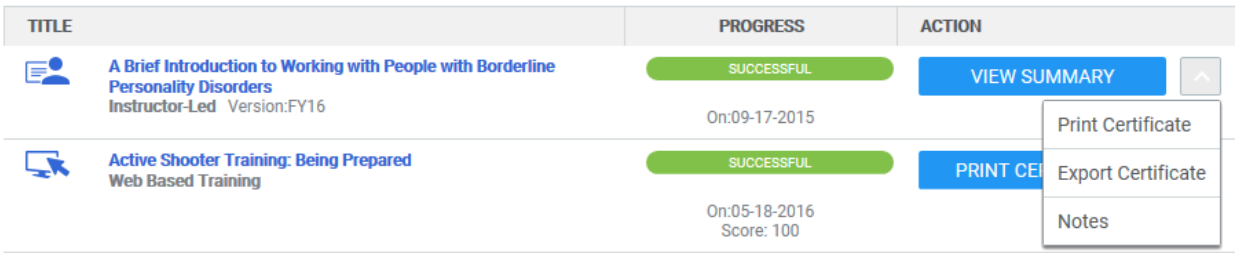

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- In the event of a cancellation due to inclement weather, all registered participants will be notified of the rescheduled class date by email.

Fall Instructor-Led Training Schedule

Date(s)	Time	Title	Facility	CEUs
9/11/2019	9:00am-12:15pm	**Ethics for Addiction Counselors: Boundaries** This three hour course will review the Connecticut Certification Board (C.C.B.) Code of Ethics with an emphasis on boundaries	CC	CCB
9/11/2019	9:00am-12:15pm	**How to have Courageous Conversations** **(NEW)** At times we struggle to engage in difficult conversations. The fear of the unknown or of offending someone prevents us from asking questions to learn more about each other. This course explores some of the barriers that set us back and provides some of the tools and strategies needed to having courageous conversations among clients and co-workers. This is especially relevant to working with staff and clients from cultural, ethnic or racial groups different than our own.	CVH	CCB, SW@, PSY *
9/13/2019	9:00am-3:30pm	**Power, Passion & Purpose: Preventing Burnout** Trainings on Clinician Burnout typically focus on balance and self-care, which may increase healthy habits but often won't alleviate burnout. This training goes to the heart of the three most common causes of burnout, a lack of power, passion and purpose, and how to develop and build upon each one.	CC	CCB, SW@, PSY
9/18/2019	9:00am-3:30pm	**Trauma Integrated Addiction Treatment** An abundance of research has pointed to poor treatment outcomes for people with co-occurring trauma and addiction. Traditional addiction treatment has ignored the significant impact of trauma on personal recovery and subsequently people have continued to struggle as a result. With recent advances in understanding the impact of trauma, it is time for a change in the approach taken toward trauma and addiction. This interactive and experiential presentation offers an overview of the impact of trauma on the recovery process from a social, biological, psychological, and spiritual perspective and will provide clinicians with skills to work people affected by trauma throughout their recovery, as well as, understanding the conceptual framework of trauma-informed practice.	CC	CCB, SW, PSY
9/18/2019	9:00am-12:15pm	**Using Empathy with Clients and Co-Workers** **(NEW)** As we get into the routine of work every day, we also bring our personal thoughts and experiences to the job. As human beings, it is something we cannot help and these feelings can be overwhelming at times. Each one of us is going through something that requires us to be more empathetic to each other. This training defines empathy, discusses the conditions in which empathy is experienced, and identifies the steps needed to develop empathy with co-workers and clients so we can be more understanding of others.	CVH	CCB, SW@, PSY

