Osawatomie State Hospital
500 State Hospital Dr.
Osawatomie, KS 66064

Phone: (913) 755-7000
wwwmail@kdads.ks.gov
www.kdads.ks.gov/Osawatomie/Osawatomie_Index.htm

Kansas
Department for Aging and Disability Services

Kari M. Bruffett, Secretary
Sam Brownback, Governor

Dr. Jerry A. Rea, Superintendent

TO: Name: Gamila Munga

Voice: _____ Fax: 443-380-6059

FROM: Name: Jerry Rea

Voice: (913) 755-_____ Fax: (913) 755-_____ E-Mail: _____@osh.ks.gov

RE: _____

Date: _____ Time: _____ No. of Pages (including this sheet): _____

SPECIFY DOCUMENT(S) SENT:

Addendum to Osawatomie State Hospital Plan of Correction (CMS-2567)

1) Clarification regarding Therapeutic Observational Status (Patient Assessments, page 1 of form 2567)

PC-10.1, Therapeutic Observation Status has been revised to change High Alert 1:1 from red to silver. High alert 15 minute check remains red. Use of the suicide preventions smocks and blankets has also been added. Language further clarifying difference between 15 minute checks and 1:1 status was added.

Staff were trained on use of the suicide prevention smocks and blankets on 2/12/15. Staff who were not present are being trained on their next shift.

Staff were trained on use of silver wristbands for patients on 1:1 status on 2/13/15. Staff who were not present are being trained on their next shift.

Individual responsible: Clinical Program Director

2) Clarification regarding non-verbal patients or patients with a language barrier

To assist in identifying medical concerns or issues regarding non-verbal patients or those who are unable to communicate, staff will be alert to non-verbal cues that may indicate discomfort or a medical issue:

- Facial grimacing
- Tense body language
- Moaning
- Guarding of a body part
- Excessive sleeping
- Combative with care
- Elevated respirations, blood pressure, and/or heart rate

3) Clarification of Clinical Pathways (Page 58 of form 2567)

Clinical Pathways and templates for 61 Medical Conditions will be implemented as nursing clinical guidelines during the month of February. These serve as guidelines for nurses to use for conditions that are of a non-critical nature. If a patient has a condition that is of a more urgent nature, the nurse will contact the attending or on-call physician immediately for the physician to exam. Those conditions that may warrant immediate medical intervention are those that delineated with an Asterisk below:

Abdominal Pain
Allergic Reactions; Non-Emergent
*Allergic Reaction/Anaphylaxis
Anxiety
*Asthma Exacerbation
Back Pain
BMI Calculation-Weight Loss or Gain
Breast Problems (Female and Male)
Burn
Sun Burn
Canker Sores
*Chest Pain
Cold Sores
Conjunctivitis
Constipation
Dental Pain
Dental Orthodontic Appliance Problems
Diarrhea
Discharge Penile/Vaginal
Ectoparasites (head lice, body lice, pubic lice & scabies)
ENT
*Eye; Foreign Body/Injury
Post Exposure Prophylaxis
Fever
*Foreign Body Ingestion & Food Impaction
*Head Injury
Headache
Health Assessment
*Heat Illness
Hemorrhoids
Human Bite
Hunger Strike Assessment
Hypoglycemia
Immunizations
Indigestion
Influenza like Illness
Menstrual Cramps
Methicillin Resistant Staph Aureus
Musculoskeletal Sprain-Fracture-Dislocation
Nausea and Vomiting
Nose Bleed: Epistaxis
Over The Counter Medication Use (Patient Started)
*Poisoning Suspected
Rabies; Post Exposure
Therapeutic Restraint Monitoring
Scalp Conditions
Segregation Clearance
*Seizure
Sexual Assault/Abuse
Skin Conditions (Acne, Tinea Pedis, Blisters, Boils)
*Sprain-Fracture-Dislocation
Stings & Bites
Suspicion of Being Under The Influence Of Alcohol Or Drugs
Tb Screening and Management
Toe Nails; Ingrown
*Trauma
Urinary Tract Symptoms
Visual Changes
Withdrawal from Alcohol
Withdrawal from Opiates
Wounds

4) High Risk Medical Conditions (page 61 of form 2567)

The Nurse Care Coordinator, in addition to monitoring patients with constipation issues, will monitor the care of patients who are considered at high medical risk. The list has been amended to reflect the high risk conditions that the Nurse Care Coordinator will follow, which includes, but is not limited to:

- History of uncontrolled hypertension;
- Mild hypotension
- Diabetes
- History of congestive heart failure
- History of chronic obstructive pulmonary disease
- History of pneumonia within the preceding six months
- History of cardiovascular accident or myocardial infarction
- History of deep vein thrombosis
- History of uncontrolled/unstable or non-therapeutic INR values
- History of seizures or seizures within the preceding six months
- History of loss of consciousness
- Healing fractures
- Pregnancy
- Cancer, not in remission, and
- Decubitus ulcer

Patients that present with or develop an acute condition that requires more intensive medical services than available at OSH will be transferred to an acute care facility.

Signature

2-13-15
Date

Title

OSAWATOMIE STATE HOSPITAL

Therapeutic Observational Status (PC-10.1)

Effective Date: February 13, 2015

Provision of Care Procedures Manual

I. POLICY

The purpose of Therapeutic Observational Status is to maintain the safety of the patient and others. The Interdisciplinary Team (IDT), along with other staff, and the patient determines which therapeutic observational status the patient needs for safety. The physician writes an order for the observational status. Only one observational status will be in effect at a time. At admission and ongoing throughout hospitalization, patients are assessed for the level of risk of danger to self or others. Observational statuses are ordered accordingly to address the patient's safety.

Observational status may be changed based on a patient's safety and level of risk but should not be used as a negative consequence for behavior. Likewise, observational status is not a privilege. Factors to consider in assessing safety and level of risk may include recent acts of aggression, hostility, refusal to follow instructions for safety, failing to engage in therapeutic activities and/or violation of other's boundaries.

Regardless of observational status, all patients are escorted after curfew.

II. PROCEDURE

A. THERAPEUTIC OBSERVATIONAL STATUS CATEGORIES:

- Green: Standard Observation
- Yellow: Escorted Observation
- Orange: Unit Observation: hourly checks
- Red: Unit Observation: 15 minute
- Silver: Unit Observation: 1:1 observation

1. A colored wristband that corresponds with the therapeutic observational status is required for each patient in addition to the wristband that the patient wears for medication and identification. (PS-2.5 – Patient Identification).

2. A patient who is not wearing a wrist band or is wearing an illegible wristband should be assisted to get the appropriate band.

3. If the patient refuses to wear a wristband, they should not be allowed off the unit except for medical emergencies.

4. If a patient is off the unit without a colored wristband, staff should educate the patient

of the need to have a wristband on at all times and return the patient to the unit.

5. Accounting for patients is completed according to hospital policy PC-5.1, Accounting for Patients and Campus Curfew.

B. INITIATING AND CHANGING THERAPEUTIC OBSERVATIONAL STATUS:

1. When an individual presents for admission, he/she is in full view of Security and/or Nursing staff at all times in the Admissions Office.

2. Upon admission, the patient is placed on **unit observational status with 15-minute checks (red)** until they are assessed by the physician.

   a. When the patient is taken to the unit, the Security and/or Nursing staff hands off supervision to the unit staff.
   b. The nurse may make a decision to observe a patient more often than every 15 minutes if warranted by the patient's mental or physical condition.
   c. Upon arrival on the unit, the patient is placed in a suicide prevention smock and provided suicide prevention blankets until assessed by the physician.
   d. The patient will remain in a suicide prevention smock and utilize suicide prevention blankets until he or she is no longer determined to be a suicide risk.

3. The physician, in collaboration with the patient and staff, assesses the patient for potential danger to self or others ("risk behaviors") at:
   a. Admission
      i. The RN and Physician assess the patient for suicidal ideation, intent or attempts. The assessment includes a review of the mental health screening materials and an interview of the patient to determine the presence of factors which would place a patient at risk to commit suicide.
      ii. The RN and physician will also assess for other risk factors to self or others.
   b. Any time the patient's condition warrants a change.

4. When a patient presents with behavior dangerous to him/herself or others, the nurse can change the observational status to one that will provide closer supervision.
   a. This change does not require a physician's order but requires notification of the physician.
   b. The nurse will enter the new therapeutic observational status, risk and details under the therapeutic observational status tab of the Patient Care System (PCS).
   c. In the details section the nurse should include "Status initiated by nurse."

