Blood Administration

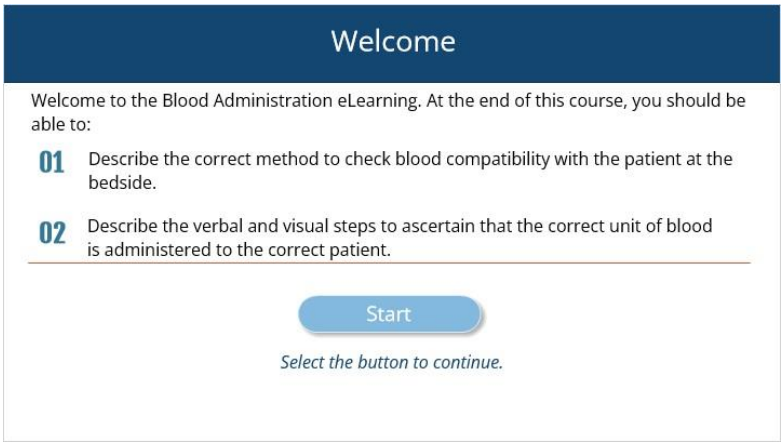
1. Home

1.1 Home



Notes:

1.2 Learning Objectives



Brockton Behavioral Health Center Nursing Best Practices

Victoria Martell MSN, RN-BC, CNE

9.2025

BOSTON MEDICAL CENTER

Objectives

Participants will be able to:

- Explain best practices related to conducting safety checks
- Identify best practices related to caring for a patient who is on 1:1 observation
- Discuss different types of safety precautions used at BBHC
- Recognize how to prevent patient elopement
- Discuss the components of a therapeutic milieu
- Articulate trauma informed care practices
- Identify components of verbal de-escalation
- Identify situations that need to be escalated to Brockton Behavioral Health Center's Leadership team

Safety Checks

- Patient's can be ordered for 5-minute checks or 15-minute checks
- Best practices for safety checks:
  - Safety checks must be completed timely. One person should be assigned to checks, and if possible, the person assigned to checks should be focused on completing the checks and no other tasks.
  - If patients have their face covered with a blanket or a towel, remove the blanket/towel to ensure patient safety.
  - If patients are in the bathroom, you must visualize the patient.
  - Enter patient rooms and observe for signs of life
    - 3 respirations
    - Use flashlight at night
- On the assignment sheet it should be clearly documented who is responsible to complete checks, and it is that person's responsibility to ensure checks are completed at the assigned time.
- Environment checks are part of safety checks
- **You must visualize every single patient in person when you are doing checks**

Please review the following policy:

Patient Checks and Surveillance (BMC Brockton) v.3

1:1 Best Practices

A 1:1 is the assignment of a qualified staff member to remain with the patient and always maintain an unobstructed view to prevent harm to the patient or others.

Key Expectations:

- The patient **may not leave the unit** unless accompanied 1:1 by a staff member.
- Staff must remain **within arm's length** of the patient at all times including in the **restroom or while bathing**.
- 1:1 at arm's length can **only** be modified by a provider order if it is not in the best interest of the patient or staff.

Important Reminders:

- **Never leave a 1:1 patient unattended** even briefly. If you must step away, request relief *before* doing so.
- **Communicate clearly** with the charge nurse or RN if you're unsure about your assignment or need coverage.
- **Document in real time** and ensure accuracy this is essential for both clinical and legal accountability.
- If you observe a lapse in 1:1 coverage, **speak up immediately** to protect the patient and support the team.

- Please review the following policy:
- Patient Observation (BMC Brockton) v.3

1:1 Best Practices/Precautions

- It is imperative you get report on why the patient is on 1:1 observation
- Swallowing precautions:
  - Remove objects in patient's room per provider's order
  - Blocked room per provider's order
  - Always be within an arms length of patient
  - Have a clear line of sight of the patient
- Suicide precautions:
  - Remove objects in patient's room per provider's order
  - Blocked room per provider's order
  - Always be within an arms length of patient
  - Always have a clear line of sight of the patient

Elopement

The following are LOCKED units, which means that patients, visitors, nor staff can enter or exit without a badge/key that allows entry:

IP 1, IP 2, and IP 3

- As mentioned, entry to the unit requires the use of a Boston Medical Center badge
- All storage rooms, closets, utility rooms, medication rooms, nursing stations, conference rooms, and group spaces are locked by key or badge swipe and **MUST remain locked at ALL times**.
- Badge and keys MUST be always kept in a secure place on staff – DO NOT PUT BADGE OR KEYS DOWN while in the patient care areas.
- Elopement is defined as an attempt by any behavioral health patient to leave a locked inpatient or partial unit willfully without authorization.
- Many of our patients are confused and disoriented. If a patient were to leave the unit unsupervised, it could result in very unsafe outcomes for the patient.
- **ANY KNOWN OR SUSPECTED ELOPEMENT MUST BE REPORTED TO NURSING STAFF AND UNIT LEADERSHIP IMMEDIATELY.**
- **Please review the following policy:**
  - Patient Absence Without Authorization (BMC Brockton) v.2

Entering / Exiting Care Areas: LOOK, LISTEN, CHECK

- When **ENTERING** or **EXITING** the unit or other locked space within the unit:
  - **LOOK FIRST** to ensure there is no patient waiting at the door or following behind you. If so, wait until the person has moved away, or call unit staff member for support before entering or exiting.
  - **LISTEN** to ensure the door has closed and latched tightly behind you.
  - **CHECK** to make sure the door is closed, latched, and locked. If someone is following behind and is claiming to be a staff member, CHECK for their badge.
    - If someone is trying to exit without a badge, or is a visitor, redirect to a staff member.
- IP 2 and IP 3 have sallyports, which is a double set of doors prior to entering the unit. This is a stop point for potential elopement.
  - Please Note: only one door can be opened at one time

Therapeutic Milieu

Patient interactions are pertinent whether the patient is in the milieu or in their rooms

- Some examples of a therapeutic milieu include:
  - Leaving nursing station to interact with patients
  - Not engaging in power struggle
  - Respecting the patients—no consequences
  - Following up on patient asks/requests

Please review the following policy:

Therapeutic Environment (BMC Brockton) v.1

Trauma Informed Care

- There is evidence that trauma is stored in the part of the brain called the limbic system, which processes emotions and sensations, but no language or speech.
- For this reason, people who have been traumatized may live with implicit memories of terror, anger, and sadness generated by the trauma, but with few or no explicit memories to explain the feelings.
- How we talk to our patients matters!
- **What communication strategies are trauma informed?**
  - Active listening
  - Nonjudgmental language
  - Being mindful of body language
  - Respecting boundaries
- **How do we create a trauma informed environment?**
  - Calming, welcoming, non-threatening space
  - Being clear in the information we provide
    - Don't say one thing and do the other
    - Always return when you say you are going to

Verbal De-escalation

Establish a Calm and Safe Presence

- **Approach**: Approach the person calmly and non-threateningly. Keep a neutral posture (avoid crossed arms, maintain a relaxed stance).
  - **Tone of Voice**: Use a calm, steady, and non-judgmental voice. Speak slowly and clearly, offering a sense of control and stability.
  - **Non-Verbal Cues**: Ensure your facial expressions and body language convey safety and openness.

Active Listening

- **Engagement**: Let the person speak and truly listen without interrupting. Show empathy and understanding through eye contact and nodding.
- **Reflective Responses**: Repeat or paraphrase what they say to show you understand ("It sounds like you're feeling…").
- **Acknowledge Emotions**: Validate their feelings, even if you disagree with their behavior ("I can see this is upsetting for you").

Maintain the Environment (Milieu Management)

- **Safety and Structure**: Ensure the physical space is safe (clear of objects that can be used as weapons, maintain adequate lighting).
- **Minimize Triggers**: Keep the environment calm and avoid overstimulation (loud noises, chaotic activity).
- **Reduce Tension**: A quiet or neutral room can sometimes provide relief. If appropriate, consider relocating to a calmer setting

Verbal De-escalation

Set Clear Boundaries

- **Firm but Respectful**: Communicate boundaries with respect and clarity. Let the individual know what behavior is unacceptable, without escalating the situation.
- **Offer Choices**: Provide options for positive behavior ("You can stay here and talk, or we can find a quieter space to discuss it").

Use De-escalating Language

- **Stay Neutral**: Avoid blame or criticism. Focus on solutions rather than problems.
- **Stay Collaborative**: Use phrases like "Let's figure this out together" or "What would make you feel more comfortable?"
- **Avoid Threatening Language**: Never use ultimatums or confrontational statements. Keep the tone supportive, not adversarial.

Observe and Adjust

- **Monitor Response**: Watch for signs of agitation, fear, or anxiety. If the person's behavior is escalating, step back and reassess.
- **Adjust Approach**: If the person seems overwhelmed, simplify your approach or give them space to calm down.

Verbal De-escalation

Utilize Team Support

- **Collaborative Approach**: If possible, involve other staff members in the de-escalation process. Ensure everyone is on the same page.
- **Avoid Isolating the Person**: Do not corner or isolate the individual. Keep them feeling like they have control and support.

Know When to Seek Additional Help

- **Escalation Signs**: If verbal de-escalation is not working and the situation is worsening (e.g., aggression, threats of harm), consider calling for additional support (security, physicians).
  - Which situations require escalation to leadership?
    - Sexual assault
- **Professional Support**: In some cases, medications or further therapeutic interventions may be necessary.

DMH Code Blue Education

RN's

January 2025

Multipurpose Room

Manavi Dhakal MSN, RN & Victoria Martell MSN, RN-BC, CNE

Brockton Behavioral Health Center

Boston Medical Center
HEALTH SYSTEM

Agenda

- Safety checks
- Patient assessments
- Staff assignment sheets
- MHS Documentation of vital signs/meals
- Code blue documentation
- Code blue roles
- What steps to take when a patient is found in distress
- Maintenance of code boxes

Objectives

- Explain the importance of patient assessments
- Explain a proper safety check
- Explain how to fill out the staff assignment sheet
- Describe the RN role related to MHS documentation
- Verbalize expectations of code blue documentation
- Describe how to check emergency equipment
- Describe actions taken if you find a patient without a pulse

Safety Checks

- Safety checks must be completed timely. One person should be assigned to checks, and if possible, the person assigned to checks should be focused on completing the checks and no other tasks.
- Checks should be rotated every 2 hours. If mental health specialists are unable to perform checks, then nurses should take the checks and complete the checks
- Nurses should complete top of the hour checks- one round of checks at the top of the hour. Oncoming charge nurse and off going charge nurse must round with each other to ensure patient safety, before report.
- If patients have their face covered with a blanket or a towel, remove the blanket/towel to ensure patient safety.
- If patients are in the bathroom, you must visualize the patient while protecting patient privacy.
- Enter patient rooms and observe for signs of life. Signs of life include observing at a minimum three respiration cycles.
- On the assignment sheet it should be clearly documented who is responsible to complete checks, and it is that person's responsibility to ensure checks are completed accurately at the assigned time.
- Environment checks are part of safety checks, all doors must be checked.

What do you do when you find a patient without a pulse?

- Scenario 1
  - You are doing safety checks and find a patient unresponsive
    - Press the canopy and call for help---do **NOT** leave the patient
    - Check for a pulse
    - Begin CPR if patient is pulseless

- Scenario 2
  - Someone calls for help and the patient is pulseless
    - Arrive on scene
    - Make sure code blue is called overhead
    - Emergency equipment arrives via responding MHS
    - Follow BLS chain of survival

Early detection is key

Staff Assignment Sheets

- Assignment sheets must be completed to its entirety.
  - Breaks should be assigned on the assignment sheet.
    - Code green responder, milieu manager, visitors, etc.
  - We will be using the same assignment sheet across all departments, these assignment sheets are mandatory.
  - New assignment sheets will be implemented on 02/17/2025.
  - The clinical leaders or the charge nurse will complete the assignment sheet, and it must be followed, no exceptions.
  - This will be audited as part of our corrective action plan.

Patient Assessments

Importance of Rounding on Patients at the Start of Each Shift

Why It Matters:

- **Engagement and Safety**: Rounding helps establish a connection with patients right away, allowing you to identify any immediate needs or concerns.
- **Early Detection**: It's the best time to spot early signs of changes in mood, behavior, or physical condition, which could indicate a need for intervention.
- **Promote Trust**: Regular, reliable check-ins build trust and show patients that you are there to support them throughout their stay.

What to Do During Rounds:

- **Assess for Immediate Needs**: Check on physical comfort, emotional state, and if patients need anything right away (e.g., water, assistance).
- **Safety Check**: Confirm that the room and environment are safe, and make sure patients aren't at risk for self-harm or unsafe behaviors.
- **Monitor for Changes**: Note any shifts in mental status, behavior, or physical condition that require further attention.
- **Ask Questions**: Use open-ended questions to encourage patients to share any concerns they may have. "How are you feeling today?" or "Is there anything you need help with?"
- **Documentation**: Make sure to document any changes or actions taken during your rounds accurately.

Patient Assessments

Offering Medications More Than Once

•**Why It Matters**:

- **Ensure Medication Adherence**: Some patients may refuse medication or forget to take it, so offering it more than once increases the chances they will take it.
- **Avoid Missed Doses**: Offering medications multiple times reduces the risk of missed or skipped doses, which is especially critical for psychiatric patients.
- **Maintain Trust**: By repeatedly offering medications, you show patients that their treatment is important, even if they don't want to take them initially.

•**How to Offer Medications**:

- **Multiple Attempts**: If a patient refuses medication, offer it again later during the shift. Make sure to explain the benefits of the medication and check for side effects.
- **Patient Education**: Explain why the medication is important, how it helps, and the potential consequences of not taking it.
- **Assess for Barriers**: If a patient repeatedly refuses, ask open-ended questions to understand why (e.g., "Is there something about this medication that worries you?"). Document these refusals and escalate concerns as needed.

Patient Assessments

Bringing Medications to Patient Rooms if They Don't Come to the Medication Window

•**Why It Matters**:

- **Patient-Centered Care**: Some psychiatric patients may be unable or unwilling to come to the medication window due to physical, emotional, or cognitive limitations. Bringing medications directly to them ensures they still receive their prescribed treatments.
- **Access and Compliance**: Not every patient can or will be able to participate in group activities, including coming to the medication window, so offering medication in the room is an essential part of meeting their needs.

•**How to Deliver Medications to Patient Rooms**:

- **Assess the Situation**: If a patient doesn't come to the window, first assess if they are physically or mentally unable to do so (e.g., physically bedridden or too anxious).
- **Respect and Dignity**: Knock before entering the room and provide privacy when administering medications.
- **Monitor Intake**: Watch the patient take the medication to ensure it is ingested and not hidden.
- **Documentation**: Document the time and reason why the medication was delivered to the room, along with patient cooperation or refusal.