Date(s)	Time	Title	Facility	CEUs
9/20/2019	9:00am-12:15pm	**Introduction to Providing Expert Testimony** **(NEW)** This course provides an introduction to testifying in Superior Court. The discussion will include preparing the forensic evaluation and understanding the Connecticut General Statutes as a framework for the clinical opinion. Other topics that will be covered include an overview of the forensic assessment, terminology and 'lingo', dealing with nerves and court etiquette. Examples of relevant cases will be discussed.	CC	CCB, SW@, PSY
9/24/2019	9:00am-12:30pm	**Diabetes and Mental Health Conditions** Diabetes affects a staggering 30,000,000 Americans, with an additional 84,000,000 diagnosed with prediabetes. That number has been steadily rising. People suffering from severe mental health disorders are at an even greater risk for developing this life threatening metabolic disorder. This training is designed to help direct care staff to recognize when a referral for assessment and treatment may be necessary. Participants will understand the impact of prescribed medications, diet, lifestyle and health care disparities. The basics of diabetes, nutrition, related conditions and medications will be explored. Strategies will be taught to educate and motivate clients to improve their health and wellness. This class in appropriate for both non-medical and nursing staff working with clients with, or at risk for diabetes.	CVH	CCB, SW, PSY
9/25/2019	9:00am-3:30pm	**Medication-Assisted Treatment and Recovery for Substance Use Disorders** This course provides the National Institute on Drug Abuse and Substance Abuse and Mental Health Services Administration's Blending Initiative product, entitled "Buprenorphine Treatment: A Training for Multidisciplinary Professionals". The primary goal is to create awareness among addiction professionals about buprenorphine in the treatment of opioid dependence. This course includes information about someone who is being treated with this medication, information about the legislation that permits office – based buprenorphine treatment, the science of addiction, the mechanism of buprenorphine, patient selection criteria, and associated patient, counseling, and therapeutic issues. In addition to the NIDA product presentation on buprenorphine, Methadone and Vivitrol, and the criteria for determining appropriate candidates for each therapy for opiate dependence, will be reviewed. Other current medications approved for the treatment of non-opiate substance use disorders will be addressed.	CC	CCB, SW, PSY
9/27/2019	9:00am-12:15pm	**Cognitive-Behavioral Therapy for PTSD** Posttraumatic stress disorder (PTSD) is common in both military and civilian populations. Patients with chronic PTSD are often difficult to treat, and the degree of functional impairment from PTSD can be extremely high. Cognitive-behavioral therapy (CBT) is among the most well-validated, evidence-based treatments for PTSD. In this workshop, we will review the principles of CBT for PTSD, including various forms of therapeutic exposure, cognitive restructuring, and stress inoculation training. We will use a mix of didactic presentation and case examples to illustrate how these treatments are implemented.	CC	CCB, SW, PSY

Date(s)	Time	Title	Facility	CEUs
10/2/2019	9:00am-12:15pm	**Drop by Drop: Micro-inequities in the Workplace** **(NEW)** This training will explore the impact of micro-inequities at work. It will describe how a bias can become prejudicial behavior and list steps to create an inclusive environment. It will identify ways for participants to become effective cross-cultural communicators.	CVH	CCB, SW@, PSY *
10/2/2019	9:00am-12:15pm	**Ethics for Addiction Counselors: Social Media** This three hour course will review the Connecticut Certification Board (C.C.B.) Code of Ethics with an emphasis on social media.	CC	CCB
10/4/2019	9:00am-3:30pm	**Treating Obsessive-Compulsive and Related Disorders** The obsessive-compulsive and related disorders (OCRDs) include obsessive-compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania, and excoriation (skin-picking) disorder. In this workshop we will describe transdiagnostic mechanisms that contribute to the maintenance of these disorders, and discuss the principles of treatment. Video examples will be used.	CC	CCB, SW, PSY
10/8/2019	9:00am-4:00pm	**Gambling Awareness 101** The normative and pervasive nature of gambling behaviors in the United States can desensitize us to the problems that can occur when a person's view of gambling shifts from entertainment to fixation. Recently reassigned in the DSM 5 from an impulse control disorder to a behavioral addiction, disordered and problem gambling affects 2-5% of adults and twice as many young people. Confounding the issues of problem identification, referral, and treatment is a lack of awareness on the part of service providers, clients, family members and the general public that, for some people, gambling can become an addiction even more devastating than alcohol or other drugs. As state governments turn more to legalized gambling as a source of revenue, studies indicate that vulnerable populations: the poor, disenfranchised, and people in recovery from mental health and substance use disorders, are disproportionally impacted in harmful ways. This training will address the social and environmental factors which influence gambling; gender and race considerations; and how our biology creates conditions conducive to the pursuit of risk and reward. Training will include lecture, large and small group discussion, learning tasks and media.	CVH	CCB, SW, PSY
10/10/2019	9:00am-3:30pm	**Recovery and Relapse: Two Sides of the Coin** The goal of "treatment" is to help people to achieve abstinence and to become full participants in society. How do we do this? Why do people relapse? Why can they not regain control over drug cravings, drug seeking, and not return to use? What can we do to enhance recovery? This training will explore the barriers to recovery such as how changes in the brain create the cognitive and behavioral aspects which impact recovery; psychosocial deficit areas; and lack of sufficient support. This training will provide hands on experiential exercises evaluating typical recovery plans and relapse prevention plans in order to see how those strategies can be expanded to meet the needs of clients.	CVH	CCB, SW, PSY

