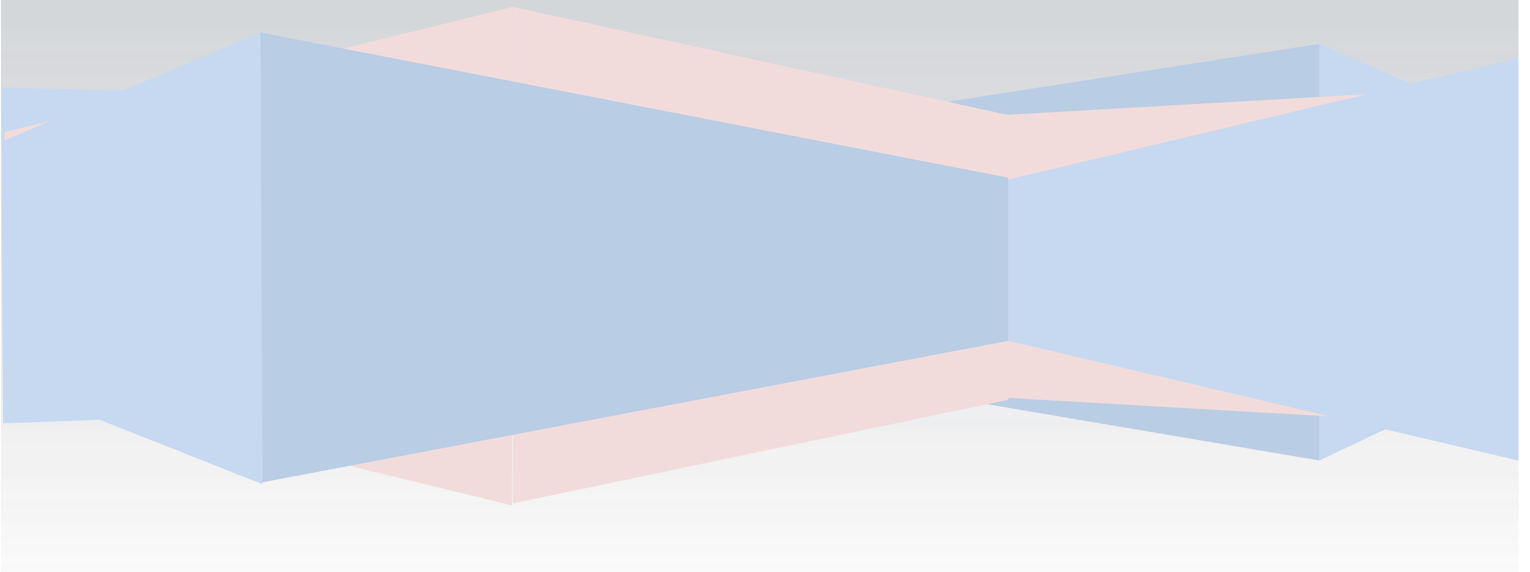
Environmental Safety Tool-Kit

NCONL



Physical and Electronic Search Policy

Purpose:

To provide a safe and secure environment for patients, visitors, and caregivers within the Emergency Department through the appropriate physical and electronic search of patients for dangerous items.

Policy:

Upon admission to the ED, the treating nurse shall request Security personnel to electronically and/or physically search any patient meeting the following criteria;

1. Patients presenting to the ED complaining of suicide, homicidal or paranoid thoughts, hallucinations or other psychological conditions who potentially present a threat of violence while in the department.
2. Patients placed in violent restraints.
3. Patients exhibiting an altered mental status who present a threat of violence while in the department.
4. Patients who threaten or assault a staff member or other individual while in the ED.
5. Patients who act aggressively in such a manner that there is risk to personal safety.

Procedure:

1. When a patient meets the search criteria, the ED treatment nurse notifies the unit secretary regarding the need for a search. The unit secretary will call Security. ED Staff should remain at bedside until security arrives.
2. Security receives request as a high priority call and responds accordingly. The search should be performed as soon as reasonable after triage to the treatment area.
3. The patient is to change into a hospital gown.
4. The Security officer then performs a physical and electronic search of patient and his/her possessions in the presence of the patient including hand-held belongings (purses, suitcases, shopping bags etc) and clothing (pockets, shoes, coats etc). A physician, RN, nursing assistant, or sitter of the same gender as the person being searched shall be witness to all phases of the search.
5. Security personnel retain all contraband and weapons removed from patients which will be placed in a belonging bag labeled with an identification sticker. Nursing will secure all medications. Security is responsible for disposition of all confiscated materials except medications or illegal drugs.
6. The security officer documents in a security report the time the search was performed and any materials confiscated. At this time, patient is verbally notified by security of items that were confiscated and how they may retrieve them. Contraband includes but is not limited to: medications, razors, glass items, compact mirrors, matches, lighters, aerosols, combustible liquids, toiletries containing ethyl/isopropyl alcohol, nail clippers, files, scissors, tweezers, pencil sharpeners, weapons, illegal substances, drug paraphernalia, ETOH etc.