Patient Assessments

Writing Detailed Nursing Notes

•**Why It Matters**:

- **Accurate Documentation**: Detailed notes help track patient progress, clarify actions taken, and provide a record for the next shift or for healthcare providers.
- **Legal and Safety Considerations**: In the event of a dispute or inquiry, thorough documentation can protect both the patient and the nurse.
- **Communication Across the Team**: Detailed nursing notes ensure the entire healthcare team is aware of the patient's current status and any interventions.

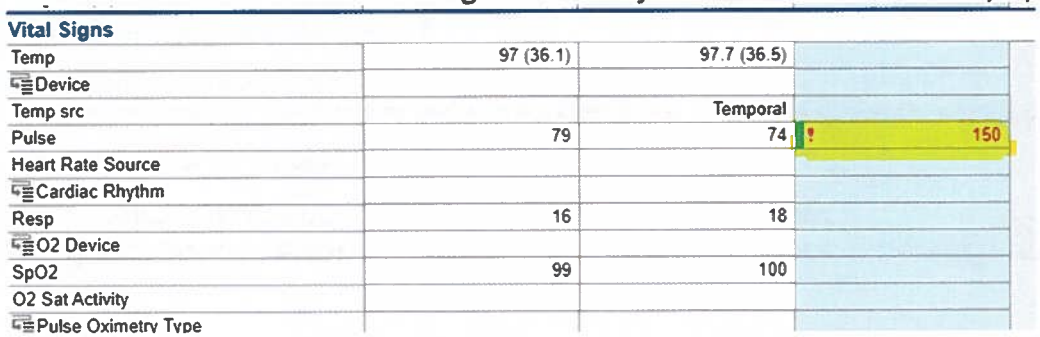
•**What to Include in Nursing Notes**:

- **Objective Information**: Include observable facts (e.g., "Patient took 5 mg of haloperidol at 10:00 AM").
- **Subjective Information**: Record what the patient communicates about their feelings, symptoms, or concerns (e.g., "Patient reports feeling anxious").
- **Actions Taken**: Document all nursing interventions, including offering medications, conducting rounds, and any changes in the patient's behavior.
- **Responses and Outcomes**: Note the patient's response to interventions (e.g., "Patient accepted medication on second offer" or "Patient exhibited calm behavior after calming techniques").

MHS Documentation

- **These are ultimately delegated tasks, and the RN is responsible for overseeing their patient's intake, vital signs, etc.**

- All documentation must be done in real time and not on paper
- Vital signs go directly in EPIC via rover as they are being done
- If you have a vital sign with a red ! Then the vital sign is out of range and needs to be reported immediately to the RN
- Meal documentation also goes directly into rover and not on paper. All patients are expected to have their intake



Vital Signs			
Temp	97 (36.1)	97.7 (36.5)	
Device			
Temp src		Temporal	
Pulse	79	74	! 150
Heart Rate Source			
Cardiac Rhythm			
Resp	16	18	
O2 Device			
SpO2	99	100	
O2 Sat Activity			
Pulse Oximetry Type			

Code Blue Documentation

- **EPIC optimization to come-** this is to ensure code blue documentation aligns with and pertains to BBHC, in interim during code blue follow the guideline below:

Document in an event note

Clearly document the sequence of events leading up to the Code Blue activation, including any preceding symptoms, vital sign changes, or interventions attempted before escalation.

Personnel Involved & Notifications:

•Specify who was notified (attending, medical NP, nursing supervisor, also identify point of escalation)

•Identify responders by role (Charge nurse, MHS, nursing supervisor, provider- medical or psychiatrist)

•Detail all life-saving measures initiated, such as:

•If CPR is initiated document on the note, document utilization of an ambu bag. For respiratory efforts- if oxygen is utilized delivery method and how much oxygen is used.

•Diagnostic Assessments: Fingerstick glucose, EKG findings, telemetry interpretation.

•Medications Administered

•Stabilization & Unit-Based Continuation: If the patient remained on the unit, note ongoing monitoring, follow-up tests, and provider orders.

•Transfer to Higher Level of Care: document if the patient is transferred to the ED

Maintenance of Emergency Equipment

- Checked each night by charge RN
  - All emergency equipment must be documented each night
    - O2 tank-is there >200L of o2?
    - AED-green light flashing, lock intact
    - Code box
      - Lock is intact
      - Box isn't expired
      - Call supervisor if box is not in expected condition

COWS assessment

What is COWS?

The **Clinical Opioid Withdrawal Scale (COWS)** is a standardized tool used to assess the severity of opioid withdrawal symptoms in patients undergoing detoxification. It helps healthcare providers determine the appropriate treatment and monitor the patient's progress over time.

Why is COWS Important?

- **Accurate Assessment:** The scale ensures that withdrawal symptoms are objectively measured, preventing underestimation or overestimation of the patient's condition.
- **Medication Management:** Medications such as **buprenorphine, methadone, or symptom-specific treatments** are administered based on the patient's COWS score, ensuring safe and effective withdrawal management. Here at BMC, methadone is utilized to manage withdrawals.
- **Improved Patient Safety:** Proper assessment helps prevent complications such as **precipitated withdrawal, severe discomfort, or life-threatening symptoms.**

COWS assessment

Where to Document?

COWS assessments should be **documented in EPIC**. It is essential to ensure that documentation is **timely, accurate, and complete** for proper medical decision-making.

How Often is COWS Documented?

- **Frequency depends on provider orders and COWS protocol.**
- Typically, assessments are conducted at regular intervals (e.g., **every 4-6 hours**) during the acute withdrawal phase.
- More frequent assessments may be required if the patient is experiencing **severe withdrawal or changes in condition.**

Following protocol ensures **safe opioid detox management** and helps guide treatment decisions effectively.

Charge Nurse Responsibilities & Shift Guidelines

Before the Next Shift Arrives:

•Assign patient care responsibilities **before** the incoming shift starts and **complete the assignment sheet.**

During Shift Change:

•**Round with the incoming charge nurse** before RN-to-RN report.

•Ensure **group report sessions** including nurses and Mental Health Specialists

•**Managing Workflow Throughout the Shift:**

•Monitor and adjust patient assignments to maintain a smooth workflow.

Staff Responsibilities:

•**Breaks & Training:**

- If a nurse is leaving the unit for a break or training, they must:
  - Notify the charge nurse or a peer.
  - Ensure appropriate **handoff report** is given on their patients.

Safety Protocols:

•**Top-of-the-hour safety checks:**

- A nurse must conduct a **safety round every hour** to ensure patient safety and compliance with protocols.

Prevention of Escalation
De-escalation
&
Restraint Training

Brockton Behavioral Health Center

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Learning Outcomes

Identify two (2) Department of Mental Health (DMH) requirements needed to consider placing a patient in restraints

Describe who can order patient restraints or seclusion.

Understand how to provide care for a patient in seclusion and restraints.

Determine staff roles during a Code Green.

Understand documentation requirements and de-briefing participation.

10 Commandments of De-Escalation

1. You shall respect personal space
2. You shall not be provoking (calm demeanor & facial expression)
3. You shall establish verbal contact (less is more)
4. You shall be concise and repeat yourself
5. You shall identify wants and feelings - patients/not yours ☺
6. You shall listen
7. You shall agree or agree to disagree
8. You shall maintain "social" eye-contact (not staring)
9. You shall offer choices
10. You shall debrief the patient

What is Prevention of Escalation?



A recovery model of mental illness

emphasizes

not just treating or managing symptoms, but focusing on building

resilience

of people with mental illness and supporting those in emotional distress."

Early Warning signs *before* a patient loses control

- Clenching teeth
- Wringing hands
- Bouncing legs
- Shaking
- Crying
- Giggling
- Singing inappropriately
- Pacing
- Breathing hard
- Shortness of breath
- Clenching fists
- Loud voice
- Yelling
- Rocking
- Can't sit still
- Restlessness

Early Strategies to Prevent Escalation



- Use of Sensory Room
- Puzzle with Staff member
- Eating (hot or cold liquids
- Listening to music (headsets)
- Rocking chair

- Offer choices
- Talking to Staff
- 1:1 with staff
- Fresh air/courtyard
- Hard candy
- Coloring
- Hugging a stuffed animal
- Deep breathing
- Ripping Paper
- Taking a cold/hot shower
- Talking to peers
- Using ice
- Weighted sensory tools

Patient moved past 'Early' and now Escalating



1. Appear calm & centered even if you do not feel it
2. Make eye contact
3. If looking away, ask them to look at you
4. Approach patient's physical space slowly
5. Try not to get closer than 2 arms length
6. Keep your hands out of your pockets and by your side
7. No shaking or pointing your finger (will see as threat)
8. Use a monotonous *low* tone of voice
9. Use short phrases
10. When a patient is threatening, do not threaten back
11. Never turn your back
12. Emphasize with feelings not behavior (feeling upset?)
13. Do not try to argue or convince

Verbal Scripting to De-escalate

- How can I help?
- Use the patient's name and address them.
- "I know you are feeling upset.

  Why don't you come talk to me?"
- "Let me see if I understand you correctly."
- "You seem afraid… do you feel something terrible is going to happen to you?

  Can I help keep you safe?"
- Ok to let the patient know that he is "scaring the other patients".
- Offer a choice: "Would you like some medication, or would you like to go outside?"
- "Can you calm down? Otherwise, I may need to call for help."

Escalating Behavior Algorithm

Routine Patient Care	No Security De-escalation	De-escalation Continues Intervention	Call "Dr. Strong" Show of Support De-escalation	Code Green	Code Green

No Signs of Aggression	Early Indicators	Signs of Aggression	Beginning of Aggression	Escalated Aggression	Danger to Self and Others
Level 0	Level 1	Level 2	Level 3	Level 4	Level 5
No Aggressive Behaviors	Crying	Pacing	Yelling/Screaming	Kicking/Punching/Slamming (no physical contact)	Punching/Kicking directed toward others
	Rocking	Restlessness	Clinched Fist	Throwing things (not directed at others)	Throwing w/ intent to harm others
	Anxious	Tone change	Unable to redirect to conversation/situation	Verbal Threats	
	Mumbling	Name calling, demeaning comments or racial slurs	Escalated/Uncontrollable/ *increased level 1 or 2 behaviors*	Spitting	
	Rudeness	ETOH/Substance Abuse w/ *additional level 1 or 2 behavior*	Hallucination (causing patient to feel scared, angry, or erratic)	Biting	
	Glaring - prolong or intense staring, eyes darting, or refusal of eye contact	Suicidal ideation/ Homicidal ideation	Levels 1, 2, or 3 behaviors outside of assigned room		
	Paranoid	Mild hallucinations and able to be reoriented			
	Irritable/Agitation				

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Restraints/Code Green

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"Every restraint I've reviewed, started with a staff member enforcing a rule."

Ross Greene, Ph.D.

RRI Grand Rounds ~ Cambridge Hospital

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Philosophy

- A restraint is the LAST resort
- We are committed to make every attempt to de-escalate a patient in order to eliminate the use of restraint and seclusion
- Our environment strives to treat people with dignity, respect and mutuality, and protects their rights
- We provide the best care possible, and work hard to support them in their recovery
- The Department of Mental Health (DMH) states that a "Restraint is a failed treatment

Our team recognizes that restraint and seclusion is traumatic, especially for patients with a past history of trauma

A show of support can immediately de-escalate a situation

Patient behaviors escalate to Level 3

When a staff member feels they need a show of support

Patient does not present imminent risk to self/others

Allows the team to be prepared for a Code Green

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When is the use of Restraint considered?

Restraint may be used only in an emergency such as:

- Substantial risk or the occurrence of serious self-destructive behavior
- Substantial risk or occurrence of serious physical assault
- Serious, imminent threat of bodily harm, where there is the present ability to affect such harm

Restraint should not be considered:

- If a patient is "yelling" or pacing the corridor – no matter how long – try other alternatives.
- Urinating on the floor
- Bothering other patients

Imminent Risk vs NOT Imminent Risk

Imminent Risk

- Posturing to punch patient/staff
- Throwing furniture/food/items at other patients/staff
- Attacking another staff/patient

Not Imminent Risk

- **Yelling profanity or screaming at staff or patient**
- Running down the hall
- Throwing food at the wall

4 Types Restraint & Seclusion with Definitions

Physical Restraint *Least restrictive*

- A brief hold restricting a patient's freedom of movement.
- Medication restraint often includes a brief hold, which by DMH is also an additional restraint.

Medication Restraint

- Non-consensual use of medication for purpose of impairing the individual's freedom of movement

Mechanical Restraint

- Any limitation of movement by a **physical** device.

Seclusion *Most restrictive*

- Involuntary confinement in a room or area where the person is physically prevented from leaving.
- Can never have a person in a mechanical restraint AND in seclusion

Regulatory compliance by DMH, Joint Commission, CMS, DPH

Examples

Physical Restraint *Least restrictive*

- Forcibly walking a patient to a quiet area in a CPI hold
- Patient refusing court ordered medications, and you are forcibly holding their arm for the medication administration

Medication Restraint

- Medications *not part* of their medication ordered treatment
- Court ordered medications are not a restraint

Mechanical Restraint

- Restraint chair with 2 or more straps applied

Seclusion *Most restrictive*

- Patient is alone behind a locked door
- Sitting with a staff member in a quiet space or ante room is not a restraint

Policy

- The RN may initiate the restraint, but *Only* an MD or an NP (Advance Practice Registered Nurse can order the restraint in EPIC
- An MD/NP must do a face-to-face within **1 hour** for all Restraints and seclusion *except* a *brief* physical hold.
- MD/NP must physically arrive to the patient's bedside even if they come in from home.
- Restraint orders are never written PRN or as a standing order.
- The Executive Director, Medical Director, Human Rights Officer (HRO) and Nurse Manager will be notified for every instance of restraint *within 1 hour* of initiating the restraint.
- A *new order* is required for each episode of restraint or for any renewal of restraint within 2 hours (use DMH form AND a new written order).

Code Green Roles: Primary RN

- Must be a team effort, led by the RN
- During an episode of restraint, the RN must remain the lead directing all clinical care, security interactions, and any restraint ordered
- The RN will also remain within several feet of the patient's head to ensure an adequate airway *at all times*
- The RN *cannot* leave the patient during the episode unless another RN is there to relieve them to watch the airway
- A second RN can call the MD/NP and obtain an order for medication if needed
- At all times, one person at bedside - ***must*** be an RN
- Best practice: The RN who takes the order should draw up the medication

Remember - restraining patients is one of the most dangerous procedures we perform

Primary RN Responsibility continued:

- Orders restraint/seclusion after assessing and determining imminent risk of harm.
- Assigns medication RN (e.g., primary patient RN).
- Instructs staff member to obtain restraint chair.
- Confirms with de-escalator.
- Designates restraint chair straps to staff members.
- Assigns staff member to call public safety for milieu management.
- Ensures checks and 1:1 observations continue.
- Arranges and documents staff de-briefing after event; contacts Human Rights Officer.

Code Green Roles: Medication RN

- Contacts provider for medication orders.
- Confirms with provider use of emergency medication.
- Verifies emergency verbal orders by repeating order 2x.
- Pulls and prepares emergency medications for administration.
- Documents medication administration in EPIC MAR and DMH Form A.
- Assess patient for release.