Date(s)	Time	Title	Facility	CEUs
10/11/2019	9:00am-3:30pm	**Best Practices for Clients with Anger Disorders** This course examines critical issues in successful anger management treatment programs including recognizing anger as a therapeutic target, de-bunking common misconceptions about anger, reviewing assessment techniques, and outlining strategies for beginning treatment. The course will present a comprehensive intervention model that prepares clients for change, supports intervention strategies, provides acceptance and adjustment approaches, and prevents relapse.	CC	CCB, SW, PSY
10/16/2019 & 10/23/2019	9:00am-3:30pm	**Biology of Addiction** Biology of Addiction will review the basics of neurotransmission and how drugs of abuse interfere with neurotransmission. The mechanism of action of alcohol, opiates, and stimulants will be covered as well as their effects on the brain, the body, and the fetus. An elementary review of medication assisted treatment will be provided. Signs of intoxication, withdrawal, overdose, and dependence will be presented. The second day of training will be a broad variety of drugs of abuse: inhalants, marijuana, synthetic cannabinoids (eg., spice) and cathinones (e.g., bath salts), PCP, Ketamine and other dissociative anesthetics, hallucinogens, and nicotine. Signs of intoxication, withdrawal, overdose, and dependence will be presented.	CC	CCB, SW, PSY
10/16/2019	9:00am-12:15pm	**Working with Muslim Clients** **(NEW)** This course is designed to provide an overview about Islam and Muslims. It is intended for clinicians, mental health assistants, social workers, and anyone else who may be working directly with clients who identify as Muslim. You will learn about the context of mental health in the religion, stigma of mental health among the Muslim community, and how to best provide support during treatment and recovery.	CVH	CCB, SW@, PSY *
10/17/2019	9:00am-3:30pm	**What's Culture Got to do with Addiction?** If a counselor is unaware of their own culture, they lack an enormous amount of self-knowledge required to be an effective counselor. On the other hand, if a counselor lacks knowledge about or ignores client culture, they are unethical practitioners. Why do I say that? Because culture is all-encompassing. It is the underpinning of our beliefs, values, norms, concepts of family and relationships.	CVH	CCB, SW, PSY *
10/18/2019	9:00am-3:30pm	**Forensic CBT** This training course is focused on developing foundational skills in Cognitive-Behavioral Therapy (CBT) for justice-involved clients. Critical distinctions between traditional mental health treatment and forensic programming will be highlighted. Practitioners will learn to recognize and elicit a range of relevant thinking patterns commonly found among justice-involved adolescents and adults and to incorporate thinking targets into case management, supervision, and programming. Finally, practitioners will have opportunities to practice CBT conversations about client values and life priorities and several CBT sequences designed to improve client decision-making. Through a series of structured learning activities that include small group exercises, role-plays, and 'real'-plays, practitioners will develop basic skills so that they can immediately apply CBT interventions in their own settings.	CC	CCB, SW, PSY

Date(s)	Time	Title	Facility	CEUs
10/24/2019	9:00am-3:30pm	**Making Sense of the DSM-5** The 5th edition of the DSM brings with it some of the most significant changes between editions. In addition to changes in the disorders themselves and how they are grouped, the diagnostic system has been revamped. Are you prepared to incorporate the changes into your practice and to diagnose your clients accurately? This training shows you how to use the DSM-5 to enhance your assessment skills.	CVH	CCB, SW, PSY
10/25/2019	9:00am-4:30pm	**A Day of DBT Skills Training** **(NEW)** This experiential, full-day training focuses on the four core skills modules in Dialectic Behavior Therapy in combination with the important cognitive behavioral therapist skills of behavioral chain analysis and "missing links" analysis. The day is designed to help clinician's thoroughly analyze: problem behaviors, emotional dysregulation, and patterns of thought distortion, and then strategically assist clients in developing the skills they need to more effectively handle these in the future. While ideal for clinicians wishing to enhance their DBT skill set, this training is also designed for non-DBT clinicians with an interest in expanding their overall therapeutic armamentarium. A basic understanding of Cognitive-Behavioral Therapy (CBT) principals is desirable, as these will be covered, but only briefly.	CVH	CCB, SW, PSY
10/25/2019	9:00am-3:30pm	**Trauma-Informed Practice in Behavioral Health Care** The Adverse Childhood Experiences (ACE) study provides a documented link between childhood exposure to violence and other traumatic experiences and later psychiatric disorders, physical illnesses, substance use and addictive disorders. SAMHSA recommends that all human service providers be trauma-informed and be able to REALIZE, RECOGNIZE, and RESPOND to the activation of trauma and support recovery in people affected by trauma, living with Post Traumatic Stress Disorder (PTSD), and other conditions that detract from their health and wellness. This course will review the history and development of current understandings of trauma and recovery, with a focus on emotional regulation and grounding interventions to assist people with co-occurring mental illness and substance use disorders in strength-focused recovery.	CC	CCB, SW, PSY
10/30/2019	9:00am-4:00pm	**How to Effectively Teach Skills** **(NEW)** Person-centered, strengths-based, recovery oriented services involve core concepts and attitudes. Skill development includes implementation of those concepts and attitudes and translating ideas into actions. More and more service providers at every level are called upon to help the people that they serve develop effective wellbeing and living skills. Developing, employing and strengthening skills is essential to sustaining progress toward sought after life goals. This action oriented workshop guides trainees in the best and evidenced based practices of effective skills development.	CVH	CCB, SW@, PSY

