VERMONT

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October 5, 2017

VIA E-MAIL ONLY

RE: VOSHA Complaint No. 1266126

Dear Mr. Whipple:

Thank you for your letter of September 21, 2017. We appreciate the opportunity to respond.

VPCH takes the safety of our staff very seriously. Per our normal procedures, right after the event referenced in your letter we immediately began actively reviewing and investigating to determine exactly what happened, what went well and what did not, and what could be done to prevent a future occurrence.

Before I delve into the specifics of our investigation and the action steps we plan to take in response, I would first like to give a little legal background as I think it is extremely relevant to this event. As you may be aware, if a patient refuses medications DMH legal must file an application with the court to seek permission to provide that patient with the psychiatrist's recommended treatment. If the court grants an order, it is specific as to the type and dose of medication that can be administered to the patient. Should a change in medications or dosage be clinically appropriate, DMH legal must again file with the court to ask permission. Not only could this court process take several weeks to even months, but the court could decide not to grant the order.

The patient who engaged in the assaultive behavior towards staff had been denied a change in their medication order prior to the September 12th event. They had a court hearing scheduled on their amended application very soon after the September 12th event and were apparently agitated about that upcoming hearing. Unfortunately, even after the event of September 12th, a change in their medication order was denied. Another court hearing was held a few weeks later and finally a change was granted.

Right after the event on September 12th (which occurred around 2140), a debriefing was held on the unit (see attachment, it was signed as completed at 2247). The recommendation that came from that event was that the patient be put on a 1:1 or 2:1. The psychiatrist ordered a 2:1 and that remains in effect currently.

The next day, September 13th, a multidisciplinary review was held (see attachment). This was attended by psychology, nursing, social work, and psychiatry. Three follow up steps were recommended after that review, all of which have been completed. One, psychology met with the patient to process the events and surrounding emotions. Psychology used this information to talk later with staff about what could be done in the future to better identify changes in the patient's mindset and how best to identify and react to triggers. Two, the psychiatrist filed another medication application. This one was ultimately granted. And three, a case conference was held on September 18th (see more discussion on this below).

Also on September 13th the event was discussed at the EIP-Unit Safety Review Committee. There was continued discussion of the event at the September 20th meeting after the case conference. This committee is comprised of the CEO(s), the medical director, the chief nursing officer, a nurse supervisor, the director of operations, psychology, and quality. The committee reviewed the documentation and the facts surrounding the event. Things discussed included the need for better environmental awareness and more instruction on how to best interact with the patient (*i.e.* do not say no, but instead offer choices). We discussed frustrations around the legal process and some ideas on how to move forward with the medication application while acknowledging our limited control in this area. It was also decided that it would be beneficial to better train staff on the emergency involuntary procedures (EIP) rule so they feel more comfortable knowing when that is a tool that can be used. Finally, we discussed the need for more mental health specialist input with doctors and nurses as well as their needed participation in more meetings.

The last formal step was the case conference. VPCH holds case conferences after serious events to provide staff a forum to address their concerns and to process the events. The case conference for this event was held on September 18th for 1.5 hours. It was open to all staff and as the attendance log indicates it was well attended by staff at all levels, including many mental health specialists. I joined along with my interim co-CEO, Emily Hawes. In addition, the medical director and attending psychiatrist attended. The conference was facilitated by psychology.

The case conference identified that there exist communication gaps amongst different levels of staff at the hospital. This is a problem we have identified and are brainstorming ideas on how to improve this. Many are contained in our settlement proposal. We also heard themes around a need for better environmental awareness and issues of staff complacency. There was a discussion around what to look for in terms of triggers for that patient and how to prepare for triggering events better.

Based on all the above analysis, VPCH intends to take the following additional actions beyond those already taken. One, we plan to pilot a process to better inform staff on 1:1s or 2:1s on how

to best perform in that role and how to best interact with that patient. We anticipate creating some type of document that will include specific tips and tools for staff to review and will be created with input from psychiatry, psychology, nursing, and mental health specialists. Two, there will be on-unit staff training using examples and hypotheticals on the EIP rule. Three, lead mental health specialists will be invited to attend the weekly EIP-Unit Safety Review Committee meetings. Longer term ideas were identified in our settlement proposal and tie into the themes identified above.

Thank you again for the chance to respond and explain the steps we have taken and those we intend to take. I hope the above information is helpful to you. Please feel free to contact me with any follow up questions or concerns. Staff safety is of utmost importance for us at VPCH.

Sincerely,

KAB

Karen Barber
General Counsel, DMH/Interim Co-CEO, VPCH

Cc: Tim McCants, VSEA VPCH Chapter President