5. Every status change that reduces the level of supervision, requires a written order from the physician on the Physician's Plans (Observational Status), form ORD-3.0, which includes the therapeutic observational status, risk(s) identified, and specific details (including a behavioral description). The details need to include current risks or behaviors to be monitored which would prevent the patient from being moved to green/standard observational status.

7. **Every change in observational status must also have a corresponding progress note in the PCS written by a member of the IDT or nurse detailing the reason for the change.**

8. When the order is transcribed, or at the time the observational status is changed, the nurse or program assistant:
   a. Enters the order (including the details and reason for the status) in the therapeutic observational status tab in the PCS.
   b. Writes the patient's name on the appropriate color wristband with a permanent marker and gives to unit staff to put on the patient.

9. Each patient will be re-evaluated by the IDT at a frequency appropriate to his / her observation status as outlined below. Documentation by the IDT Leader, or designee, will include any assessment, recommendations, and changes or reasons for continuing the status.

   a. Unit Observation Silver, 1:1 – Daily (The physician will perform this re-evaluation in the absence of the entire IDT).
   b. Unit Observation Red, 15 minute checks – Three (3) times a week (Monday, Wednesday and Friday).
   c. Unit Hourly Check (Orange) – Two (2) times a week (Tuesday and Thursday).

C. STANDARD OBSERVATION (GREEN)

1. Individuals whose psychiatric conditions have been stable, who have not displayed any risk behaviors and who are assessed by the IDT as not being likely to engage in any risk behaviors may be assigned Standard Observation status.

2. A patient may leave the unit unescorted for up to sixty (60) minutes during "Free Time" and must stay within the approved hospital boundaries. For OSH campus, see attached map.
   a. Patients are allowed to sign out only during "Free Time."
   b. Free time is not offered during treatment times or blocks of treatment time (i.e. when groups and activities are available for the patient).
   c. Patients who are not scheduled in a group are not considered as having "Free Time."
   d. "Free Time" is outlined on a program treatment schedule and/or "Fresh Air" schedule with final approval by the Clinical Program Director.

3. A patient may sign out during "Free Time" when specific criteria are met (e.g. physical exam, room cleaned, attended schedule, treatment compliance, completed personal hygiene, etc.). At the discretion of the RN or IDT Team, sign-outs may be delayed until the above criteria are met.

4. Patients on Standard Observation Status are required to sign out each time they leave the unit unescorted and sign in when they return.
   a. Upon departure from the unit, the patient signs out.
   b. Upon return to the unit, the patient signs in.

c. Patients who have not signed in within sixty (60) minutes must be accounted for by staff and documented on sign-in/sign-out form as to whereabouts.
d. Patients may be accounted for by visual observation, accounting for patient checks or a report from other staff.
e. If the patient is not accounted for, then hospital protocol for unaccounted for patients is initiated. (For OSH, follow procedure EC-2.4 - Organized Searches.)
f. Sign-In/Sign-Out sheets are kept until the end of the day and then shredded.

D. ESCORTED OBSERVATION STATUS (MODERATE ALERT) Yellow

1. Individuals who have demonstrated increasing stability with their psychiatric symptoms, and who are not believed likely to engage in dangerous behaviors may be assigned Escorted Observation Status.

2. Patients on escorted observation status are expected to attend available groups, appointments, activities provided off the unit and meals in the Cafeteria.

3. A patient is accompanied (escorted) by staff any time he/she leaves the building. If a patient is transferred to another staff:
   a. The escorting staff member accompanies the patient(s) to the receiving staff member and **informs** the staff that the patient(s) is/are on **escort**.
   b. The receiving staff member verbally acknowledges responsibility for the patient(s).

4. Patients may not go off unit with visitors, including guardians, unless escorted by staff.

E. UNIT OBSERVATION - THREE (3) TYPES

1. **Unit observation (Orange – Moderate Alert)**
   a. Individuals whose psychiatric symptoms have begun to stabilize and who are assessed as being unlikely to engage in risk behaviors, but who still are thought to need the structure and support provided on the unit, may be assigned to unit observation Orange status.
   b. Patients on unit observation Orange status must remain on the unit with hourly checks being completed by Nursing Staff. Groups and meals are on the unit (except for patients on East Biddle who can have meals at the cafeteria since the cafeteria is also a part of the Biddle building)
   c. They may leave the unit only for medical / diagnostic tests, court hearings, or appointments.
   d. Anyone trained in Therapeutic Options may escort Orange status patients off the unit for these appointments.
   e. Orange Status may
      i. Have visitors in the visiting area but need to be observed during the visit. *If the visitor is an individual who the patient has a right to meet with privately as outline in hospital procedure RI-2.7, Limitations on Patient Rights and a private visit is requested, the RN must educate the visitor of the risks that may be associated with a private visit, ascertain*

the patient and visitor's wishes and document the education and any decisions.