Date(s)	Time	Title	Facility	CEUs
11/1/2019	9:00am-3:30pm	**Supporting Grief-Work in Behavioral Health Treatment** Loss, mourning, and grief are an integral and unavoidable experience in human life. Substance use, Post-Traumatic Stress Disorder, Physical & Mental Illnesses greatly increase the risk of unexpected, tragic, and traumatic losses and multiply challenges to engaging in the important "work" of grieving.	CC	CCB, SW, PSY
11/7/2019	9:00am-4:00pm	**Gambling As A Co-occurring Disorder** **(NEW)** Over the course of the past several years, there has been a dramatic shift in the way in which treatment services are delivered. Providers are recognizing the importance of integration and the need to provide co-occurring disorder treatment for both substance use and mental health disorders. However, the screening, assessment and treatment of problem gambling often falls through the cracks, even in well-developed co-occurring disorder enhanced programs. In this workshop, the correlation of substance use and mental health disorders with problem gambling will be reviewed. Brief-assessment tools will be discussed and evaluated. Participants will also gain an understanding of the treatment of problem gamblers, therapeutic tools they can utilize within their own agencies and what services are specialized. Prevention and education strategies for helping clients at risk for developing gambling problems will also be covered.	CVH	CCB, SW@, PSY
11/8/2019	9:00am-3:30pm	**Assessing Risk and Suicidality: Interviewing Skills for Clinicians and Helpers** Front line clinicians and helpers are often in the best position to obtain the most comprehensive information about suicidal ideation and other self-harming behaviors. This course will present a proven, research-based interviewing approach to maximize skills in obtaining information needed to assess and manage acute risk in patients with co-occurring disorders.	CC	CCB, SW, PSY
11/8/2019	9:00am-3:30pm	**Getting in the Weeds: Emerging Issues with Cannabis** **(NEW)** The movement towards legalizing cannabis for medical and/or recreational use seems to indicate its greater acceptance. This training will help participants to understand what cannabis is, the history of cannabis use, potential medical benefits and possible adverse effects. Issues related to risk factors, assessment and treatment of cannabis use disorders will be explored.	CVH	CCB, SW@, PSY
11/13/2019	9:00am-3:30pm	**Coming into the Light: Breaking the Stigma of Substance Use Disorders** Stigma is a major barrier preventing millions of people who are struggling with substance use from entering treatment today. This presentation is designed to help professionals break that stigma that creates an unnecessary barrier to treatment by understanding recovery oriented language and strategies that can be integrated into practice immediately.	CC	CCB, SW, PSY

Date(s)	Time	Title	Facility	CEUs
11/15/2019 & 11/22/2019	9:00am-3:30pm	**Motivational Interviewing Intensive** This training will provide participants with insight into peoples' intrinsic motivation to accept and maintain recovery. Motivational Interviewing (MI) is a person-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. This therapeutic skill-based course will also address how to be a guide to recovery, how to engage people into services who are reluctant or not interested, and how to tap into the resources in your community to assist people on the pathway to attaining and sustaining recovery. Participation in group exercises and experiential (role-play) activities is expected of all participants. Homework assignments will be given to develop the participant skills.	CVH	CCB, SW, PSY
12/12/2019	9:00am-3:30pm	**Cultural Intelligence: Understanding and Incorporating CLAS Standards into Practice** The one-day workshop is designed to highlight and explore the needs of treatment professionals working with culturally diverse individuals, organizations, and communities. The participants will learn about Health Disparities, Cultural Intelligence, CLAS Standards and proven techniques and strategies for engagement and improving outcomes.	CVH	CCB, SW, PSY *
12/13/2019	9:00am-3:30pm	**Increasing Hepatitis C Knowledge for Behavioral Health and Medical Providers** **(NEW)** This is a 5 hour training for professionals working in Opioid Treatment Programs, Federally Qualified Health Centers, and other primary care, substance use treatment, and prevention settings. This five module curriculum is designed to instruct behavioral health and medical providers on opportunities for screening and testing for hepatitis C (HCV), incidence of viral infections and opioid injection drug use, treatment options and patient considerations, and essential elements of effective linkage to care for persons infected with HCV.	CC	CCB, SW@, PSY

@ NASW/CEU application pending.