Code Green Roles: Provider

- Participates in decision-making about the level of intervention and assists staff as needed throughout the entire process.
- Within **1 hour** of restraint/seclusion, provider/responding clinician will evaluate, write restraint initiation and D/C orders, and medication orders on patient.
- The order for seclusion / mechanical restraint is active for a **two-hour period.**
- Documents an EPIC event/progress note in the patient's medical record describing the rationale for restraint/seclusion.
- Documents signature and date on DMH Form A.

Code Green Roles: Restraint Chair Manager

Restraint Chair Manager (RN/MHS)

- Retrieves restraint chair, ensures brakes are on before placing patient in chair.
- Removes excess furniture from room.
- Assists with restraint by attaching shoulder restraint to patient.
- Evaluates restraint fit while patient is secured by staff.

Code Green Roles: Public Safety

Public Safety

- Removes other patients from immediate area.
- Remains with other patients to ensure safety.

Monitoring Time Requirements

1. Every **15 minutes**, the patient will be checked for comfort, body alignment and circulation.

2. Monitoring may be done by an RN
   - Circulation, vital signs and ROM
   - Hydration and Feeding – Offer fluids/food, hygiene or toileting while in restraints
   - Toileting
   - Behavioral observations and any psychological comfort needs

3. Every 30 minutes, the RN will assess physical and mental status, response to interventions, and readiness for release.

Care of the Patient in Restraints

NO locked door seclusion when patient is in restraints

Must have a true one-to-one observer, who may NOT be watching any other patients

No patient will be placed in a prone position while in a restraint

Restraints are to be applied as to avoid any undue physical discomfort, harm or pain

Patient's will remain fully clothed and shall be afforded maximum personal dignity

Restraint Forms and Documentation (7 forms in total)

1. **The Emergency Restraint or Seclusion Form** (Part A – DMH)
   - Always filled out. Part A is required for all types of restraints, including Physical hold only.

2. **The Monitoring and Assessment Form** (Part B – DMH)
   - Part B (2nd page) is required for Medication, Mechanical Restraint or Seclusion.

3. **The Patient Debriefing and Comment Form** (Part C – DMH)
   - Within 24 hours, patient has opportunity to debrief
   - If declines, will re-offer the form within the next 24 hours
     - ✓ Document date and time on the form each time the patient refuses

4. **Staff Debriefing Form**:
   - Before end of the shift, with all staff present, participate in a formal debriefing led by the Charge Nurse
   - Everyone on the shift must sign the debriefing form.

Restraint Forms and Documentation (7 forms in total)

5. Restraint Treatment Plan

- Part of the restraint package. Be sure to date and time.

6. Update the Inpatient Multidisciplinary Treatment Plan:

- DMH requirement that we document the information on the 2nd treatment plan.

7. Personal Crisis Safety Plan:

- If not already done, ensure it is started with the patient or updated.

DMH – Part A

COMMONWEALTH OF MASSACHUSETTS---DEPARTMENT OF MENTAL HEALTH

EMERGENCY RESTRAINT OR SECLUSION (R/S) FORM – PART A – Revised 10/2022

NEW ORDER _____ ***RENEWAL ORDER*** _____ **PATIENT DEBRIEFING & COMMENT FORM**
Use new forms for each renewal **MUST BE ATTACHED**

NAME _____ *DOB* _____ *Med. Rec.#* _____ *Gender:* ___*M*_____*F*

Facility _____ *Unit* _____ *Primary Language* _____ *Race* _____

Date this Admission _____ *Date R/S Started* _____ *Time R/S Started* _____ *Time R/S Ended* _____ *Total R/S Time (at end of R/S)* _____

WHAT TRIGGERED THE INCIDENT? _____

_____

DESCRIBE ALTERNATIVES TRIED FROM INDIVIDUAL CRISIS PREVENTION PLAN (SAFETY TOOL) BEFORE RESTRAINT/SECLUSION USED: _____

_____

_____

_____

CHECK/DESCRIBE OTHER INTERVENTIONS ATTEMPTED:

_____ Ask: HALTT (are you Hungry? Angry? Lonely? Thirsty? Tired?)
_____ Sensory Interventions
_____ Activity change
_____ Separate from situation
_____ Offer quiet space
_____ Offer a PRN medication
_____ One-on-one intervention
_____ Other: _____

TRAUMA CONSIDERATIONS: history. R/S preferences including position & staff gender

DESCRIBE BEHAVIOR REQUIRING EMERGENCY USE/CONTINUANCE OF R/S:

_____

_____

_____

EMERGENCY INTERVENTION(S) USED: Number interventions in the order used. This form covers all interventions used in response to the emergency situation covered by this order. Also place check mark beside intervention used for the most amount of time during an episode.

_____ Physical restraint
_____ Seclusion
_____ Mechanical restraint - Type: _____
_____ Medication restraint (fill in information below)

TIME	MEDICATION	DOSAGE	ROUTE

NURSE signature for medication restraint: _____

DMH – Part B

COMMONWEALTH OF MASSACHUSETTS—DEPARTMENT OF MENTAL HEALTH
***EMERGENCY RESTRAINT OR SECLUSION (R/S) FORM - PART B* – Revised 10/22**

NAME _____ Med. Rec. # _____ Date _____ Time R/S Started _____

MONITORING & ASSESSMENT: VITAL SIGNS/CARE, CIRCULATION/ROM & CURRENT CONDITION must be documented every 15 minutes by a trained staff person*. An Authorized Staff Person/Clinician must assess the patient at least every 30 minutes.

PHYSICAL STATUS AT R/S INITIATION/APPLICATION

Time _____ Date _____

Difficulty breathing Y/N? _____
Breathing complaint Y/N? _____
Observable skin color change Y/N? _____
Skin condition (e.g., warm, dry, clammy) _____
Injury due to R/S Y/N? _____
Bleeding _____ Cuts _____
Scratches _____ Bruises _____
Rug burn _____
Other _____

Complaint of pain _____

Additional concerns _____

Medical action planned/taken if necessary: _____

Authorized Staff Person/Clinician signature required: _____

Time Date	Time Date	Time Date	Time Date
VITAL SIGNS/CARE	**VITAL SIGNS/CARE**	**VITAL SIGNS/CARE**	**VITAL SIGNS/CARE**
BP* _____ Pulse* _____ Temp* _____ Resp* _____ Describe Skin Condition _____	BP* _____ Pulse* _____ Temp* _____ Resp* _____ Describe Skin Condition _____	BP* _____ Pulse* _____ Temp* _____ Resp* _____ Describe Skin Condition _____	BP* _____ Pulse* _____ Temp* _____ Resp* _____ Describe Skin Condition _____
Offered or Provided (O or P): Fluids/Food _____ Toileting _____ Hygiene help _____ * Document actual reading	Offered or Provided (O or P): Fluids/Food _____ Toileting _____ Hygiene help _____ * Document actual reading	Offered or Provided (O or P): Fluids/Food _____ Toileting _____ Hygiene help _____ * Document actual reading	Offered or Provided (O or P): Fluids/Food _____ Toileting _____ Hygiene help _____ * Document actual reading
EXTREMITY CIRCULATION & ROM CHECK	**EXTREMITY CIRCULATION & ROM CHECK**	**EXTREMITY CIRCULATION & ROM CHECK**	**EXTREMITY CIRCULATION & ROM CHECK**
Left Arm ____ Right Arm ____ Left Leg ____ Right Leg ____ Neck/Head Position: _____	Left Arm ____ Right Arm ____ Left Leg ____ Right Leg ____ Neck/Head Position: _____	Left Arm ____ Right Arm ____ Left Leg ____ Right Leg ____ Neck/Head Position: _____	Left Arm ____ Right Arm ____ Left Leg ____ Right Leg ____ Neck/Head Position: _____
CURRENT CONDITION	**CURRENT CONDITION**	**CURRENT CONDITION**	**CURRENT CONDITION**
Maintaining Control** ____ Calm** ____ Sleeping** ____ Agitated ____ Thrashing ____ Crying ____ Threatening: Suicide ____ Homicide ____ Self-Abuse ____ Assault ____ Other: _____ ** Requires justifying continuation Signature _____ Title _____	Maintaining Control** ____ Calm** ____ Sleeping** ____ Agitated ____ Thrashing ____ Crying ____ Threatening: Suicide ____ Homicide ____ Self-Abuse ____ Assault ____ Other: _____ ** Requires justifying continuation Signature _____ Title _____	Maintaining Control** ____ Calm** ____ Sleeping** ____ Agitated ____ Thrashing ____ Crying ____ Threatening: Suicide ____ Homicide ____ Self-Abuse ____ Assault ____ Other: _____ ** Requires justifying continuation Signature _____ Title _____	Maintaining Control** ____ Calm** ____ Sleeping** ____ Agitated ____ Thrashing ____ Crying ____ Threatening: Suicide ____ Homicide ____ Self-Abuse ____ Assault ____ Other: _____ ** Requires justifying continuation Signature _____ Title _____
RELEASE READINESS	**RELEASE READINESS**	**RELEASE READINESS**	**RELEASE READINESS**
**Justify continuation: _____ RELEASE: Yes ____ No ____ Authorized Staff Person/Clinician Signature _____	**Justify continuation: _____ RELEASE: Yes ____ No ____ Authorized Staff Person/Clinician Signature _____	**Justify continuation: _____ RELEASE: Yes ____ No ____ Authorized Staff Person/Clinician Signature _____	**Justify continuation: _____ RELEASE: Yes ____ No ____ Authorized Staff Person/Clinician Signature _____

Multiple Episodes exceeding 6 hours

1. Greater than five (5) hours but less than **six (6) hours** in restraint/seclusion, the Nurse Manager, Medical Director, and Executive Director shall be notified.

2. **16 through 17** years old cannot be in restraint/seclusion more than **two hours** in a 24-hour period.

3. The Medical Director, the Executive Director, and Nurse Manager shall review with senior leadership team:
   - The circumstances of the episode(s) of restraint or seclusion.
   - *Efforts* made to facilitate release.
   - *Impediments* to facilitating the release.
   - Help to *identify* additional measures or resources that might be beneficial in facilitating release or preventing additional episodes.

EPIC Documentation

Select the patient to document the R/S note

Click the Notes tab

Click

A text box will open, in the smart text field, search for “restraint”

Scroll down to find “Event Note Nursing Restraint/Seclusion”

Use the template to document the episode of R/S

Ensure this information matches what was documented on the DMH Emergency Restraint / Seclusion Form – Part A

Code Green Tips

Safety checks and 1:1 observation staff <u>do not respond</u> to Code Green

- Staff must be CPI trained to apply restraints.
- **Patient is placed on 1:1 observation STAT after being placed in restraints/seclusion**
- Contact the Human Rights Officer at x89219 for all restraint/seclusion episodes and to conduct patient de-briefing.
- Notify family/guardian as indicated in patient's individualized care plan.
- Seclusion and mechanical restraint **cannot** be used simultaneously.

- No minor through age 17 shall be in seclusion for more than 2 hours in a 24-hour period.
- Treatment plan and individualized crisis plan updated after restraint.

Recognizing Patient Distress: Notify RN STAT

- Difficulty breathing
- Increased heart rate or respiratory rate
- Increased agitation
- Undesired change in blood pressure
- Change in level of consciousness
- Impaired circulation / injury to extremity

Staff Training

- Restraint and seclusion training occurs no later than 1-month after the hire date and annually.
  - Harmful and emotional effects on patients & staff.
  - Impact of trauma and how it affects an individual as well as witnessing the event.
  - Prevention of escalation and techniques.
  - Sensory interventions and calming/soothing strategies.
  - Applicable legal and clinical requirements.
- Annually, staff will complete in ____Restraint module and demonstrate hands-on of the mechanical restraint equipment.
- All staff are required to have CPI training within 1-month of hire and re-certify every 2-years.
- No MDs/NPs can order a restraint without receiving training.
- All RNs and MHS will be trained and educated on 'Observation Checks'.

Restraint Chair Video

https://vimeo.com/408176139

Please Commit!

Restraint is the LAST resort!!!

BOSTON MEDICAL CENTER

BOSTON UNIVERSITY

Restraint Use/Seclusion (BMCHS Inpatient Psychiatry)

Policy #:	46.01.018
Issued:	July 2022
Reviewed/ Revised:	9/2022, 1/2023, 5/2024, 2/2025, 9/2025
Section:	Inpatient Psychiatry

Purpose:

To promote the safe use and monitoring of patient restraint or seclusion.

Policy Statement:

Boston Medical Center (BMC) Health System (BMCHS) affirms that patient safety and dignity will be maintained at all times. Patients have the right to be free from restraint/seclusion of any form which is not medically necessary. The use of restraint or seclusion is a **last-resort intervention**, employed only to ensure the **immediate safety of patients, staff, and others**. Our approach prioritizes the **least restrictive alternatives**, emphasizing de-escalation, trauma-informed care, and individualized interventions. Restraint use is continuously monitored, minimized, and evaluated to promote **patient safety, dignity, and well-being**, while supporting staff competency and ongoing quality improvement.

The judicious and humane use of restraint/seclusion may be necessary after alternative measures have failed or when there is imminent risk of a patient physically harming either themselves or others. The decision to use restraint/seclusion is not driven by the diagnosis but by the comprehensive individual assessment that concludes that for this patient, at this time, the use of less restrictive measures poses a greater risk than the risk of using restraint/seclusion. BMCHS does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation.

Application:

All patients at BMCHS Inpatient Psychiatric Units

Exceptions:

None.

Definitions:

Term	Definition
Authorized Clinician	Any Psychiatrist or Qualified Advanced Practice Registered Nurse (NP) who has been authorized to order medication, mechanical, or physical restraint, and/or seclusion; to examine patients in such restraint or seclusion; to assess for readiness for release; and to order release from restraint or seclusion.
Authorized Staff Person	Any member of the licensed clinical staff who has been authorized by the Executive Director to initiate or renew mechanical restraint, physical restraint, or seclusion; to assess for readiness for release; and order release from restraint or seclusion.
Mechanical Restraint	Physical device(s) used to restrain a patient by restricting movement or normal function of a portion of their body. Mechanical Restraints utilized in BMCHS inpatient psychiatric units are Restraint Chair, 4- point restraints, soft velcro restraints and mitts.
Physical Restraint	A manual method that is used to restrain a person by restricting the patient's freedom of movement or normal access to their body. Physical restraint does

	not include non-forcible guiding or escorting or taking reasonable steps to prevent a patient at imminent risk from entering a dangerous situation
Medication Restraint	Medication restraint occurs when a patient is given a medication or combination of medications to control the patient's behavior or restrict the patient's freedom of movement and which is not the standard treatment or dosage prescribed for the patient's condition. Medication restraint does not include: a. Involuntary administration of medication when given in an emergency to prevent immediate, substantial, and irreversible deterioration of serious mental illness, provided that the requirements of 104 CMR 27.10(1)(d) are complied with; or b. For other treatment purposes when administered pursuant to a court-approved substituted judgment treatment plan
Seclusion	Involuntary confinement of a patient in a room and prevented from leaving, or reasonably belief that they will be prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.
Emergency Situation	The occurrence of, or serious threat of, extreme violence, personal injury, attempted suicide, or significant property destruction. Emergencies include only situations where there is a substantial risk of, or the occurrence of, serious self-destructive behavior, serious physical assault, or property destruction. Substantial risk is defined as a serious and imminent threat of bodily harm or property damage, where the individual has the present ability to carry out such harm.