7. Contraband (excluding illicit drugs) and medications will be returned to the patient upon discharge to home or transferred with the patient if going to a psychiatric bed/facility. Any confiscated weapons will be handled according to standard Security Department Policy.
8. Illicit drugs will be wasted by an RN in the presence of the Charge Nurse.
9. The RN assigned to care for this patient will document in the nurse's notes that search was completed per ED policy.

Contraband:

- ☐Necklaces
- ☐Belts
- ☐Drawstrings in clothing (that are not sewn in)
- ☐Shoelaces
- ☐Bandanas or Doo-rags
- ☐Panty Hose
- ☐Razors or other sharp objects
- ☐Home medications must be sent to pharmacy
- ☐If alcohol is listed within the first 5 ingredients = must be taken away
- ☐Aerosol cans
- ☐Nail polish and remover – also metal files/tweezers/clippers
- ☐Glass bottles/containers or mirrors (to include compacts)
- ☐Hairdryers/flat irons/curling irons (must be inspected by engineering before placing in the sharps closet for use by the patient)
- ☐CPAPs must be inspected by engineering as well
- ☐Suitcases/bags and purses must be locked in the sharps closet
- ☐No plastic bags of any kind
- ☐No aluminum cans
- ☐No perfume or cologne to be used on the unit at ANY time
- ☐No cigarette lighters or matches
- ☐No hair dye or sunless tanning products
- ☐No stuffed animals with removable ribbons or bows (has to be sewn to the animal)
- ☐Cash over $10 must be sent to the safe along with credit cards/check books and other items of value
- ☐No weapons or knives – must be sent to security until discharge from the hospital
- ☐No OTC medication in rooms – must be checked in with the RN on admission
- ☐When O2 is not in use the tubing must be removed from the room and stored in the med room for future use (with a label)
- ☐No radios in rooms
- ☐No IPOD's
- ☐No computers (unless approved by the doctor)
- ☐No food in rooms

Security Risk Assessment Tool

- Law Enforcement CANNOT be released before initiation of Medical Screening Exam
- Reassessment at least q4 hours and PRN

Date/Time /	/			/			/			/		
	INITIAL Assessment			Reassessment			Reassessment			Reassessment		
	0 pts	1 pt	2 pts	0 pts	1 pt	2 pts	0 pts	1 pt	2 pts	0 pts	1 pt	2 pts
1. Previous history of violence to others?												
2. Previous history of harm to self?												
3. Evidence of substance misuse?												
4. Evidence of poor compliance with treatment or medication?												
5. Presence of recent severe stress, loss?												
6. Presence of specific threats to self or others?												
7. Access to potential victims?												
8. Degree of immediacy of risk?												
9. Symptoms exacerbated by custodian interactions?												
TOTAL POINTS												
Initials												
Signatures												

RISK ASSESSMENT SCORE:

Points	Risk	Recommendation
Points = 10 – 13	High Security Risk	Recommend Law Enforcement stay with patient
Points = 8 – 9	Medium Security Risk	Trial release prior to releasing law Enforcement
Points = 1 – 7	Low Security Risk	Recommend releasing Law Enforcement

Security Assessment Item	Definition
1. Is there a history of documented evidence of actual violent behavior directed towards other people, animals or property?	0 points if absent 1 point if cruelty to animals or serious damage to property 2 points is actual physical assault on another person
2. Is there a history of documented evidence of self-harming behavior such as cutting, taking overdoses, etc.? This does not have to show evidence of specific suicidal intent, exclude nonspecific self-damaging behavior such as excess alcohol consumption or substance abuse	0 points if absent 1 point if present
3. Is there history of documented evidence of substance misuse	0 points if absent 1 point if present
4. Is there a history of poor compliance with treatment or disengagement with psychiatric services	0 points if absent or no previous psych history 1 point if present
5. Is there any evidence of severe stress, loss, threatened loss or significant life event within the last week (immediate) or over past year (recent)? This excludes criminal justice consequences of offenses such as imprisonment but includes losses as a result of the offense	0 points if absent 1 point for recent 2 points for immediate
6. Have there been any specific or current threats made by the individual?	0 points if absent 1 point if threat made about a general group of victims 2 points if threats made about a named victim