*Meets the requirements for Cultural Competence Continuing Education

CC – Connecticut Clearinghouse, Plainville

CVH – Connecticut Valley Hospital, Beers Hall, 3rd Floor, Cocilovo Room, Middletown

Thanks to the New England Addiction Technology Transfer Center for co-sponsoring trainings

New England (HHS Region 1)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

DMHAS
WORKFORCE DEVELOPMENT

INSTRUCTOR-LED TRAINING

Spring 2019 Catalog

www.ct.gov/dmhas/workforcedevelopment

7 New Trainings

DMHAS WORKFORCE DEVELOPMENT PERSONNEL

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KIMBERLY PLATT, LCSW, LADC	kimberly.platt@ct.gov

CONTINUING EDUCATION UNITS (CEU) INFORMATION

These instructor-led trainings offer continuing education contact hours approved by the Connecticut Certification Board for Counselors. Participants MUST ATTEND 100% of the class to be eligible to receive this certificate. Please retain your certificate of completion for your records.

The trainings listed in this catalog are open to DMHAS Operated staff and DMHAS Funded staff.

REGISTRATION INFORMATION

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- For information on available web-based trainings, please see our Web-based Training Offerings List on our website: www.ct.gov/dmhas/workforcedevelopment.
- Upon registering for a training, you will receive an email from Workforce.Development@ct.gov regarding your enrollment status (confirmed or waitlisted), room assignments, and session information. Please read your emails completely and mark your calendar!
- Check your SPAM filter to mark Workforce.Development@ct.gov as SAFE. Contact your IT (Information Technology) person if you have questions.
- If you are on a waitlist and a seat becomes available, you will receive an email, offering you the seat. You must ACCEPT the offered seat through the LMS within five calendar days.
- Directions and instructor biographies, as well as other training resources and links, are on our website: www.ct.gov/dmhas/workforcedevelopment.

AMERICANS WITH DISABILITIES ACT (A.D.A.)

If you need an accommodation based on the impact of a disability or medical condition, make the request **immediately upon registering for training** by contacting Workforce.Development@ct.gov.

FREQUENTLY ASKED REGISTRATION QUESTIONS

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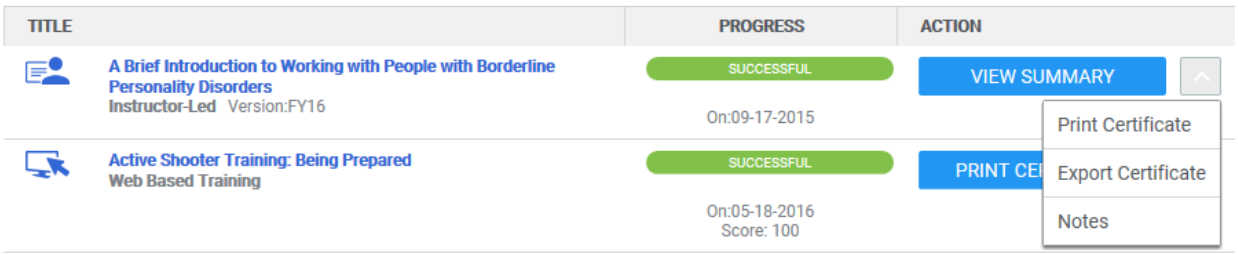

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Spring Instructor-Led Training Schedule

To view the description, CEUs, instructor and location of the training, click the title of the offering prior to registering in the LMS.