Procedure:

Use of Restraint/Seclusion:

1. **Indications**
   - Restraint or seclusion may be used only in emergencies, defined as the occurrence or serious threat of extreme violence, personal injury, attempted suicide, serious self-destructive behavior, or significant property destruction.
   - Substantial risk is a serious and imminent threat of harm to self, others, or property, where the individual has the present capacity to act.
   - Less restrictive alternatives must be attempted first unless deemed inappropriate or ineffective.
2. **Authorization**
   - Authorized staff may initiate restraint; only a licensed provider may issue the order and must conduct a face-to-face evaluation within one (1) hour.
   - No standing orders, including 'PRN' or 'as required,' are permitted for any form of restraint or seclusion.
3. **Duration and Monitoring**
   - No episode shall exceed two (2) hours; continued use requires reassessment and a new provider order.
   - Restraint/seclusion must be the least restrictive and shortest duration possible, considering patient history, preferences, and cultural background.
   - Continuous one-to-one monitoring by assigned staff is required throughout the episode.
4. **Reporting and Assessment**
   - Episodes exceeding six (6) hours, two (2) or more non-continuous episodes in 12 hours, or more than 12 hours total in 48 hours must be reported to the Medical Director and Nursing Leadership.

- The patient shall receive a medical assessment, and the episode must be reported per policy and regulatory requirements.

5. **Debriefing**
   - A debriefing shall occur with all involved staff as soon as possible following any use of restraint or seclusion.

Alternatives to restraint/seclusion:

Less restrictive, alternative methods are always attempted and considered prior to restraint initiation.

Alternative interventions include but are not limited to:

1. Ask HALTT (Are you hungry, angry, lonely, thirsty, tired?)
2. Sensory interventions
3. Activity change
4. Separate patient from situation
5. Offer quiet space
6. Offer PRN medication
7. Relaxation techniques
8. 1:1 intervention
9. Verbal de-escalation
10. Offer family or social supports including phone calls, meetings or visits

Restraint and Seclusion Monitoring:

Medication Restraint Monitoring

- Monitoring shall include observation, interaction, and direct examination of the patient.
- The RN is responsible for ongoing reassessment and monitoring.

Mechanical Restraint Monitoring

- Patients must be assigned to continuous one-to-one monitoring for the entire duration.
- Staff must be positioned to hear and be heard by the patient and maintain visual observation at all times.
- Staff shall continually monitor physical and psychological status, comfort, body alignment, circulation, vital signs (as indicated), and readiness for release.

Seclusion Monitoring

- Seclusion may not be combined with mechanical restraint.
- Staff must remain immediately outside the seclusion space and maintain continuous visual observation of the patient.
- The RN is responsible for assessing readiness for release.

Release Monitoring

- Staff must continually assess whether the patient is ready for release.
- The RN must evaluate and authorize release from restraint or seclusion.
- If a patient falls asleep, or is briefly released for personal needs, monitoring staff must notify the RN or provider for reassessment and release as appropriate.

Nurse Restraint Documentation

- All restraint and seclusion episodes, including monitoring and release, must be documented in EPIC unless otherwise indicated.

Authorized Clinician Documentation:

- A written order from a licensed provider is required for any application of restraint.
- All restraint orders require a documented face-to-face assessment by the provider within one (1) hour of initiation.
- The initial order and assessment must include:
  - Physical and behavioral assessment
  - Reason for restraint or seclusion
  - Type of restraint
  - Criteria for release
- A new order is required for each new episode of restraint; renewal orders are required for restraints exceeding two (2) hours.
- A new episode begins when the type of restraint changes or after an order has been discontinued.
- If a patient remains in restraint or seclusion beyond two (2) hours, a new order must be obtained within that timeframe.
- Post-restraint provider documentation or face-to-face assessment must include:
  - Physical and behavioral assessment
  - Patient's response to the restraint

Staff Qualifications and Safe Use of Restraints:

- Only staff who have completed de-escalation and restraint training, including orientation and annual refreshers, and who have demonstrated competency, may participate in restraint procedures.
- Competency to care for patients in restraints will be assessed during competency-based orientation and annually.
- Staff must safeguard the patient's rights, privacy, dignity, and safety at all times.
- Patients must be placed in proper body alignment while in restraint.
- Restraints are a last-resort intervention; staff must use the least amount necessary to ensure patient safety.
- No locking devices may be used to secure restraints.

Debriefing Procedures Following Restraint or Seclusion:

A. Staff Debriefing
   - Immediately following an episode, supervisory staff and directly involved staff shall participate in a structured debriefing.
   - Discussion shall include:
     - Identification of triggers and events leading to the incident
     - Review of adherence to the patient's Crisis Plan
     - Evaluation of alternative interventions attempted prior to restraint/seclusion
     - Assessment of the patient's physical, psychological, and privacy needs
     - Consideration of counseling, medical evaluation, or treatment for the patient and staff
     - Assessment of impact on other patients or staff and potential need for their debriefing
     - Notification and involvement of the patient's legally authorized representative, if appropriate
     - Evaluation of additional staff training, supervision, or support needs
     - Determination of whether senior administration review is required

B. Patient Debriefing
- Within 24 hours, the patient shall be offered an opportunity to debrief using the DMH Patient Debriefing and Comment Form; a staff member not directly involved should conduct the debriefing whenever possible.
- If the patient is unable or unwilling, two additional attempts shall be made within 48 hours.
- Documentation shall be completed on the DMH Debriefing Form.
- The patient's Individual Crisis Plan shall be reviewed and updated based on the debriefing.

C. Administrative Debriefing
- All restraint/seclusion episodes shall be reviewed the next business day by clinical leadership in collaboration with direct care staff.
- Reviews shall focus on identifying patterns, supporting affected staff and patients, and evaluating episodes involving multiple restraints or those lasting up to or beyond 12 hours within 48 hours.

Staff Training:

A. All clinical staff must complete BMCHS approved de-escalation and safety training upon hire and annually, demonstrating competency in:
- Alternatives to restraint/seclusion
- Recognition of behaviors warranting restraint/seclusion
- Purpose, trauma, and safe application of restraint/seclusion
- Age, developmental, gender, cultural, and trauma considerations
- Trauma-informed assessment and safety tools
- Review of restraint/seclusion policy
- Additional training for nursing staff responsible for monitoring and assessing patients in restraint/seclusion includes:
  - Understanding provider orders and assessment requirements
  - Documentation of care and monitoring
  - Nutrition, hydration, and elimination assessment
  - Monitoring physical and psychological status, comfort, and readiness for discontinuation
  - Recognizing when to contact a provider

B. Date of Death or Injury
- Any injury or death occurring during restraint/seclusion, or within 24 hours of release, must be reported to Risk Management and the DMH.
- Patients who expire within seven (7) days of restraint/seclusion are evaluated for possible association; if use of restraint/seclusion may have contributed, Risk Management must be notified.

C. Quality Improvement and Patient Experience
- Monthly submission to the Commissioner or designee of all restraint/seclusion forms and an aggregate report per 104 CMR 27.2.
- Units shall post a statement visible to patients, demonstrating commitment to preventing and minimizing restraint/seclusion.
- Documentation of staff training competencies shall be maintained.
- A monthly multidisciplinary review of all restraint/seclusion episodes shall occur, with aggregate data used to identify trends, improve staff interventions, and prevent/minimize future use.

Responsibility:
All staff at BMCHS Inpatient Psychiatric Units

Other Related Policies/Protocols/Guidelines:
None

References:
104 CMR 27.00
Comprehensive Accreditation Manual for Hospitals: The Official Handbook. The Joint Commission.
42 CFR 482.13(e)

Initiated by:
Associate Chief Nursing Officer, BMCHS Brockton Behavioral Health.

Contributing Departments:
BMC Brighton and BMC Brighton Inpatient Psychiatric Units

Patient Observation (BMCHS Inpatient Psychiatry)

Policy #:	46.01.012
Issued:	July 2022
Reviewed/ Revised:	9/2022, 1/2023, 9/2025
Section:	Inpatient Psychiatry

Purpose:

To establish a procedure for patient observation in order for patient and staff safety in Boston Medical Center Health System (BMCHS) Inpatient Psychiatric Units.

Policy Statement:

BMCHS Inpatient Psychiatric Units provide a closely supervised and structured environment that ensures safety for both patients and staff, while supporting patient choice and fostering responsibility. A patient's observation level shall not be decreased, nor shall a Special Observation be discontinued, without a written or verbal order Licensed Independent Practitioner (LIP). Nursing staff may increase a patient's observation level, or initiate a Special Observation, if the patient's condition necessitates a more restrictive environment or closer supervision. An order a LIP must be obtained as soon as possible following the intervention.

Application:

All patients at Boston Medical Center Health System (BMCHS) Inpatient Psychiatry Units

Exceptions:

None

Definitions:

Term	Definition
One to One (1:1) Observation	Assignment of a qualified staff member to remain with the patient and maintain an unobstructed view of the patient at all times to prevent harm to the patient or others. The patient may not leave the unit unless accompanied 1:1 by a staff member. Staff members are to always be within arm's length of the patient, including when in the restroom or bathing. 1:1 at arm's length could be changed by an order from the provider if at arm's length was not in the best interest of the staff monitoring or for the patient.
One to One (1:1) Observation while awake (WA):	Assignment of a qualified staff member to remain with the patient and maintain an unobstructed view of the patient at all times to prevent harm to the patient or others, while the patient is awake. The patient may not leave the unit unless accompanied 1:1 by a staff member. Staff members are to always be within arm's length of the patient while the patient is awake including when in the restroom or bathing. 1:1 at arm's length could be changed by an order from the provider if at arm's length was not at the best interest of the staff monitoring or for the patient. While asleep, the patient must be checked on every 5 minutes to ensure safety.
Routine Patient Safety Checks	Assignment of a qualified staff member to conduct safety checks of all patients at fifteen (15) minute intervals. The staff member assigned to

	safety checks is to visualize each patient, determine their safety and confirm the presence of life signs. Staff must be alert to the patient's behaviors during routine checks and that might indicate need for special precautions. Additionally, staff must be alert to patient behaviors/concerns that have been identified for each of the special observation categories and precautions as defined. Any behaviors of concern should be reported immediately to an RN for assessment and appropriate intervention.
Staff Escort Off Unit	Adult patients escorted off the unit are accompanied by a staff member at all times. Nursing staff may at their discretion increase the staff to patient ratio for off unit escorts but may not decrease it.
Qualified staff member	A hospital staff member who has successfully completed competencies in the observation of patient.
Higher levels of observation	Assigned to patients based on assessment of behaviors or clinical history and directly related to the patient's observation needs. A patient is checked more frequently than 15 minutes with special focus on the reason for the addition of the Special Precaution. A doctor's order must dictate the level of observation whether it's 5 minute checks, 1:1 or constant observation. All staff is expected to observe for such behaviors during routine checks. Flashlights are used when the room is dark to ensure patients' life signs can be observed (breathing at least 3 times to ensure there is no medical distress).

Procedure:

Higher levels of observation

Higher levels of observation may be assigned to a patient on admission or at any time during their clinical stay. Nursing staff should be monitoring patient's behaviors and actions for the need for special observation categories and precautions. All staff are expected to observe for such behaviors during routine checks, including but not limited to:

- Suicide risk
- Elopement risk
- Sexual acting out
- Homicidal thoughts
- Seizure
- Falls
- Sexual victimization
- Sexual perpetration
- Sleep apnea

1) Once a patient has been identified as needing a change in watch status, nursing staff will notify the physician or nurse practitioner to obtain an order to increase the level of observation.
2) Nursing staff will notify the person doing checks of the patient's new observation level.
3) All patients on higher levels of observation will be noted on the nursing report sheet and reviewed and communicated to all nursing staff at the beginning of each shift.
4) Any patient on higher levels of observation will have their observation level discussed with the multidisciplinary treatment team. Any significant changes will be documented and discussed.
5) In order to be removed from higher levels of observation, a physician or nurse practitioner will need to write an order once the patient no longer meets the criteria for a higher observation level.

Responsibility:
All staff at BMCHS Inpatient Psychiatric Units

Other Related Policies/Protocols/Guidelines:
46.01.008 Patient Checks and Surveillance

References:
104 CMR 27.12
The Joint Commission NPSG 15.01.01, PC 01.02.01, PC 01.02.03, PC 01.02.05
Medicare Conditions of Participation 42 CFR 482.13
244 CMR 3.05

Initiated by:
Senior Director/Associate Chief Nursing Officer Brockton

Contributing Departments:
None

Patient Checks and Surveillance (BMCHS Inpatient Psychiatry)

Policy #:	46.01.008
Issued:	July 2022
Reviewed/ Revised:	1/2023, 2/2025, 9/2025
Section:	Inpatient Psychiatry

Purpose:
To ensure patient safety by checking on patients and their environment.

Policy Statement:
Boston Medical Center Health System (BMCHS) Inpatient Psychiatry staff will routinely assess patients and their environment for safety and safety hazards. The staff person assigned to checks is responsible for checking all patients on the unit and their environment at least every 15 minutes, 24 hours a day. This person is also responsible for surveying the environment for safety hazards.

Application:
All patients at BMCHS Inpatient Psychiatry

Exceptions:
None

Definitions:
Patient Safety Checks:

- The safety check involves visualizing the patient and documenting the check in the electronic health record (EHR).
- The safety check will entail the staff person checking: proper body alignment, signs of life (observed breathing at least 3 times), safe environment, and equipment kept at safe location/distance from patient. The staff member completing the safety check will also document patient's level of activity, for example: in bed or in chair. On the overnight shift, the staff person will complete safety checks with the use of a flashlight.

Procedure:
1. At all times (24 hours a day), there is a nursing staff member assigned the responsibility of safety checks which will be documented on the assignment sheet.

2. A nurse, or a Licensed Independent Practitioner (LIP), is responsible for determining if a greater level of observation is necessary.

3. Only LIPs can decrease the level of observation or discontinue 1:1 observations.

4. During the length of their assignment, the assigned safety checks person is responsible for visualizing each patient at least every 15 minutes or as indicated to ensure their well-being and the safety of the environment around each patient. Patients may be assigned to higher levels of observation based on observed behavior outlined in the Patient Observation Policy.

5. While assigned to perform checks, the safety checks person will have no other assigned responsibilities.

6. Nursing staff on all shifts monitor all patients to assess changes in physiological status. Any status change must be reported to the charge nurse.