7. Does the individual have access to potential victims?	0 points if no access 1 point if access to a general group (i.e. women, health care workers, community) 2 points if access to specifically identified or named victim
8. Are potential victims in a position of immediate risk from the individual under the current conditions?	0 points if no 1 point if yes
9. Are there signs that the guardian/custodian may be negatively impacting the behavior or the patient?	0 points if absent 1 point if yes

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Violence Risk Screening

Date: Time:	Patient Name:
Referred from:	DOB:
Staff Assesser:	Female □ Male □

Scoring Instructions:

Collect information about each of the risk factors, referring to scoring information as described under each item. Put a check in the box to indicate the degree of risk potential for the prospective patient. The scoring is as follows:

- No: 0 Does not apply to this patient
- Maybe/moderate: 1 Maybe applies/present to a moderately severe degree
- Yes: 2 Definitely applies to a severe degree
- Do not know: - Too little information to answer

1. Previous and/or current violence: **Yes:** Severe violence refers to physical attack (including use of weapons) towards another individual with intent to inflict severe physical harm. **Maybe/moderate:** Less severe aggressive acts such as kicks, blows, and shoving that does not cause severe harm to another individual. No (0) □ Maybe/Moderate (1) □ Yes (2) □ Do not know □
2. Previous and/or current threats (verbal/physical): **Verbal:** Statements, yelling, that involve threat of inflicting other individuals physical harm **Physical:** Movements and gestures that warn physical attack No (0) □ Maybe/Moderate (1) □ Yes (2) □ Do not know □
3. Personality disorder history: Eccentric (schizoid, paranoid) and impulsive, uninhibited (emotionally unstable, antisocial) types No (0) □ Maybe/Moderate (1) □ Yes (2) □ Do not know □
4. Shows lack of insight into illness and/or behavior: This refers to the degree to which the patient lacks insight in his/her mental illness, for example, with regard to need of medication, social consequences, or behavior related to illness or personality disorder. No (0) □ Maybe/Moderate (1) □ Yes (2) □ Do not know □
5. Expresses suspicion: The patient expresses suspicion towards other individuals either verbally or nonverbally. The person appears to be "on guard" towards the environment. No (0) □ Maybe/Moderate (1) □ Yes (2) □ Do not know □
Total Score:

Suicide Precautions

Policy: To have a procedure in place to assure the safety of the individual who has expressed/demonstrated suicide ideation. All patients admitted to non-psychiatric units of the hospital after a suicide attempt, and any expression of suicide ideation during the hospital stay, will be placed on suicide precautions to insure the safety of the patient. The psychiatric consult will be initiated on admission to assure assistance from psychiatry services and to facilitate a timely transfer to a psychiatric unit/facility. When medically cleared by the medical doctor, suicidal patients will be transferred to an appropriate psychiatric unit/facility upon acceptance of the psychiatric physician.

Performed By: Registered Nurse, Licensed Practical Nurse, Nursing Assistant

Procedure:

Minimum Procedures for all Patient Care Departments and Facilities

1. Any time a patient care provider identifies that a patient has suicide ideation (thoughts about harming self or wanting to die); they will either notify the nurse who is in charge of the patient or, if the patient care provider is a nurse, notify the physician.
2. The room will be searched and procedures will be initiated to assure that the environment in which the patient is receiving care is safe. The patient will be in a hospital gown (no personal clothing) and will be kept under observation to prevent suicide attempts..
3. Physician orders will be obtained for assessment and further treatment related to the suicide threat.

Emergency Department

Patients presenting to the Emergency Department with suicide ideation will be placed in a treatment room where Security/Sitters and/or law enforcement will sit with the patient. Once the ED physician completes the medical screening and orders a "psych consult," the (psychiatrist, psychiatrist via telemedicine, psychiatric social worker, psychiatric clinical nurse specialist) will evaluate and determine need for further treatment options or the patient will be discharged per ED physician.

Acute Care Hospital

1. The nurse will immediately initiate direct observation suicide ideation monitoring and notify the physician for emergency assessment and orders. The patient will not be left alone until a physician orders the suicide precautions discontinued.