ii. Take fresh air breaks and/or participate in outside groups with patients who are on standard and escort observational status with staff on the following areas:
   1) Biddle and C2 courtyard
   2) A2, B2, and C1 fenced patio areas
   3) Take fresh air breaks outside on the unit's patio during <u>scheduled</u> breaks separate from patients on standard or escorted observation status. At least one staff member is designated to observe a maximum of five (5) patients on unit observational status on A1 or B1 patio areas.

f. The RN assigns nursing staff to write a progress note every AM and PM shift describing the patient's behavior related to the reason for unit observation Orange.

g. Nursing staff will complete the 60-minute checks as ordered, complete the Timed Check Sheet (PRG-1.14), and document whether there are any behavioral changes in a progress note.

h. Assigned nursing staff periodically interacts with the patient to ascertain behavioral changes and potential risk to self and /or others.

i. Each patient will be re-evaluated by the IDT two (2) times a week (Tuesday and Thursday). Documentation by the IDT Leader, or designee, will include any assessment, recommendations, and changes or reasons for continuing the status.

2. **Unit Observation (Red – High Alert) 15 minute Check**

a. Individuals who are newly admitted and/or not well known to hospital staff; have the potential to become an imminent threat of harm as evidenced by having recently engaged in such behavior, but who are not currently communicating threats to self or others, and are cooperative with staff requests to avoid harm to self or others; or anyone assessed by the interdisciplinary team as requiring close monitoring should be placed on Unit Observation with 15 minute checks.

b. Any patient determined to be a suicide risk will be provided a suicide prevention smock and suicide prevention blankets until no longer assessed to be at risk.

c. Patient on unit observation Red status are not to leave the unit and /or building for any reasons, except as otherwise described below. Any other exceptions must be ordered by the physician.

d. <u>The R.N. Assigns:</u>
   i. Staff to complete the Timed Check Sheet (PRG-1.14).
   ii. The patient to a room as close to the nursing station as possible.

e. Nursing staff ensure that patient's personal property and person were checked at the onset of the special precautions check for any possible object they could use for self–harm (such as belt, shoe strings, cords, necklaces, purses with long handles, items that could be tied together, strings in clothes, sharp objects, breakable objects). If found, such items should be taken from the patient, reported to the RN immediately, and secured in the designated closet.
   i. This search does not require a physician's order.

ii. These searches shall be conducted in a manner to protect the patient's dignity and privacy.

f. Nursing Staff
   i. Periodically interacts with the patient to ascertain mental status and potential risk to self or others.
   ii. Writes a progress note for patients on 15 minute checks every shift describing the patient's behavior related to the reason for unit observation.

g. When risk factors are present that suggest a potential for self-harm, nursing staff notifies the RN so the patient can be further evaluated for suicidal thinking and possible plans to engage in self-harm.

h. The Nursing Staff:
   i. Completes the Timed Check Sheet (PRG-1.14)
      1) Enters the date, reason for check, sixty (60) or fifteen (15) minutes as the frequency of the check, time the check starts, initials and any appropriate codes.
      2) Makes all subsequent entries by entering the time of the check, initials, and appropriate codes at **frequent, irregular** intervals, at least every fifteen (15) minutes.
   ii. During checks,
      1) Determines the patient's location, activity and behavior.
      2) If the patient appears to be sleeping, observes for visible respirations.
      3) Remains alert to safety and heightened risk issues when a patient takes a bath/shower. Patients on 15 minute check must be attended at all times by staff while in the bathtub rooms.
   iv. Upon discontinuation of the check, the assigned staff documents the discontinuation of the Timed Check Sheet by entering the time, initials and any appropriate codes.