7. The transfer of checks from one staff member to another includes proper communication about each patient's location, level of precautions, and plan of care per hospital policy and guidelines. Precautions and policy/guidelines are as follows:

    a. Falls – Policy #03.58.000 Fall Prevention
    b. Suicide/1:1 Observation – Policy #46.01.011 Suicide Precautions/
    c. Latex Allergy –Policy #03.72.000 Latex Allergy Sensitivity
    d. Elopement Risk – Policy #46.01.006 Patient Absence without Authorization
    e. Patient Observation (BMC Brockton) Policy- Policy # 46.01.012
    f. Assault history
    g. De-escalation preferences

Responsibility:
Registered Nurses
Mental Health Specialist

Other Related Policies/Protocols/Guidelines:
02.42.000 Chain of Command
03.58.000 Fall Prevention
03.72.000 Latex Allergy Sensitivity
03.77.000 Patient Handoff Standardization
46.01.006 Patient Absence without Authorization
46.01.011 BMC Brockton Inpatient Psychiatry Suicide Precautions
46.01.012 Patient Observation (BMC Brockton)

References:
104 CMR 27.00
Trauma Assessment Safety Tool

Initiated by:
Patient Care Director, BMC Brockton

Contributing Departments:
None

Inpatient Psychiatry Suicide Precautions

Policy #:	46.01.011
Issued:	July 2022
Reviewed/ Revised:	9/2022, 12/2022, 9/2025
Section:	Inpatient Psychiatry

Purpose:
To establish guidelines for the care and management of patients identified as being at risk for suicide.

Policy Statement:
All patients at Boston Medical Center Health System (BMCHS) Inpatient Psychiatric Units that are identified as at risk for suicide will receive safe and appropriate care.

Application:
All patients at BMCHS Inpatient Psychiatric Units.

Exceptions:
None

Procedure:
1) All patients admitted to BMCHS Inpatient Psychiatric Units are screened for suicide risk. The Columbia Suicide Severity Rating Scale (C-SSRS) (completed by a RN) and Columbia Suicide Severity Scale Risk Assessment (completed by a physician or nurse practitioner) is used to evaluate risk upon admission. If the patient's condition precludes a suicide risk screening or assessment, safety interventions are individualized to each patient depending on clinical status and reason for care until the screening or assessment is able to be completed. Collateral information may be utilized in completing the suicide screening or assessment if information is unable to be obtained from the patient. The screening and assessment assists, in conjunction with the clinical evaluation, to determine the risk mitigation strategies, including the level of observation required for the patient.

2) A Licensed Independent Practitioner (LIP) can increase or decrease monitoring based on risk. The RN may initiate an increase in the level of observation but all orders to increase or decrease the level of observation must be placed by a LIP .

3) Patients are assessed by the RN daily and with a new occurrence of suicidal behavior, ideation, statement or other relevant clinical change. The RN will document changes in behavior and ideation using the flowsheet in the electronic health record (EHR). The RN is responsible for notifying the LIP regarding the change in patient condition.

4) A behavioral health assessment is completed by the RN every shift.

5) An environmental risk assessment is completed to identify features in the physical environment that could be used to attempt suicide or otherwise impose harm. The room/environment is modified by removing objects that pose a risk, if they can be removed without adversely affecting the patient's care.

6) Notification to the person doing checks must be clear that the patient is on suicide precautions (may include an order for finger foods, hospital gown, removal of objects in room/environment that may

pose a risk, 1:1 observation). Staff must assess the patient for safety in the bathroom, OT groups, and milieu activities. Staff must assess the patient for safety with certain clothing. The patient may require a hospital gown temporarily for safety. Staff must assess safety with meals and determine if the patient requires finger foods for safety. An order for finger foods must be entered in the EHR.

7) All patients on suicide precautions will be noted in the nursing report. This will be reviewed with and communicated to all nursing staff at the beginning of each shift. The patient's suicide status will also be discussed with the multidisciplinary treatment team. Any significant changes will be discussed and documented.

8) Staff will evaluate and document the patient's response to interventions.

9) The patient's overall level of risk for suicide and the plan to mitigate the risk will be documented.

10) Staff will educate the patient on the management of suicidal thoughts using the Teach Back Method. The patient should be able to teach back by discharge.

11) At discharge, the patient will be asked to complete the Columbia-Suicide Severity Rating Scale Inpatient Setting-Discharge Screener, and the Stanley Brown Safety Tool. The patient will also be provided with counseling about suicide prevention including information about crisis hotlines. The treatment team will work to refer the patient for follow-up care.

12) The hospital provides training and competence assessment regarding the screening of patients at risk of harm to self or others, the identification of environmental patient safety factors and mitigation strategies to all direct patient care employees prior to providing patient care and annually thereafter.

13) The hospital monitors the implementation and effectiveness of policies and procedures for screening, assessment, reassessment and management of patients at risk for suicide and takes action as needed to improve compliance.

Responsibility:
All staff members at BMCHS Inpatient Psychiatric Units

Other Related Policies/Protocols/Guidelines:
46.01.008 Patient Checks and Surveillance
46.01.012 Patient Observation

References:
104 CMR 27.00
The Joint Commission (2022). National Patient Safety Goals Effective January 2022 for the Hospital Program
The Joint Commission (2019) Issue 18, Nov. 27. 2018 Updated November 20, 2019 R3 Report Requirement, Rationale, Reference

Initiated by:
Senior Director/Associate Chief Nursing Officer, BMC Brockton.

Contributing Departments:
BMC South and BMC Brighton Inpatient Psychiatric Units

Boston Medical Center
HEALTH SYSTEM

BMC Health System, Inc. includes the hospitals:
Boston Medical Center
Boston Medical Center – Brighton
Boston Medical Center – South

BMCHS Violence Prevention Protocol (Inpatient Psychiatry)

Policy #:	46.01.028
Issued:	September 2022
Reviewed/ Revised:	9/2025
Section:	Inpatient Psychiatry

Purpose:
To establish a protocol for screening for risk factors for violence and preventing violence on the inpatient units.

Policy Statement:
Boston Medical Center Health System (BMCHS) is committed to promoting a safe and secure environment for patients and staff.

Application:
All Inpatient Psychiatry Staff

Exceptions:
None

Procedure:
1. All patients will be asked to participate in the development of an Individualized Crisis Prevention Plan.

2. On admission, the patient will be asked to complete a violence risk screen.
   If the patient reports a history of or current thoughts of harm to others, homicidal ideation, homicidal intent, homicidal plan, harm to others or criminal charges involving violence, or if the referral or collateral information or other records note such, the patient will be assessed at each shift using the Broset Violence Checklist.

   If the patient's condition precludes the ability to provide an accurate history, safety interventions are individualized to each patient depending on clinical status and reason for care, until the assessment is able to be completed. Collateral information may be utilized in completing an assessment if information is unable to be obtained from the patient.

3. For Broset Scores of 1-2, staff will implement preventive measures such as reviewing and utilizing the safety plan strategies from the Individualized Crisis Prevention Plan with the patient.

   For Broset Scores >2, staff will implement preventive measures such as reviewing and utilizing the safety plan strategies from the Individualized Crisis Prevention Plan with the patient and in addition, available members of the treatment team will meet to develop a plan to manage potential violence.

4. Restraint and Seclusion may only be used after the failure of less restrictive alternatives, including strategies identified in the Individualized Crisis Prevention Plan, or after a determination that such alternative would be inappropriate or ineffective under the circumstances, and may be used only for the purpose of preventing the continuation or renewal of such emergency condition.

5. Licensed mental health professionals will comply with M.G.L. Chapter 123 Section 36B as below:

   (a) There shall be no duty owed by a licensed mental health professional to take reasonable precautions to warn or in any other way protect a potential victim or victims of said professional's patient, and no cause of action imposed against a licensed mental health professional for failure to warn or in any other way protect a potential victim or victims of such professional's patient unless:

      i. the patient has communicated to the licensed mental health professional an explicit threat to kill or inflict serious bodily injury upon a reasonably identified victim or victims and the patient has the apparent intent and ability to carry out the threat, and the licensed mental health professional fails to take reasonable precautions as that term is defined in section one; or

      ii. the patient has a history of physical violence which is known to the licensed mental health professional and the licensed mental health professional has a reasonable basis to believe that there is a clear and present danger that the patient will attempt to kill or inflict serious bodily injury against a reasonably identified victim or victims and the licensed mental health professional fails to take reasonable precautions as that term is defined by said section one.

      Nothing in this section shall be construed to require a mental health professional to take any action which, in the exercise of reasonable professional judgment, would endanger such mental health professional or increase the danger to potential victim or victims.

   (b) Whenever a licensed mental health professional takes reasonable precautions, as that term is defined in section one of chapter one hundred and twenty-three, no cause of action by the patient shall lie against the licensed mental health professional for disclosure of otherwise confidential communications.

Responsibility:
All Inpatient Behavioral Health Staff

Attachments:
Broset Violence Checklist

Other Related Policies/Protocols/Guidelines:
46.01.018 Restraint Use/Seclusion (BMC South Brockton Inpatient Psychiatry)

Initiated by:
Inpatient Medical Director

Contributing Departments:
None

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The Brøset Violence Checklist © (BVC) - quick instructions:

Score the patient at agreed time on every shift. Absence of behaviour gives a score of 0. Presence of behaviour gives a score of 1. Maximum score (SUM) is 6. If behaviour scores 1, e.g. if a well know client normally is confused (has been so for a long time) this will give a score of 0. If an increase in confusion is observed this gives a score of 1.

Patient data

Monday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Tueday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Wednesday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Thursday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Friday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Saterday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Sunday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

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The Brøset Violence Checklist © (BVC) - quick instructions:

Interpretation of scoring:

Score	
Sum = 0	The risk of violence is small
Sum = 1-2	The risk of violence is moderate. Preventive measures should be taken.
Sum = 3-6	The risk of violence is high. Preventive measures should be taken. In addition, plans about how to manage an attack should be made.

Confused	Appears obviously confused and disoriented. May be unaware of time, place or person.
Irritable	Easily annoyed or angered. Unable to tolerate the presence of others.
Boisterous	Behaviour is overtly "loud" or noisy. For example slams doors, shouts out when talking etc.
Verbal threats	Where there is a definite intent to physically threaten another person. For example talking at an aggressive stance; the grabbing of another persons clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.
Physical threats	A verbal outburst wh'ch is more than just a raised voice; and where there is a definite intent to intimidate or threaten another perso . For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.
Attacking objects	An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or slamming windows; kicking, banging or head-butting an object; or the smashing of furniture.

NB: For the behaviours/items physically threatening, verbally threatening and attacking objects the operationalisation was adapted from the Behavioural Status Index (Reed, Woods & Robinson, 2000) by one of the authors (Woods).

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Questions about this document?

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BMCHS Inpatient Psychiatry and CSS Nursing Admission Assessment/Reassessment & Documentation of Care

Policy #:	46.01.029
Issued:	10/2025
Reviewed/ Revised:	
Section:	Inpatient Psychiatry

Purpose:

To standardize the manner in which all patients at Boston Medical Center Health System (BMCHS) inpatient psychiatry and clinical stabilization units are assessed, reassessed, and their care needs documented

Policy Statement:

All patients at BMCHS will receive a comprehensive nursing admission assessment addressing identified care needs, including actual or potential health problems. All assessment screenings must be completed within 24 hours of admission.

Application:

Registered nurses (RN's), at BMCHS Inpatient Psychiatric Units and RN's and Licensed Practical Nurses (LPN's) at Brockton Behavioral Health Center's (BBHC) clinical stabilization unit.

Exceptions:

None

Procedure:

Nursing Assessment and Documentation for Inpatient Psychiatry

1. **Admission Assessment:** Completed upon patient arrival, capturing medical history, presenting symptoms, risk assessment, and immediate care needs.
2. **Shift Notes and Flowsheet documentation:** Required every shift, detailing mental status, response to treatment, medication compliance, safety concerns, and interventions provided.
    a. Vital signs Flowsheet
        i. Vital signs include temperature, blood pressure (BP), heart rate (HR), respiratory rate (RR) and oxygen saturation (O_2 sat).
        ii. Vital signs are obtained and documented upon admission and at least daily thereafter.
3. **Treatment Plans:** Initiated upon admission, ensuring alignment with the patient's clinical needs and goals.
4. **Critical Incident Documentation:** Records significant changes in patient status, restraints/seclusion events, or emergent medical needs per regulatory requirements; updates must also be reflected in the treatment plan.
5. **Treatment Plan Updates:** Conducted per organization to reflect patient progress, response to interventions, and any modifications to care.
6. **Behavioral Health (BH) RN Shift Assessment:**
   RNs are responsible for documenting the following behavioral health assessment each shift:
    a. Mental Status Assessment
    b. Columbia Suicide Severity Rate Scale (screener since last contact)
    c. Broset Violence Assessment
    d. Self Harm Assessment
    e. Elopement Assessment

f. Edmonson Fall Risk Assessment
g. Safety
h. Neurological
i. Head, Eyes, Ears, Nose, and Throat (HEENT) Assessment
j. Respiratory
k. Cardiac
l. Peripheral Vascular
m. Braden Scale (optional)
n. Musculoskeletal
o. Gastrointestinal
p. Genitourinary
q. Sleep
r. Provider notification (optional)

7. **Restraint/Seclusion documentation**
   a. RNs are to document all episodes of restraint and seclusion in the electronic medical record (EMR).
   b. RNs must also create an event note following all episodes of restraint/seclusion.

Nursing Assessment and Documentation for Clinical Stabilization Services (CSS)

1. Notes:
   a. Admission note upon patient admission to CSS
   b. Event notes as needed for any changes in patient's status (i.e. fall, change in mental status)
   c. Group notes for every group run by the nurse
   d. Discharge note upon patient discharge from CSS
2. Flowsheets:
   a. Vital signs (BP, HR, O_2 sat, temperature, RR) as needed
   b. Weights as needed (upon admission, daily)
   c. Provider notification as needed

Responsibility:
Registered Nurses, Licensed Practical Nurses

Other Related Policies/Protocols/Guidelines:
03.58.000 Fall Prevention
46.01.011 BMCHS Inpatient Psychiatry Suicide Precautions
46.01.018 Restraints Use/Seclusion (BMCHS Inpatient Psychiatry)
46.01.025 Admission Nutrition Assessment and Referral (BMCHS Inpatient Psychiatry)

Initiated by:
Patient Care Director, Brockton

Boston Medical Center
HEALTH SYSTEM

BMC Health System, Inc. includes the hospitals:
Boston Medical Center
Boston Medical Center – Brighton
Boston Medical Center – South

BMC South Brockton Behavioral Health Center Patient Absent Without Authorization – Elopement (Code Purple)

Policy #:	46.01.006
Issued:	July, 2022
Reviewed/ Revised:	2/2025, 5/2025, 7/2026
Section:	Inpatient Psychiatry

Purpose:
To establish a standardized, regulatory-aligned approach for the prevention, identification, classification, response, and safe return of patients who are absent without authorization (AWA)/elopement from Boston Medical Center South (BMC South) Brockton Behavioral Health Center (BBHC), ensuring patient safety while maintaining the least restrictive therapeutic environment.