2. The following suicide precautions are included in direct observation suicide ideation monitoring:
   a. The sitter will be fully informed of the patient's plan of care.
   b. Sitter will have the patient under direct observation at all times, leaving the door open when the patient is in the bathroom, and accompanying the patient 1:1 in the rare event the patient is out of the room for a test or procedure.
   c. Sitter will not wear or take into the room any items a patient could use

for harm, such as (but not limited to) razors or plastic bags, telephones, etc.

d. Sitter will document required information on a Suicide Precautions Sitter Form which will become part of the patient's permanent record.
e. Sitter will be provided relief for lunch/breaks by other staff members.
f. Sitter will notify the nurse immediately of any change in patient statements or behavior. The nurse will assess the patient and notify the physician as needed.
g. The patient will be in a hospital gown at all times.
h. A patient who cannot be safely maintained through less restrictive measures will be restrained as a last resort to prevent self-harm. The sitter will continue to stay with the patient and provide direct observation as the nursing staff follows the Behavioral Restraint/Restrictive Intervention Policy.

3. The patient's plan of care will reflect suicide precautions and other nursing interventions. Nurses will reassess the patient's emotional well-being, document the patient's behavior, nursing interventions, and patient response to interventions and make changes to the plan of care as appropriate.
4. The physician may initiate a psychiatry consult to assure assistance from psychiatry services. The on-call psychiatry consult physician will be notified when a consult is ordered. Referral to Pastoral Care and Social Work will be made when indicated.
5. Support will be offered to family members. **Family members and friends may not act as sitters for patients on suicide precautions.**
6. Any comment related to suicide will be taken seriously. If the patient demonstrates a loss of control and threatens harm to self, others, or the environment, a Psychiatric Crisis Code/Violent Response Team Code can be called.
7. The nurse will search the room and the patient's clothing and personal possessions for items such as medications, sharps, cords, ceramic pieces, glass, lights, matches, belts, etc. that could cause harm to the patient or others. All clothing and other personal possessions will be removed, given to a family member, or secured per the valuables protocol until patient is discharged.
8. Nursing staff may serve as sitters for patients on suicide precautions after completing the mandatory educational program and competency-based test titled "Guidelines for the Care of Patients on Suicide Precautions – Sitter Responsibilities."

Suicide Precautions Search List

The patient on Suicide Precautions will have clothing and shoes removed and be in a hospital gown and slippers. A nurse will search the patient's personal possessions and room each (4, 8, 12) hour shift for items which could cause harm to the patient or others. Such items might include, but are not limited to:

1. Medications
2. Lighters
3. Matches
4. Sharps container
5. Sharps
6. Scissors
7. Knives
8. Razors
9. Glass
10. Ceramic pieces
11. Flower vases
12. Glass/metal utensils
13. Tape
14. Gauze
15. Phone cords
16. Cords
17. Shoelaces
18. Dental floss
19. Belts
20. Retractable name badge
21. Handheld controls for the bed
22. Plastic bags
23. Trash can liners
24. Alcohol
25. Aerosol sprays
26. Plastic/metal hair care products
27. Gloves

A nurse signature on the **Suicide Precautions Sitter Form** will verify that the nurse has searched the patient's clothing, personal possessions, and room for items which could cause harm to the patient or others. If found, such items will be removed, given to a family member, or secured per the valuables protocol until discharge.

Suicide Precautions Sitter Form

Date: _________________Time Started: ______________

Initials every 15 minutes verify the sitter was with the patient

	7a	8	9	10	11	12	1p	2	3	4	5	6	7	8	9	10	11	12	1a	2	3	4	5	6
00																								
15																								
30																								
45																								

Initials	Signature	Title	Initials	Signature	Title

Nurse signatures verify patient was in a hospital gown and room was searched each shift.

7a-3p	3p-11p	11p-7a
7a-7p	7p-7a	

Suicide precautions by sitters monitoring patients for suicide ideation include:

1. Each sitter will be fully informed of the patient's plan of care.
2. Sitters will remain with the patient at all times and never leave the patient alone.
3. Sitters will have the patient under direct observation at all times, leaving the door open when the patient is in the bathroom, and accompanying the patient 1:1 in the rare event the patient is out of the room for a test or procedure.
4. Sitters will not wear or take into the room any items a patient could use for harm.
5. Articles that could be used to inflict harm, such as but not limited to razors or plastic bags, are not used while the patient is on suicide precautions.
6. Sitters will document required information on a Suicide Precautions Sitter Form.
7. Sitters will be provided with relief for lunch/breaks by other staff members.
8. Sitters will notify the nurse immediately of any change in patient statements or behavior. The nurse will assess the patient and notify the physician, as needed.
9. Patient will be in a hospital gown at all times.
10. A patient who cannot be safely maintained through less restrictive measures will be restrained as a last resort to prevent self-harm. The sitter will continue to stay with the patient and provide direct observation as the nursing staff follows the Behavioral Restraint/Restrictive Intervention Policy.