Date(s)	Time	Title	Facility	CEUs
4/2/2019	9:00am-12:15pm	A Brief Introduction to Working with People with Borderline Personality Disorders	Connecticut Valley Hospital, Beers Hall	CCB, SW, PSY
4/3/2019	9:00am-12:15pm	Ethics for Addiction Counselors	Connecticut Clearinghouse	CCB
4/4/2019	9:00am-3:30pm	Buried in Treasures: The Nature and Treatment of Hoarding Disorder **NEW**	Connecticut Valley Hospital, Beers Hall	CCB, SW@, PSY
4/5/2019	9:00am-4:30pm	Opioid Use Disorders: Whole-Person Approaches to Treatment and Recovery **NEW**	Connecticut Valley Hospital, Beers Hall	CCB, SW@, PSY
4/5/2019	9:00am-3:30pm	The Art of Diagnosis	Connecticut Clearinghouse	CCB, SW, PSY
4/8/2019	9:00am-12:15pm	Diabetes and Mental Health Conditions **NEW**	Connecticut Valley Hospital, Beers Hall	CCB, SW@, PSY
4/24/2019	9:00am-3:30pm	Cultural Intelligence: Understanding and Incorporating CLAS Standards into Practice	Connecticut Valley Hospital, Beers Hall	CCB, SW, PSY*
4/26/2019	9:00am-3:30pm	Supporting Grief-Work in Behavioral Health Treatment	Connecticut Clearinghouse	CCB, SW, PSY
4/30/2019	9:00am-4:00pm	Working with Persons Affected By Problem Gambling	Connecticut Valley Hospital, Beers Hall	CCB, SW, PSY
5/1/2019	9:00am-12:15pm	Ethics for Addiction Counselors: Boundaries	Connecticut Clearinghouse	CCB

Date(s)	Time	Title	Facility	CEUs
5/2/2019	9:00am-3:30pm	The Clinical Interview	Connecticut Valley Hospital, Beers Hall	CCB, SW, PSY
5/7/2019	9:00am-3:30pm	Understanding Mental Health Conditions	Connecticut Valley Hospital, Beers Hall	CCB, SW, PSY
5/8/2019	9:00am-4:30pm	Medication-Assisted Treatment and Recovery for Substance Use Disorders	Connecticut Clearinghouse	CCB, SW, PSY
5/9/2019	9:00am-12:15pm	Understanding Bipolar Disorders **NEW**	Connecticut Valley Hospital, Beers Hall	CCB, SW@, PSY
5/10/2019	9:00am-3:30pm	Best Practices in the Treatment of Co-Occurring Depression and Substance Use	Connecticut Clearinghouse	CCB, SW, PSY
5/14/2019	9:00am-4:00pm	Current Gambling Trends and Strategies to Address Them	Connecticut Valley Hospital, Beers Hall	CCB, SW, PSY
5/15/2019	9:00am-4:30pm	Developing Successful Person Centered Recovery Plans **NEW**	Connecticut Valley Hospital, Beers Hall	CCB, SW@, PSY
5/16/2019	9:00am-3:30pm	Family Dynamics and Addiction: If Addiction is a Family Illness, Why Don't We Educate and Treat the Family?	Connecticut Valley Hospital, Beers Hall	CCB, SW, PSY
5/17/2019	9:00am-3:30pm	What's Culture Got to do with Addiction?	Connecticut Clearinghouse	CCB, SW, PSY*
5/22/2019	9:00am-12:15pm	Older Adults: The Impact of Substance Use **NEW**	Connecticut Clearinghouse	CCB, SW@, PSY
5/30/2019	9:00am-3:30pm	Making Sense of the DSM-5 **NEW**	Connecticut Valley Hospital, Beers Hall	CCB, SW@, PSY
5/31/2019	9:00am-3:30pm	HIV/AIDS Today: What You Need to Know	Connecticut Clearinghouse	CCB, SW, PSY
6/7/2019	9:00am-3:30pm	Assessing Risk and Suicidality: Interviewing Skills for Clinicians and Helpers	Connecticut Clearinghouse	CCB, SW, PSY

Date(s)	Time	Title	Facility	CEUs
6/7/2019	9:00am-3:30pm	Using Clinical Supervision to Improve Direct Services	Connecticut Valley Hospital, Beers Hall	CCB, SW, PSY

@ NASW/CEU application pending.

*Meets the requirements for Cultural Competence Continuing Education

Thanks to the New England Addiction Technology Transfer Center for co-sponsoring trainings

DMHAS
WORKFORCE DEVELOPMENT

Web-Based Training Offerings

Updated July 2019

www.ct.gov/dmhas/workforcedevelopment

REGISTRATION INFORMATION

The training listed in this catalog is open to DMHAS operated staff and DMHAS funded staff.

- To register for training, you must go through our Learning Management System (LMS) https://ctlms-dmhas.ct.gov. You will not be able to login unless you have a valid username and password.
- If you do not have a username, or to update your email or other profile information, fill out and return the My Profile Information Form. You will receive an email with your login information.
- For help registering, searching the catalog, transcripts, and more, check out our interactive tutorial, Introduction to the LMS.

FREQUENTLY ASKED REGISTRATION QUESTIONS

Q: **What do I do if I forgot my password?**
A: On the log in page of the LMS, click the "Forgot Password?" link. The system will prompt you to enter the email address that is associated with your LMS account. When you've entered the information, the system will send you an email with a temporary password.