Policy Statement:
BMC South BBHC is committed to maintaining a safe environment while supporting patient autonomy consistent with clinical status, legal requirements, and regulatory standards.

All patients will undergo ongoing elopement risk assessment at admission and throughout their stay. Patients who leave the facility or fail to return within an expected timeframe may be classified as AWA in accordance with Massachusetts Department of Mental Health (DMH) regulations (104 CMR 27.15), which may trigger required notifications to law enforcement, guardians, and other relevant parties.

The facility will initiate Code Purple immediately upon suspected or confirmed elopement and will coordinate a timely and appropriate response to ensure patient safety and regulatory compliance.

Application:
This policy applies to all BMC South BBHC staff, including nursing, medical staff, social work, public safety, and administrative leadership involved in patient care, supervision, and incident response across inpatient programs.

Exceptions:
Clinical and legal exceptions related to discharge, return, or retention of AWA patients must align with MGL c.123 statutes and be determined by the treatment team and facility leadership.

Definitions:
Absent Without Authorization (AWA): A patient who leaves facility grounds or an authorized activity without permission and fails to return within a reasonable period of time.

AWA Classification: A formal designation by facility leadership, in consultation with a psychiatrist, that a patient is AWA. This classification triggers required third-party notifications and must occur no later than the midnight census on the day of elopement unless delayed due to known patient safety and confirmed whereabout.

Code Purple: The BMC South BBHC emergency response activation for a patient elopement or AWA event.

Access Levels: Clinically ordered permissions that define a patient's movement on or off unit/grounds, ranging from fully restricted to unsupervised off-grounds access, based on clinical readiness and legal status.

Elopement Risk Assessment: A clinical evaluation of factors that indicate increased likelihood of elopement, including but not limited to history of elopement, forensic status, and risk of harm to self or others.

Treatment Plan: An interdisciplinary care plan that includes patient goals, interventions, and risk mitigation strategies, including those related to elopement risk.

Minor: Any patient under the age of 18 years.

Legal Guardian: An individual authorized to make decisions on behalf of a patient, including a parent or court-appointed guardian.

Procedure:

Risk Assessment, Documentation, and Patient Education

1. All inpatient units are secured and require badge access for entrance and exit of the program. Badge access is provided to necessary staff only, as determined by program leadership in conjunction with the facility Executive Director.
2. Upon initial evaluation, the admitting clinician will review the patient's history of elopement and will document such in the patient's medical record.
    a. Potential risk factors for elopement include:
        i. Previous elopement attempts
        ii. Prowling, loitering around program doors
        iii. Layering clothing
        iv. Putting on shoes
        v. General restlessness, racing or expressing desire to leave
        vi. Distress after hearing "bad news"
        vii. Active psychosis, confusion, or neurocognitive disorder disrupting the patient's ability to think/process clearly
3. Patients shall not be permitted to leave the program, once admitted, until the treatment team can determine if the patient is safe enough to leave the program.
    a. Patients meeting certain legal or clinical criteria (e.g., section 12, section 7 and 8, high risk of harm) may be designated for immediate AWA classification if they leave without authorization.
4. Patients may be required to move between units within the facility to gain access to services outside of their designated care areas. This movement must be in accordance with the provider's order, as noted in the patient's medical record.
    a. Staff or an authorized adult must accompany the patient off unit per unit protocol.
    b. Whenever a patient is taken off the unit, the Charge Nurse or designee should be notified of the transition, and the patient(s) should be noted as being off unit as part of the patient checks procedure.
5. Elopement risk must be:
    a. Documented in the medical record
    b. Addressed in the Treatment Plan
    c. Reassessed:
        i. During treatment team reviews
        ii. With any behavioral change
        iii. Prior to off-unit/off-grounds access
        iv. Following any elopement event

6. Patients will be informed upon admission of:
    a. AWA classification criteria
    b. Potential notifications (e.g., law enforcement, family)
    c. Possible use of identifying information (e.g., photograph) to support recovery efforts

Prevention and Access Management

1. Access levels must be ordered by a provider and based on clinical readiness and legal status.
2. A structured pre-departure assessment should be completed prior to off-grounds activity to evaluate risk and ensure safe return planning.
3. Patients identified as high risk require enhanced supervision and mitigation strategies.

Suspected or Confirmed Elopement (Code Purple Activation)

1. A patient will be considered to have eloped any time they leave the campus.
2. Upon notification that a patient may be missing, the unit staff should search all rooms, group spaces, stairwells, and other immediate areas for the patient.
3. If a patient cannot be found within 10 minutes of being identified as "missing," the person shall be considered to have eloped and the following must occur:
    a. Upon notification, awareness, or suspicion of a patient elopement, the employee will immediately contact Public Safety to activate a CODE PURPLE. In addition, the following individuals should be notified: Attending Provider, Nurse Director, Associate Chief Nursing Officer, Senior Director of Risk, Quality, & Compliance, Medical Director – Psychiatry, and the Executive Director, or the Nursing Supervisor (during off-hours). Staff will need to provide the following:
        i. Name of caller; building/unit/area of elopement; time of incident; call back number; and a description of the patient (name, age, race, gender, height, clothing, and direction of travel)
        ii. If staff is with a group of patients, staff should secure the group before addressing the elopement and should call for additional resources whenever possible. Staff must never leave a group of patients unattended.

Leadership Oversight:

1. Nursing Supervisor will:
    a. Coordinate and supervise search efforts
    b. Notify Public Safety and Administrator on Call
    c. Ensure adherence to response protocol
2. AWA Classification and Notifications
3. The patient will be formally classified as AWA:
    a. Immediately (if criteria met), or
    b. No later than midnight census on day of elopement
4. Required notifications include:
    a. Law enforcement
    b. Legal guardian/next of kin
    c. Other parties as required by law/regulation
5. All notifications must be documented.

Search and Recovery Efforts

1. A reasonable attempt must be made to secure the patient's safe return to include:
    a. Whenever possible, attempt to follow the patient
    b. Once off campus, staff should not attempt physical management of the patient unless risk of imminent danger warrants (e.g., runs into traffic, assaults a pedestrian, etc.)

c. If patient is no longer observable, out of sight, or non-compliant with verbal direction to return, Public Safety will notify local police:
   i. Brockton Police (508) 941-0200
   ii. When police arrive on site, the Nurse Director, Nursing Supervisor, or designee should be prepared to provide them with a photo of the patient (whenever possible) and may be required to file a missing person's report.
d. The Charge Nurse or another member of the clinical team should make every effort to notify the legal guardian (for minor patients) or next of kin/emergency contact (for adult patients) as soon as possible.
e. If the minor patient is in the custody of the Massachusetts Department of Children and Families (DCF), notify the minor's primary worker, supervisor, or utilize the 24-hour hotline, off-hours (1-800-792-5200).
f. If a patient is not located within one hour from the time, they were identified as missing, the patient will be discharged from the hospital.

Upon Patient Return

1. When the patient has been located, unless they exhibit physiological or psychiatric decompensation, they may be readmitted directly to the unit through the direct admission process (an exception may be made for "seen within 24 hours" if there is no suspected deterioration in clinical status).
   a. If the patient is found, returned safely to the facility, and the Nurse Director, Nursing Supervisor or designee have determined the code to be complete, the CODE PURPLE will be cleared.
   b. Upon patient return to the unit, the nurse assigned to the patient must contact the provider and search the patient in accordance with patient search procedure.
2. A licensed provider must perform immediate clinical reassessment to include:
3. Medical and psychiatric evaluation

Documentation & Additional Follow-up

1. The nurse assigned to the patient must document the incident of elopement in the patient's medical record.
2. Patient should be placed on elopement precautions and an order indicating elopement risk should be entered by the physician into the patient's medical record.
3. Treatment Plan with revised risk mitigation strategies
4. One staff member involved in the incident must file an incident report.
5. If the patient sustains injury or abuse during the period of elopement or injury or abuse is suspected, the staff must contact the provider and assess for injury, substance abuse, or sexual assault. If injury or abuse is identified, staff must provide immediate treatment and/or assess for further medical intervention.
6. A report must be prepared for DMH and DCF (for minors) and will be managed by the Senior Director of Risk, Quality, & Compliance, or designee.
7. If police were notified of the incident, even if they were not involved in the safe return of the patient, Public Safety or designee should inform the local police department of the safe return of the patient.
8. Staff must notify all previously contacted parties of patient return within one business day.

Disposition of AWA Patients

1. Patients may be returned under original legal status if criteria are met.
2. Discharge decisions must comply with MGL c.123 and require leadership and psychiatric review.

Responsibility:

All Staff:

- Maintain patient awareness
- Immediately report missing patients
- Participate in response efforts

Nursing Supervisor:

- Lead Code Purple response
- Coordinate search and notifications

Providers (Psychiatrist/APP):

- Assess elopement risk
- Determine AWA classification (with leadership)
- Document rationale and reassess upon return

Facility Leadership:

- Ensure regulatory compliance
- Oversee AWA classification and reporting
- Ensure staff training and policy adherence

Public Safety:

- Support search efforts
- Coordinate with law enforcement

References

Massachusetts Department of Mental Health (DMH), 104 CMR 27.15
MGL c.123 (Massachusetts Mental Health Statute)
CMS Conditions of Participation

Other Related Policies/Protocols/Guidelines:

04.01.000 Online Incident Reporting
46.01.008 Patient Checks and Surveillance (BMCHS Inpatient Psychiatry)
46.01.012 Patient Checks and Surveillance (BMCHS Inpatient Psychiatry)
46.01.023 BMC South BBHC Safety and Security

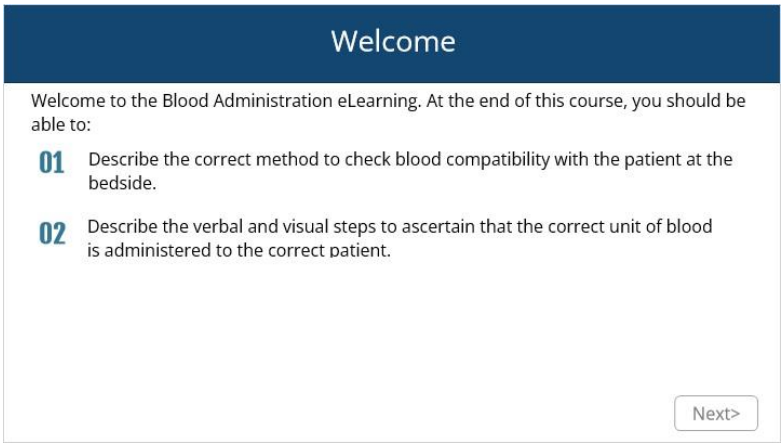
Initiated by:

Associate Chief Nursing Officer, BMC South BBHC
Executive Director, BMC BBHC
Senior Director Risk and Quality Compliance, BMC South BBHC

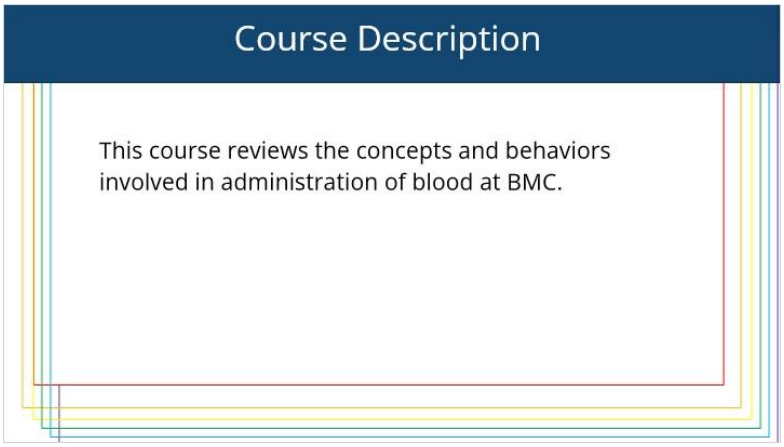
Contributing Departments:

None

Hidepretestlayer (Slide Layer)



1.3 Course Description



Notes:

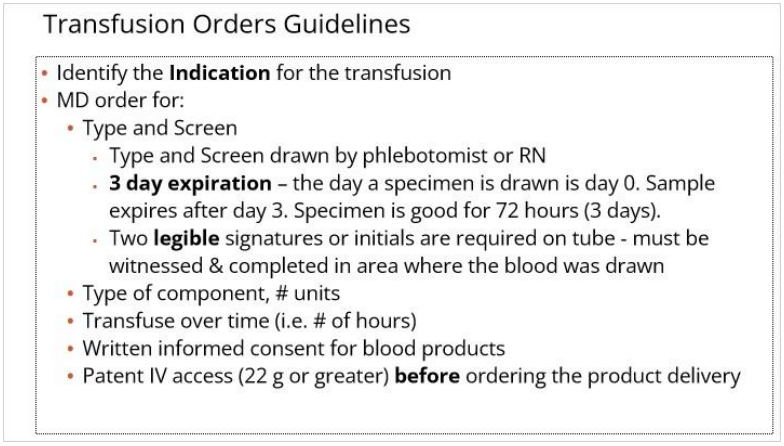
2. Blood Product Administration

2.1 Transfusion Orders



Notes:

2.2 Transfusion Orders Guidelines



Notes:

2.3 BMC Informed Consent for Blood Components Transfusion

BMC Informed Consent for Blood Components Transfusion

- Informed Consent means that the patient has been provided with sufficient information to make an informed decision regarding consent to treatment
- Blood Consent is valid for **60** days **or** the duration of the hospital admission as long as it is related to the same illness
  - A new consent form must be signed if the reason for the transfusion has changed
- Check **surgical** consent for transfusion consent if patient is post-op and bleeding is related to the surgery
- **Chronic** on-going transfusion consent requires an annual consent

2.4 Blood Bank Specimens

Blood Bank Specimens

- Two people must be present at the time a type and screen is collected
  - One person collects the specimen and both people independently verify the accurate patient identifiers - full name and complete MRN
  - Both people sign **(legible signature or initials)**, date & time the tube prior to exiting room
- Specimens will be rejected by the blood bank if they do not have 2 legible names or initials



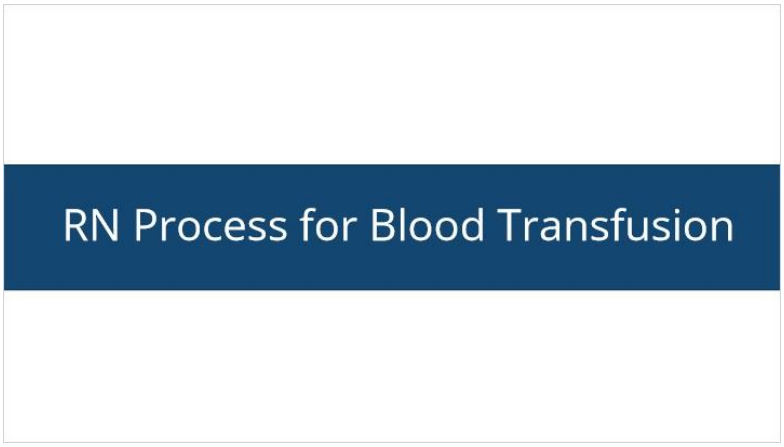
2.5 Verification of Blood Type

Verification of Blood Type

- Patients who have no history with the BMC Blood Bank will require a second specimen be sent to the Blood Bank to verify ABO/Rh
- Blood Bank will notify the nursing unit if the second sample is required and send a white top tube and label
- This sample also requires:
  - 2 legible signatures or initials
  - Date and time labeled in the presence of the patient at the time of the blood draw