Sitter Observation and Documentation Form

Room#: ________ Date: ________

Time	Pt. OBS Key	Sitter Response Key	Sitter Initials	Time RN Alerted		Time	Pt. OBS Key	Sitter Response Key	Sitter Initials	Time RN Alerted
0700						1900				
0800						2000				
0900						2100				
1000						2200				
1100						2300				
1200						2400				
1300						0100				
1400						0200				
1500						0300				
1600						0400				
1700						0500				
1800						0600				

Patient Observation Key		Sitter Response Key
A. Threatening to harm self		1. Talking with patient
B. Threatening to harm others		2. Assisting patient with meal
C. Striking out at others		3. Reading to patient
D. Screaming out/talking loudly or inappropriately		4. Walking with patient
E. Attempting to pull out IVs/tubes, etc.		5. Playing cards/board games, etc, with patient
F. Attempting to climb over side rails/chair		6. Watching TV/movies with patient
G. Attempting to leave patient care area		7. Reorienting patient to time/place
H. Lying/ sitting quietly		8. Accompanying patient for test/ procedure
I. Sleeping/ resting quietly		9. Alerted nurse to patient behavior
J. Talking to staff/family/physician		10. Providing care: VS, ADLs, etc.
K. Eating meal/snack		11. Observation
L. Toileting		
M. Performing ADLs		
N. Leaving unit for test/procedure		

Instructions for use as follows:

1) The person assigned to observe the pt. is to document the pt's behavior in "Pt. OBS" column, using the letters above every hour. (You may need to use more than one letter per hour).
2) Your responses to the behavior(s) are to be documented in "Sitter Response" column. If pt's behavior needs attention, alert the nurse immediately and place time nurse alerted in the "RN alerted" column.
3) Sitter must document starting time, initials; full printed name and time off in spaces provided.
4) Retain as a permanent part of the medical record and file the Patient Care Tab.

Sitter Checklist for Patients on Suicide/Involuntary Precautions has been completed.

Time ON	Print Full Name and Title (Sitter, NA, RN, LPN, Lab Tech, etc.)	Initials	Time OFF

Sitter's Checklist for Patients on Suicide Precautions/Involuntary Commitment

Maintain Safety of Environment and document the following items every 8 hours or with change in Caregiver:

Please complete this form by checking the appropriate boxes, signing and dating the bottom of the form.
Maintain in Designated File on Patient Care Unit

Room is free from potentially dangerous items:
_belts
_cigarette lighters
_razors
_sharp objects
_any item containing glass, including compact mirrors
_aerosols
_scissors/ tweezers/nail clippers/ nail files
_keys
_shoe strings
_medications

Be aware of the potential hazard of cords in the room (remove from the room; if not possible then tie up, **DO NOT CUT**. Examples not all inclusive include: EKG cords, pulse oximetry cords, curtain pulls

Patient belongings bag removed from the room

Trash can liners/ plastic liners removed from room

Keep closet/ wardrobe closed at all times

Wire coat hangers removed from the room

Use paper products and plastic utensils **(No knives allowed including plastic knives)**

No cleaning supplies should be left unattended in the room at any time in the room

Staff member does not leave patient in room alone

Leave bathroom door open if patient must go to the bathroom, keep patient in sight at all times
Search drawers for potentially dangerous items

*** Be aware the bedside table has a mirror, after risk assessment it was determined not likely a patient can pull this off to use as a weapon. Check mirror to confirm it is not broken.**

Date: ________ Time: ________ Signature: ____________________________________

Psychiatric Crisis Response Team

POLICY: The Psychiatric Crisis Response Team (PCRT) will function in the acute care hospital setting under the guidance of this policy, in collaboration with the patient's attending physician and nursing team.

OBJECTIVE: To assist in providing early intervention for patients outside the Psychiatric Unit who experience changes in their mental condition.