i. At the discretion of the R.N., patients may go out of the building for the following reasons:
   i. Attend medical consultations/diagnostic tests, court hearings, appointments, with a 1:1 designated staff person.
   ii. Have visitors in the visiting area but need to be observed during the visit by a specific assigned staff member to do the checks in addition to the staff member supervising the overall visiting area. *If the visitor is an individual who the patient has a right to meet with privately as outline in hospital procedure RI-2.7, Limitations on Patient Rights and a private visit is request, the RN must educate the visitor of the risks that may be associated with a private visit, ascertain the patient and visitor's wishes and document the education and any decisions.*
   iii. Take fresh air breaks and/or participate in outside groups with patients who are on standard and escort observational status with staff on the following areas:
      1) Biddle and C2 courtyard
      2) A2, B2, and C1 fenced patio areas
   iv. Take fresh air breaks outside on the unit's patio during scheduled breaks separate from patients on standard or escorted observation status. At least one staff member is designated to observe a maximum

of five patients on unit observational status onA1 and B1 patio areas.

j. Each patient will be re-evaluated three (3) times a week (Monday, Wednesday and Friday) by the IDT. Documentation by the IDT Leader, or designee, will include any assessment, recommendations, and changes or reasons for continuing the status.

3. **Unit Observation with 1:1 (Silver High Alert)** – Patients on Unit Observation with 1:1 must not go outside or leave the unit for any reasons without a physician's order except in an emergency.
   a. Individuals actively engaging in self-injurious behaviors with or without intent to kill themselves; those who present as an imminent threat of harm toward themselves or others (that is, they are actively seeking the means to commit harm, and/or they are writing or voicing threats to others with the ability to immediately follow through on those threats); or anyone assessed by the interdisciplinary team should be placed on 1:1 Unit observation.
   b. Any patient determined to be a suicide risk will be provided a suicide prevention smock and suicide prevention blankets until no longer assessed to be at risk.
   c. 1:1 requires a specific assigned clinical staff member, who has been trained in Therapeutic Options, to have constant 1:1 supervision of the patient.
   d. The staff member must remain in the personal proximity (within 5 feet) of the patient at all times and must maintain visual contact of the patient at all times (including while using the restroom, taking a shower and when sleeping). There are **NO** exceptions.
   e. The staff member reports any change in the behaviors (e.g. increased activity, calmer demeanor, avoidance of contact) to the RN and / or physician.
   f. At the **discretion** of the R.N.:
      i. A patient may receive visitors in the visitor's area **only** if the visitor's area is on the unit. An assigned staff member must remain within five (5) feet of the patient. *If the visitor is an individual who the patient has a right to meet with privately as outline in hospital procedure RI-2.7, Limitations on Patient Rights and a private visit is requested, the RN must educate the visitor of the risks that may be associated with a private visit, ascertain the patient and visitor's wishes and document the education and any decisions.*
      ii. Patients may attend therapies, groups, activities or meals on the **UNIT** only. An assigned staff member must remain within five (5) feet of the patient.
   g. Each patient will be re-evaluated **daily** by the IDT (The physician will perform this re-evaluation in the absence of the entire IDT). Documentation by the IDT Leader, or designee, will include any assessment, recommendations, and changes or reasons for continuing the status.
   h. The R.N.:
      i. Notifies the Nurse Specialist (or designee) of any patient requiring 1:1.
      ii. Assigns staff for the 1:1.
      iii. Assigns relief staff for the 1:1 as appropriate.
      iv. Assesses the patient's condition and document at the initiation of the 1:1 and every shift thereafter until discontinued.
      v. Takes appropriate action, if necessary, and documents findings in a

progress note.

i. The Assigned Staff:
   i. The assigned staff writes a progress note describing the patient's behavior related to the reason for unit observation with 1:1 each time the assigned staff hands off the patient to another staff.
   ii. When leaving the building/unit, and/or while being escorted, the patient is not to be with any other patients. **Two (2)** staff must remain within five **(5) feet** of the patient at all times and must **not** be responsible for the observation of other patients.
   iii. When the patient is in bed, the bed is placed near the entrance to the room (without blocking it) to allow the observing staff member to be within five (5) feet of the patient while remaining outside the room.

Osawatomie State Hospital

By: _____
Jerry Rea, Ph.D.
Superintendent

Submitted by: Executive Clinical Program Team

Origination:	June, 1997
Reviewed:	
Revised:	6-00, 6-02, 2-03, 5-03, 6-04, 4-05, 12-06, 5-07, 11-07, 3-09, 4-09, 1-10, 7-10, 9-10,11-11, 1-13, 6-13, 12-14, 2-15, 2-13-15

Attachments: PRG-1.14 – Timed Check Sheet
OSH Map – Sign-out Boundaries