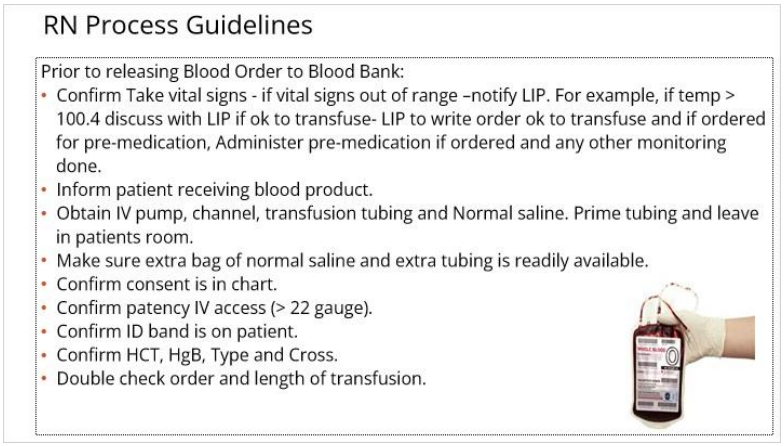


2.6 RN Process for Blood Transfusion

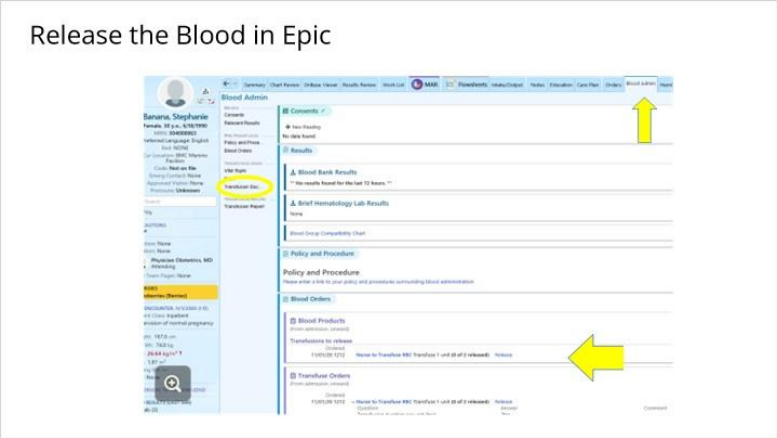


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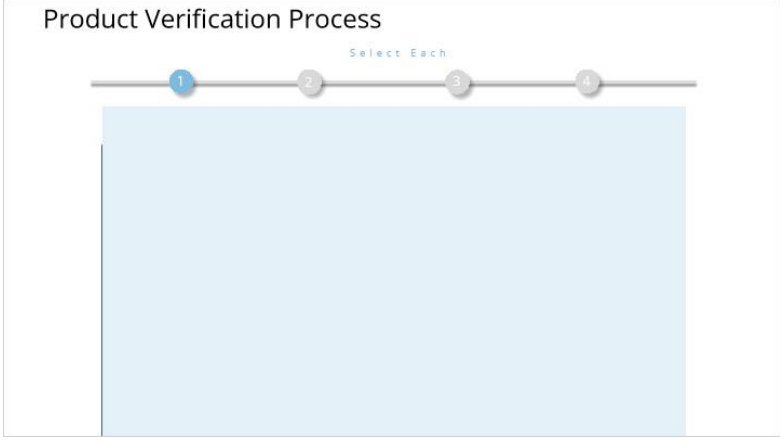
2.7 RN Process Guidelines



2.8 Release the Blood in Epic

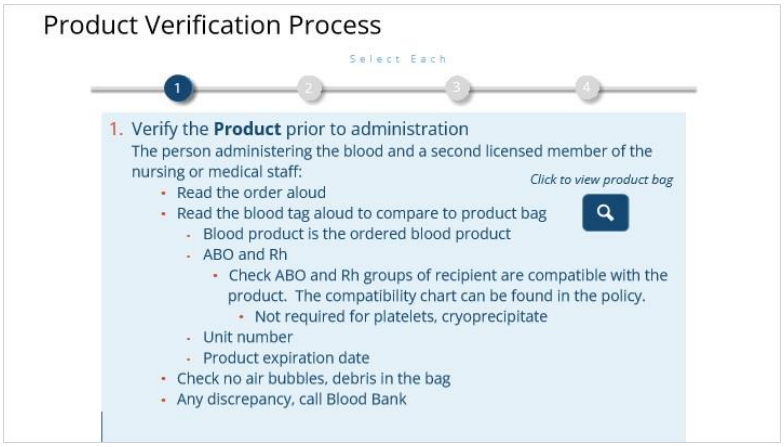


2.9 Product Verification Process

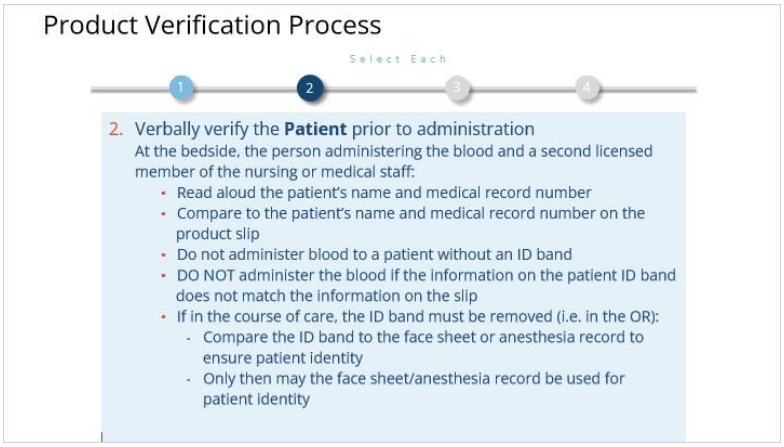


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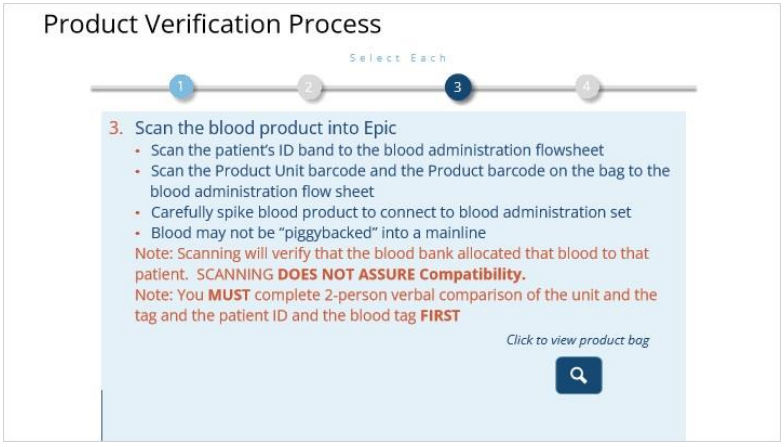
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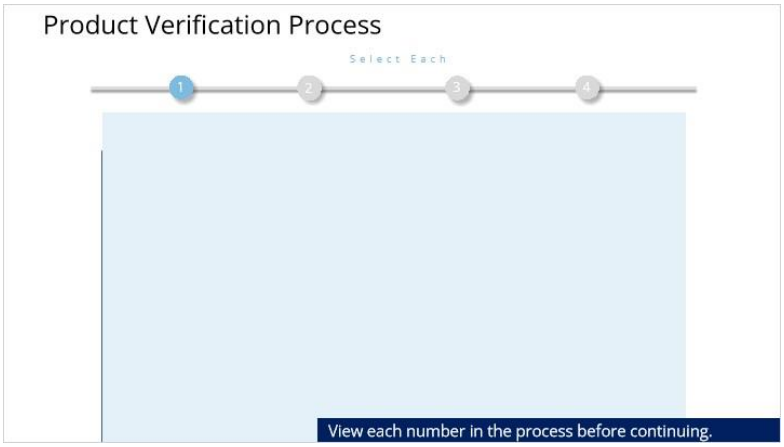
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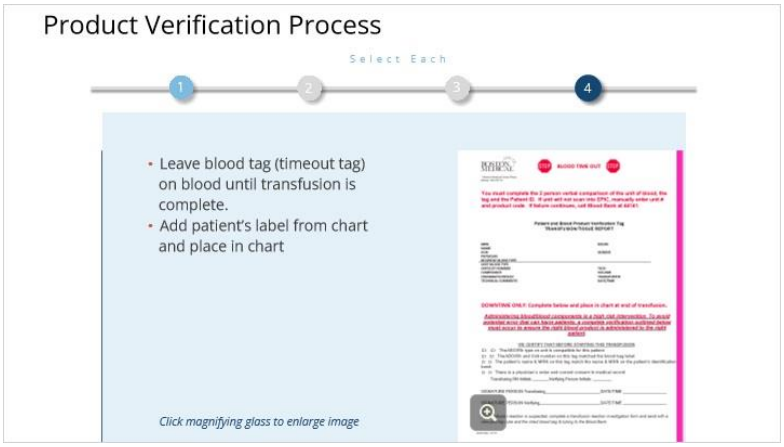
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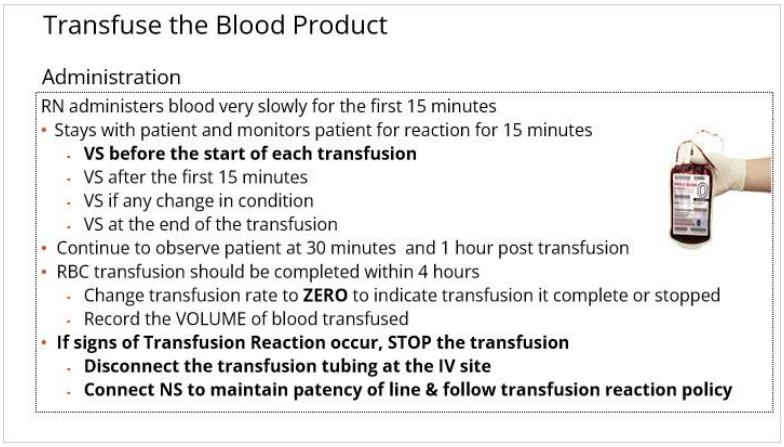
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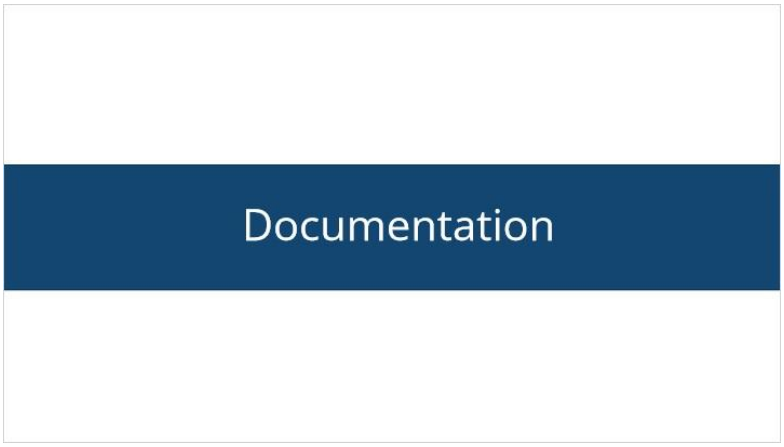
4 (Slide Layer)



2.10 Transfuse the Blood Product

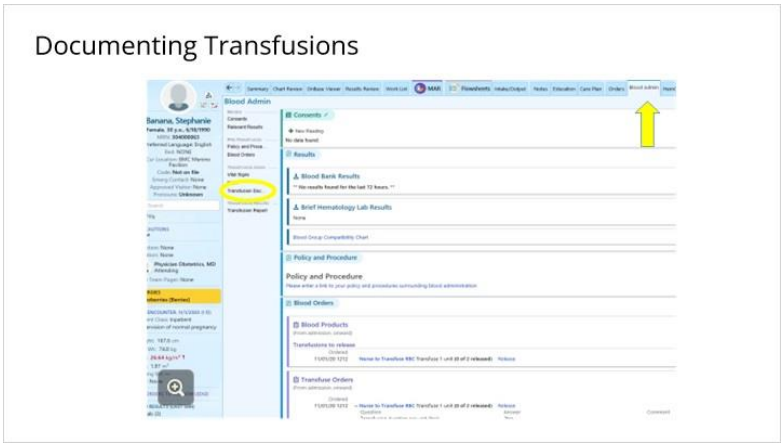


2.11 Documentation

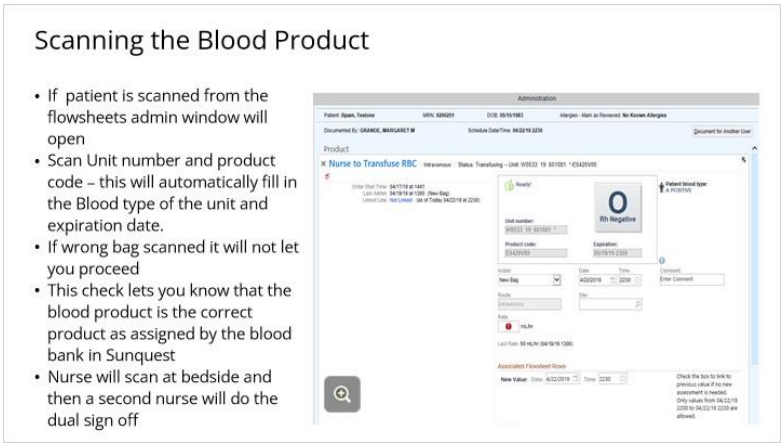


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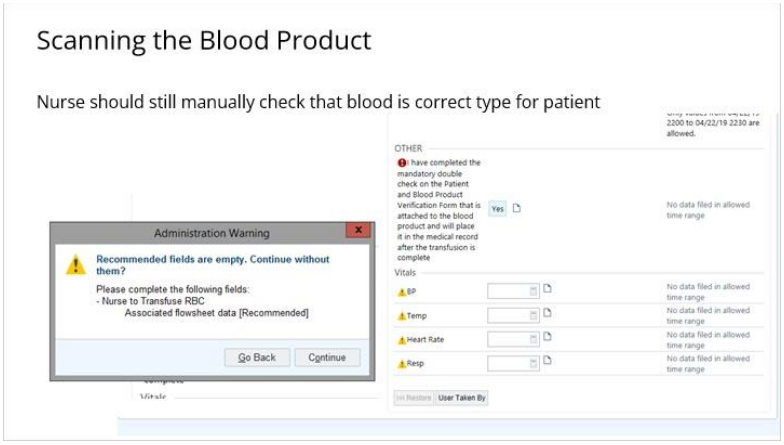
2.12 Documenting Transfusions