PERFORMED BY: Psychiatric Crisis Response Team

PROCEDURE

1. The Psychiatric Crisis Response Team will consist of an RN from the Psychiatric Unit, plus the Nursing Director of the Psychiatric Unit or his/her designee. When on duty the nursing coordinator will respond to activation calls in place of the Nursing Director or designee.
2. The following criteria may be used to activate the Psychiatric Response Crisis Team:

Concern	Parameters
Mental Status Change/Abnormal Behavior	Uncontrolled / Acute – psychosis, agitation, hallucinations
Restraint / Seclusion Assessment	Behavior is aggressive, violent, and uncontrollable with alternative measures tried
Suicidal/Homicidal/Psychotic Patient Attempting to Leave AMA	Behavior is aggressive, violent, and uncontrollable with alternative measures tried.
Worried / Frightened	Something does not "feel" right
1:1 Supervision	To evaluate the need for direct 1:1 supervision of a patient for any of the criteria listed above.

3. The patients nurse will notify the attending physician of the need to activate the Psychiatric Crisis Response Team.
4. The Psychiatric Crisis Response Team may be activated by any nurse and/or physician.
5. Upon activation of the Psychiatric Crisis Response Team, a Team member will be on the respective unit within 15 minutes of the call.
6. The Psychiatric Crisis Response Team will collaborate with the patient's bedside nurse to assess the patient's condition/needs, utilize the pre printed orders as appropriate, and document the actions of the team during the call.

Documentation:

1. The Psychiatric Crisis Response Team will document the events of the call and any action taken on the Psychiatric Crisis Response Team Call form. This form will become part of the patient's permanent record.
2. The Psychiatric Crisis Response Team will maintain a record of each call.
3. The patient's nurse will indicate in the patient's medical record that the Psychiatric Crisis Response Team was called and for what reason.

Post Activation of the PCRT:

1. Report response statistics quarterly to the Performance Improvement Committee.

Psychiatric Crisis Response Team Call Form

Call Information **Time**

Date:________________Room#:_____________ Call Initiated: ___________________

PCMT Arrived:__________________

Unit:________________ Completed:_____________________

Primary Reason for Call:_________

*Primary Physician Notified

________________________(physician name)

Time:____________________By:____

Person Initiating Call

_____Staff RN _____Physician ______Other

Assessment:

____

____

____

____

Recommendations/Interventions:

_____Psychiatric Consult

_____Involuntary Commitment

_____Restraint/Seclusion

_____Medication

_____Sitter

_____Attending to contact Psychiatrist on call

_____Initiate call to Mental Health Facility for transfer

Outcome:

____

____

____

Signature/Title:__________________________________Date:____________Time______

Violent/Self Destruction Restraint
Face to Face Evaluation Elements:

Patient's Immediate Situation:
___See History Present Illness (HPI)

Patient Reaction to Intervention:

Physical Assessment (including patient history, drugs, medications, recent labs)
___See Review of Systems (ROS) ___See HPI ___See Past Medical History (PMH)

Injury to Patient:

Behavioral Assessment:
___See HPI ____See PMH

Need to continue or terminate restraint:

Date:______________Time:_______________Signature:_______________________

Patient Identifier/Sticker (here)

Violent Response Team QA Form

Date:________Time VRT Called:_________Unit:_______________Room Number_____

To be completed by the VRT team Leader:
Brief Event Description:____
____
____
____

Responders: ED Staff:____
House Supervisor:____
Security Staff:____

Any patient/staff injuries? Yes No
Briefly Explain:____
____
____
____

Physician Notified:____

Face to face assessment form completed within 1 hour by Physician: _________________

Documentation initiated? Yes No If no, explain _______
____
____

To be completed by the person who initiated the VRT call:
Was the Violent Response Team beneficial to you for this event? Yes No
Please explain:____
____
____

Do you feel your needs and the patient's needs were met by the responding VRT members?

Yes No Please explain:_
____
____

Any additional comments or suggestions regarding the VRT?_______________________
____
____

*************Please return this form to the (designated person) for PI purposes************

SUBJECT: SEARCH AND SEIZURE OF CONTRABAND

Definition:

Contraband is any item that is potentially dangerous if used or misused by patients on the unit.

Purpose:

To maintain a safe environment for patients, families, visitors, and staff while not violating the patient's constitutional rights. To investigate situations in which the presence of contraband may cause injury. Providing a safe environment is the responsibility of all staff. Each patient will be free from an unwarranted invasion of privacy.