Q: **How do I get a copy of my transcript?**
A: Online transcripts are available for classes that have been held after 1/1/09. Once you've logged into your LMS account, go to the Me tab, then click Analytics in the left-hand menu. Click on the report entitled User Transcript. Your transcript will open in a new window. Click on the Download button at the top right of the window to export your transcript to PDF (recommended) or Excel. For more detailed instructions, see Introduction to the LMS.

For class records prior to January 1, 2009, please email Workforce.Development@ct.gov.

Q: **What does my computer need (system requirements) for me to take web-based training?**
A: Your computer must have internet access (DSL or Cable recommended for faster connection) and Adobe Flash Player. Pop-up blockers must be disabled on your Browser and Google toolbar. We strongly recommend a wired internet connection. If the problem persists, contact Workforce.Development@ct.gov.

Q: **If I don't finish the web-based training in one sitting, how do I get back to it to finish?**
A: After logging in, click on the Me tab. Scroll down to find the name of the training that you want to finish. To the right of the training name, click the "Launch" button.

Q: **I completed a web-based training, but it did not show up on my transcript. What should I do?**
A: If you have been taking the training over a wireless internet connection, connect your computer to the internet with a wired connection and log on to the LMS. Launch the training again, and retake the quiz to get credit.

Q: **How do I get a certificate with Continuing Education Units (CEUs) for a web-based training?**
A: Upon successful completion of the training and quiz, go to your Me tab, then click on Completed Learning in the left-hand menu. Find the training you want, then click the Print Certificate button. You can click on the down arrow next to the Print Certificate button, then click Export Certificate to download a PDF copy of the certificate.

Q: **What if I have reviewed the information above and am still having problems?**
A: Check out our tutorial, Introduction to the LMS, then email Workforce.Development@ct.gov.

Web-Based Training Offerings

L**icensed clinical psychologists** in Connecticut will have to complete a minimum of **ten** (10) hours of approved continuing education in the twelve months following their license renewal. Not more than **five** (5) continuing education units during each registration period shall be completed via the Internet, distance learning or home study. DMHAS Workforce Development self-directed web-based trainings that have been approved are noted with PSY under the CEU column.

Licensed social workers, marital and family therapists, and certified and licensed alcohol and drug counselors are to complete **one** (1) contact hour of continuing education coursework in **cultural competency** during each license registration period. Trainings with an asterisk (*) by the title meet that requirement.

Beginning **1/1/16**, **licensed clinical psychologists, licensed social workers, marital and family therapists, licensed professional counselors, and certified and licensed alcohol and drug counselors, and physicians** are to complete **two** (2) contact hours of continuing education related to mental health conditions common to veterans and family members of veterans during their next license renewal period and not less than once every six years thereafter. Trainings with a number sign (#) by the title meet that requirement.

Training Title	Credit Hours	CEUs Offered
Addressing Behavioral Health Needs of Veterans#	2	CCB, SW, PSY
An Introduction to Post-Traumatic Stress Disorder (PTSD)	1	CCB, PSY
Anaphylactic Allergic Reactions and Epinephrine Auto-Injectors	3	—
Assessment in Community Support Programs (CSP) and Recovery Pathways (RP)	1	CCB, SW, PSY
Back Safety and Lifting Techniques	0.5	—
Basics of Child Occupant Safety in Motor Vehicles	0.5	—
Bed Bugs: Know the Facts	0.5	—
Blood and Body Fluid Clean Up: Overview	1	—
Bringing the Full Power of Science to Bear on Drug Abuse and Addiction	1	CCB, PSY
Cocaine: Abuse and Addiction	1	CCB, SW, PSY
Collaborative Documentation	1	CCB, SW, PSY, CME
Community Support Programs (CSP): From Maintenance to Rehabilitation	2	CCB, SW, PSY
Connecticut Legal Rights Project: Protecting Rights to Rebuild Lives	0.5	—
Co-Occurring Disorders: A General Introduction	1.5	CCB, SW, PSY
Cultural Competence Primer for Behavioral Health Practitioners and Settings*	1	CCB, SW, PSY