Policy Detail:

1. Staff will not act arbitrarily in initiating this procedure. Before a search and seizure may be initiated, one of the following situations MUST exist:
   a. suspicion that a patient(s) may be in possession of a dangerous substance or object that may be harmful to the patient and/or others.
   b. a valid warrant from police to participate in gathering evidence.

2. After the possibility of an unsafe situation has been verified by at least two staff members, the patient will be asked directly if he or she is in possession of any contraband. If the patient(s) denies possession and staff are still suspicious, the involved patient(s) will be requested to allow a search of their personal belongings for the presence of contraband.

3. If the patient refuses consent, a search of the patient's possessions will proceed if the decision involves protecting the patient from potential harm. If behavior permits, patient may be present during the search.

4. The search will be performed by at least two staff members. The patient's belongings will be handled in a respectful manner. The areas searched may include the patient's clothes worn at that time. The patient must give consent to the two staff present to search clothes worn by the patient at that time. Patients' privacy and dignity must be maintained at all times.

5. The patient will be informed as to any contraband found during the search and the disposition of the seized contraband.

6. When illegal drugs or firearms are confiscated, they must be placed in a secure locked area on the unit. The AOD or Administrator, and Hospital Public Safety Officer will be informed. Refer to the Administrative Policy Manual. Hospital legal counsel should be consulted regarding the reporting and/or disposal requirements of the state.

7. The patient's attending physician will be notified immediately if contraband is found, to assess for any needed treatment plan changes.

Documentation:

1. Patient Progress Notes: - rationale for the search, scope of search, it's findings with description of contraband found and disposition of confiscated items.

Reference: North Carolina Administrative Code, NCAC 27D.0103

SUBJECT: Patient Belongings/Valuables

Policy

On admission, a staff member will search all patient belongings and document on the 'Patient Belongings Record', (refer to Appendix A). On admission, the patient will be given a copy of the completed 'Patient Belongings Record'. The staff will also be responsible for obtaining the consent of the patient and/or legally responsible representative. A nurse will perform an assessment of the patient's physical condition including height, weight, and vital signs. This assessment will require the patient to change into a hospital gown/paper scrubs. This assessment will be performed in a respectful and professional manner. The patient should already be in a hospital gown/paper scrub if admitted via the Emergency Department. Education will be provided regarding the procedure and the reason for the assessment. Every attempt will be made to have the patient and/or significant others present during the belonging checks. Items not allowed on the unit will be sent home with the legally responsible representative or stored at the nurses station (refer to list below).

Visitors will be asked if they are bringing items for the patient and these items will be checked (refer to Appendix B). Nursing staff will search the belongings in the presence of the patient and document as needed on the 'Patient Belongings Record'.

Patients received in transfer from other units in the hospital are subject to this policy.

At discharge, all belongings will be returned to the patient and documented on the 'Patient Belongings Record' (refer to Appendix C).

Items allowed in the patient's room

Clothes- estimated quantity for five days
Shoes- soft soled with shoestrings removed and replaced with substitute
Toothpaste in a soft plastic container
Toothbrush
Non-metal comb or brush
Soap Shampoo
Deodorant
Non-aerosol spray
Make-up in plastic container
Books/magazines
Paper
Eye glasses
Hearing Aids
Walking aids as assessed
Dentures or partials Contact
lens supplies

All items will be assessed prior to releasing to the patient. Prohibited items will be placed in a secure location at the nursing desk or length of stay storage and documented. Restriction of items at nursing discretion will be documented in the progress notes, including explanation to the patient.

Items not permitted on unit but may be stored at nurses' station or designated area

Sharps: nail clippers, tweezers, glass of any kind, pins/needles, mirrors, crochet hooks, porcelain, and craft equipment.

Cosmetics: cologne, perfume, aftershave, mouthwash, astringent, aerosol cans, medicated creams, any item containing alcohol.

Flammables: of any kind, including: matches, lighters, cigarettes, cigars.

Valuables: cash over $10.00, credit cards, checkbooks, driver's license, social security card, keys, jewelry, cell phone. Items that may be used as weapons, such as credit cards, keys, and/or driver's license, will not be allowed to stay with patient. These items should be stored in the locked file cabinet in the medication room until discharge. (If patients insist on keeping valuables on their person, a release will be obtained)

Medications: Medications should be sent to pharmacy for labeling and re-dispensing or for storage until discharge (refer to Appendix A). Any patient medications labeled and re-dispensed by pharmacy will be stored in the medication room on unit and sent home with patient at discharge.

Items not allowed in patient rooms and stored at nurses' station or designated area may be used under supervision.

Violent Response Team

Policy

A. The Violent Response Team will be assigned and available to assist and manage patients throughout the hospital whose violent or self destructive behavioral jeopardizes the immediate physical safety of the patient or others.
B. The Violent Response Team representatives should respond to the situation immediately upon activation by an overhead page announcement of Violent Response and location, as well as ASCOM paging.
C. The Violent Response Team Intervention is intended as a therapeutic intervention to prevent the deterioration of a patient crisis and also to respond and deal with a patient whose behavior presents a potential imminent danger to self and/or others that may require the use of restraints.

Summary

A. This policy describes the process by which a Violent Response Team response is activated, the team members who respond and their roles, and the steps team members take to ensure the situation is safely handled.
B. A specialized team response shall occur to provide immediate de-escalation expertise and crisis prevention techniques to the patient who is displaying escalating behaviors.
   a. This occurs to provide early and rapid intervention designed to prevent further escalation of symptoms.
   b. If it is a patient who is unable to be "de-escalated, the team can assist with application of restraints and/or with transfer of patient to an appropriate level of care, if needed.
   c. This intervention always occurs in the best interest of the patient/family/staff safety, patient/family/staff rights.

Performed By

A. Violent Response Team Members
   a. Primary Care RN
   b. Unit Charge RN
   c. House Supervisor
   d. 1 additional ED staff member (as indicated)
   e. Security Officer(s)
   f. Pastoral Care, if available

Equipment

A. Appropriate level of restraint. ED Staff is to bring Velcro restraints
B. Violent/Self-Destructive Restrictive Intervention Order Form
C. Violent/Self-Destructive Face to Face Physician assessment Form
D. Violent Response Team QA Tool
E. PPE as indicated

Intervention

A. Activation of the Violent Response Team (VRT)
   a. Any time a staff member is concerned about the violent or self destructive behavior of a patient and needs immediate crisis intervention.
   b. Activate VRT by calling 0000 and notifying operator Violent Response Team needed and the location
   c. The operator will immediately page via the overhead paging system "VRT and the location" for a total of 3 times. The ASCOM phones for the House Supervisor, ED Charge RN, Pastoral Care will also be text paged with the information for the Violent Response.
B. Violent Response Team Responsibilities
   a. The House Supervisor and/or the ED Nurse
      i. A brief report of the situation may be given on arrival of these persons as indicated.

   - ii. If needed to ensure patient/staff safety, the Supervisor or ED Nurse may immediately take control of the situation and direct additional staff present in needed interventions.
   - iii. All other staff members will take direction from the team leader.

b. The team leader will assess and implement appropriate interventions and direct other team members to respond as needed.

c. The patient's primary nurse or staff most aware of the situation/background/history will provide background information and assist the Violent Response Team as needed.

d. Security Officers
   - i. Security Officers will assist in de-escalation techniques as indicated.
   - ii. Security Officers can assist in holding patient during restraint process as indicated and directed by team leader.
   - iii. If an individual shows a deadly weapon or deadly force Violent Response is changed to a Code Grey and Security is in charge and law enforcement is involved as necessary/per policy.

e. The patient's assigned nurse and the Violent Response Team Leader shall further assess the patient, analyze the assessment findings and implement appropriate Crisis Prevention Intervention (CPI) techniques and interventions as indicated.
   - i. Immediately separate family, friends, or others if they are creating or contributing to the confrontation if possible.
   - ii. Secure the room or remove medical equipment or furnishing that can be used as weapons.
   - iii. Communicate behavioral expectations to the patient as well as potential consequences if the patient does not comply.
   - iv. If the behavior continues, the Violent Response Team Leader will determine the need for restraint and direct implementation.

f. Nursing Staff will be responsible for applying restraint devices to patient and assessing, monitoring and documenting following Violent/Self-Destructive guidelines per the Restrictive Interventions Policy.

C. Physician notifications, assessments, and documentation will occur according to Restrictive Interventions policy and procedures.

<u>Documentation</u>

A. The Violent Response Team Leader will be responsible for ensuring all documentation is initiated (and completed as appropriate)

   a. Proper physician notification has occurred and order forms are signed.

   b. The face to face physician documentation form is completed within one hour, order forms are signed.

   c. Online documentation initiated appropriately.

   D. Violent Response Team QA tool completed.