Training Title	Credit Hours	CEUs Offered
Cultural Elements in Treating Hispanic and Latino Populations*	1	CCB, SW, PSY
Depression	1.5	CCB, SW, PSY
Diabetes Mellitus Basics	2	—
DSM-5: A Brief Introduction	1	CCB, SW, PSY, CNA
DSM-5: Substance-Related and Addictive Disorders	1	CCB, SW, PSY, CNA
Elder Abuse: Identification and Reporting*	0.5	CCB, SW, PSY
Employee Safety: Preventing Slips, Trips and Falls	1	—
Family Therapy with Problem Gamblers and their Families: The First Steps to Recovery	1	CCB, SW, PSY
Fentanyl ***NEW!***	1	CCB, SW, PSY
Gender Dysphoria: A Behavioral Health Perspective on Transgender People*	1	CCB, SW, PSY
Gender Responsive Substance Abuse Treatment for Women*	2	CCB, SW, PSY
Grounding Techniques	1	CCB, PSY
Helping Patients who Drink Too Much	2	CCB, SW, PSY
Hepatitis A Virus (HAV): An Introduction	1	CCB
Hepatitis B Virus (HBV): An Introduction	1	CCB
Hepatitis C Virus (HBV): An Introduction	1	CCB
Infection Control and Prevention for Community Health Care Workers *(available for DMHAS Funded Agency Staff ONLY)*	1	—
Inpatient Care of the Person with Dementia	0.5	—
Introduction to Integrating Gambling and Problem Gambling into Substance Use and Mental Health Disorders Programs	3	CCB, SW, PSY

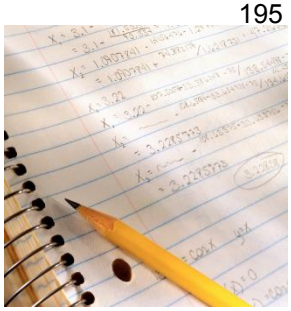
Medication and Entitlement Access for Connecticut	1	CCB, SW

Training Title	Credit Hours	CEUs Offered
MRSA Overview	1	—
Medications Used in the Treatment of Mental Health Disorders	2	CCB, SW, PSY
Naloxone in the Prevention of Opioid Overdose	0.5	CCB, PSY
Older Adult Behavioral Health	1	CCB, SW, PSY
One Key Question and the Every Woman Connecticut Learning Collaborative	1.5	CCB, SW, PSY
PCP: Understanding Phencyclidine	0.5	CCB, PSY
Person Centered Treatment Planning	3	CCB, SW, PSY
Prescription Drugs: Abuse and Addiction	1	CCB, SW, PSY
Recovery Planning and Documentation in Community Support Programs (CSP) and Recovery Pathways (RP)	1	CCB, SW, PSY
Safe Food Handling	1	—
Substance Abuse and HIV/AIDS	1	CCB, SW, PSY
Suicide Risk Using the Columbia Suicide Severity Rating Scale	1	CCB, SW, PSY
The CCB Certification Process	0.5	—
The Criminal Justice System	2	CCB
Tobacco Addiction	1	CCB, SW, PSY
Tools for Engaging Clients in Services	2	CCB, SW, PSY
Treating Clients with Traumatic Brain Injury in Substance Abuse Treatment	1	CCB, SW, PSY
Understanding Bipolar Disorder	2	CCB, SW, PSY

Understanding Compulsive Hoarding	2	CCB, SW, PSY
Understanding Drug Abuse and Addiction: What Science Says	0.5	CCB, PSY
Understanding Opioid Addiction and Treatment	1	CCB, SW, PSY
Understanding Trauma	2	CCB, SW, PSY
Working with People Diagnosed with Schizophrenia	2	CCB, SW, PSY
Working with People Presenting Gambling Problems and Financial Issues in Behavioral Health Settings	1	CCB, SW, PSY

@= NASW/CEU application pending. New web-based training offerings are posted as they become available.

INTERESTED IN CERTIFICATION?



Overview of the Certification Process

The Overview of the Certification Process course is designed to assist participants with the certification process and is ideal for anyone interested in learning more about certification with the CCB. This course is also designed to provide participants with tools and information to simplify the process, as well as answering commonly held questions about the certification process. The course is designed to provide assistance to people seeking certification for all CCB credentials, and will provide an overview of CCB products and services as well as address questions about licensure and certification of alcohol and drug addiction professionals with the Department of Public Health in Connecticut. The session includes a coaching session for all interested participants.

Overview of the Certification Process
9:00 a.m. – 4:00 p.m.

Thursday, January 10
Tuesday, March 12
Tuesday, April 9
Tuesday, May 14
Tuesday, June 11

Walk-in Certification Process

Walk-in Coaching sessions for Certification are offered every Wednesday from 1 p.m. to 4 p.m. at the CCB Offices in Wallingford, CT

To register for or to obtain more information about the courses listed above, please contact Jeff Quamme, CCB Director at jquamme@ctcertboard.org.