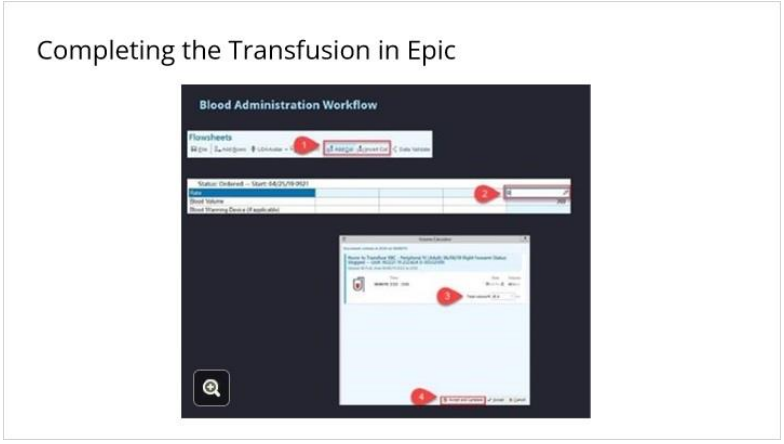
2.13 Scanning the Blood Product



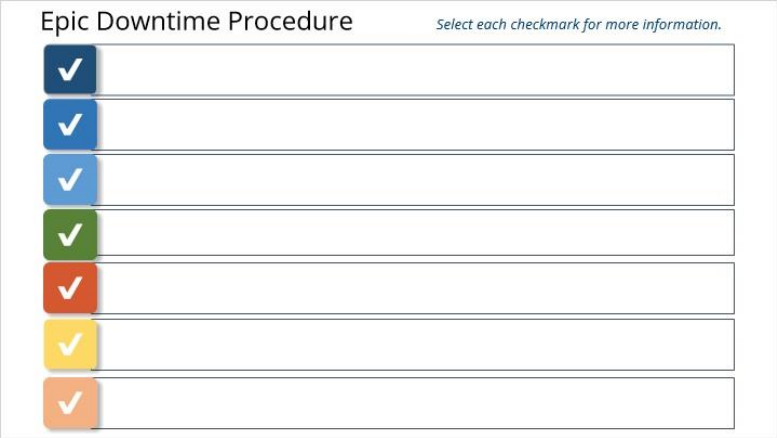
2.14 Scanning the Blood Product



2.15 Completing the transufion in Epic

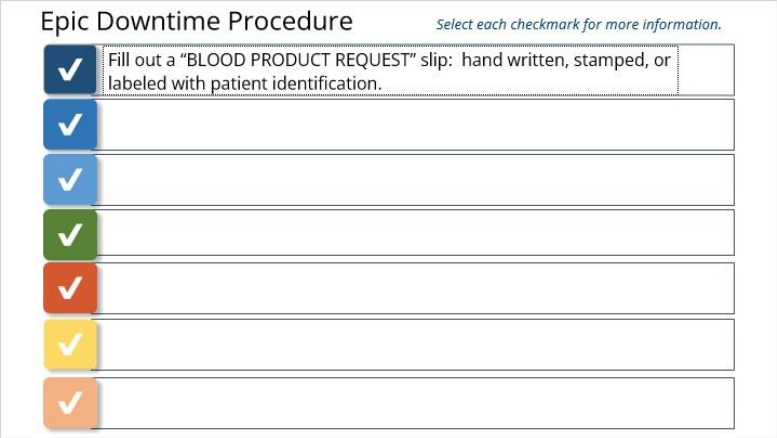


2.16 Epic Downtime Procedure

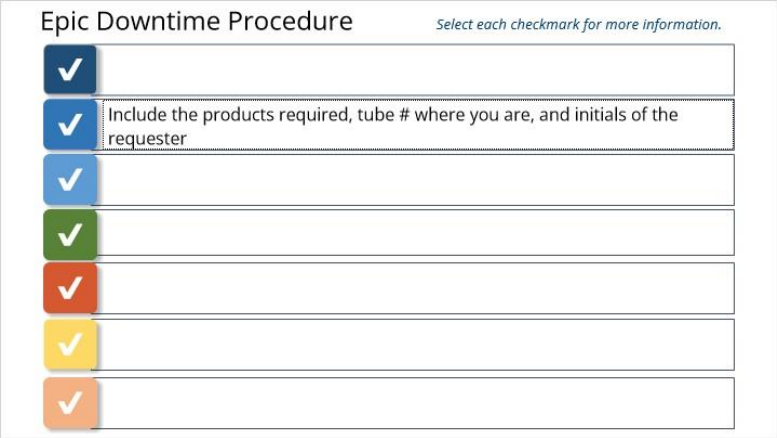


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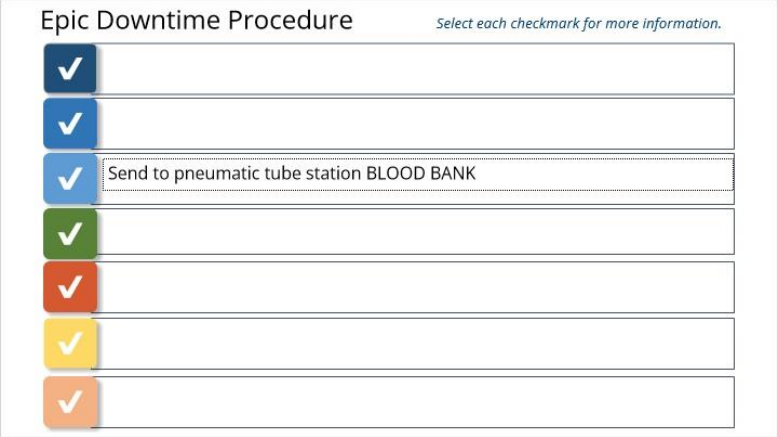
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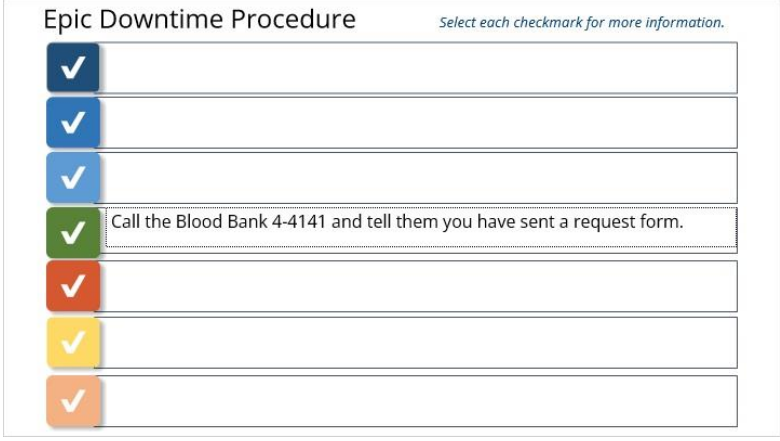
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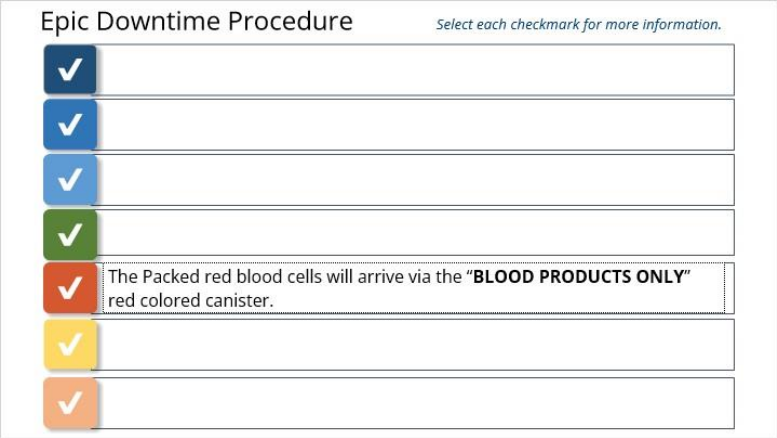
3 (Slide Layer)



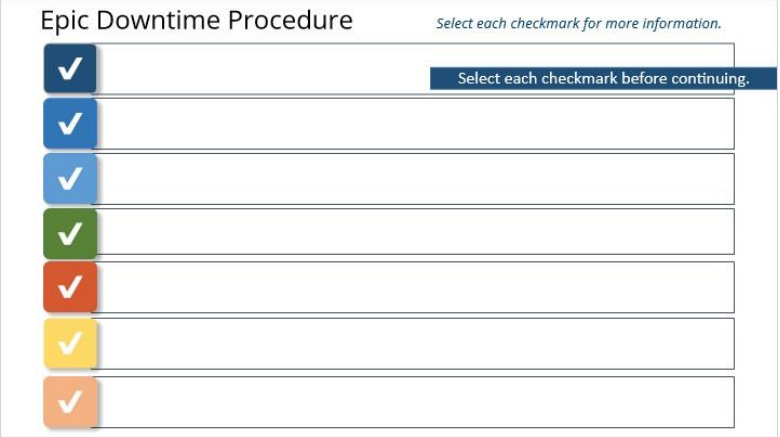
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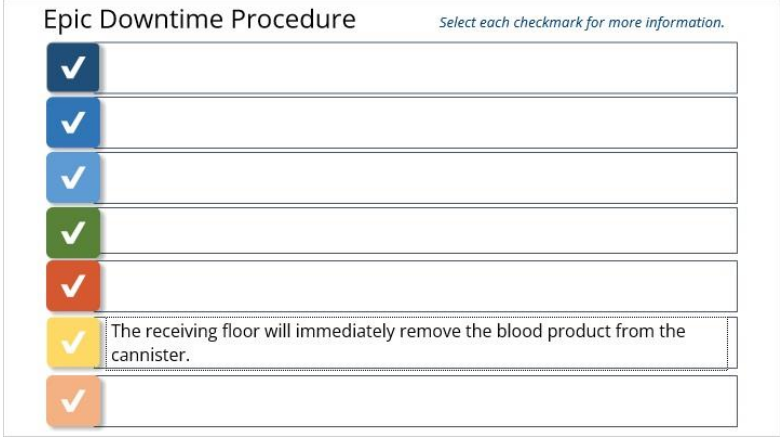
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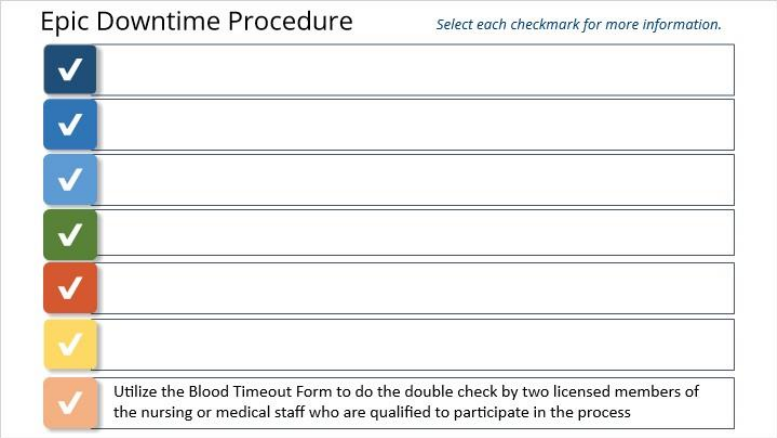
Reminder (Slide Layer)



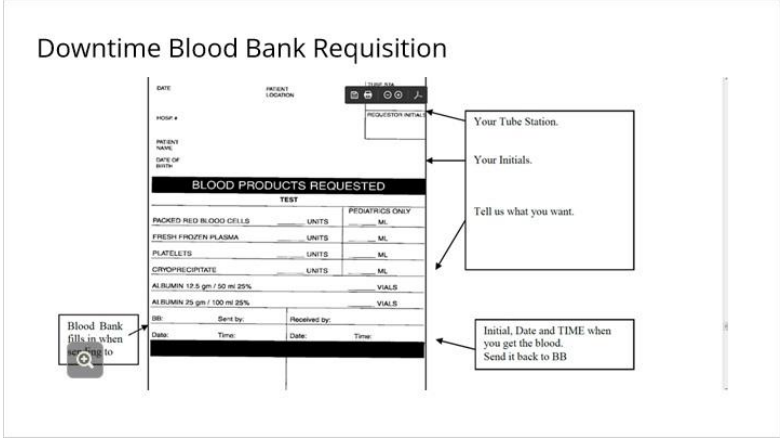
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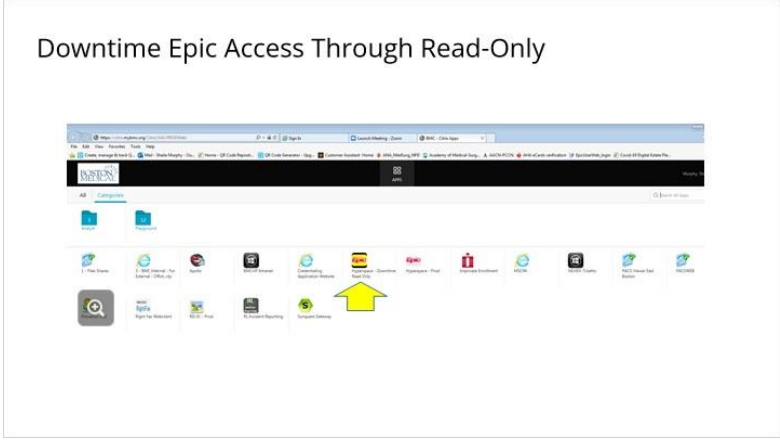
7 (Slide Layer)



2.17 Downtime Blood Bank Requisition

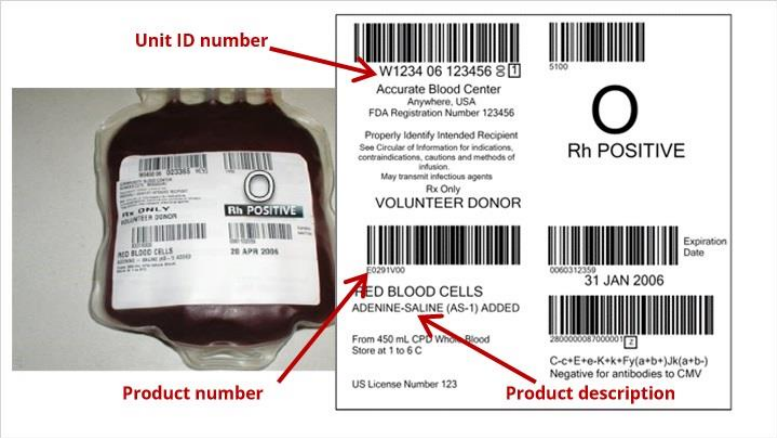


2.18 Downtime Epic Access Through Read-Only



3. Lightboxes

3.1 Light Box Blood Component Label



3.2 Light Box Blood Component Scan



4. Untitled Scene

4.1 Thank you



Notes:

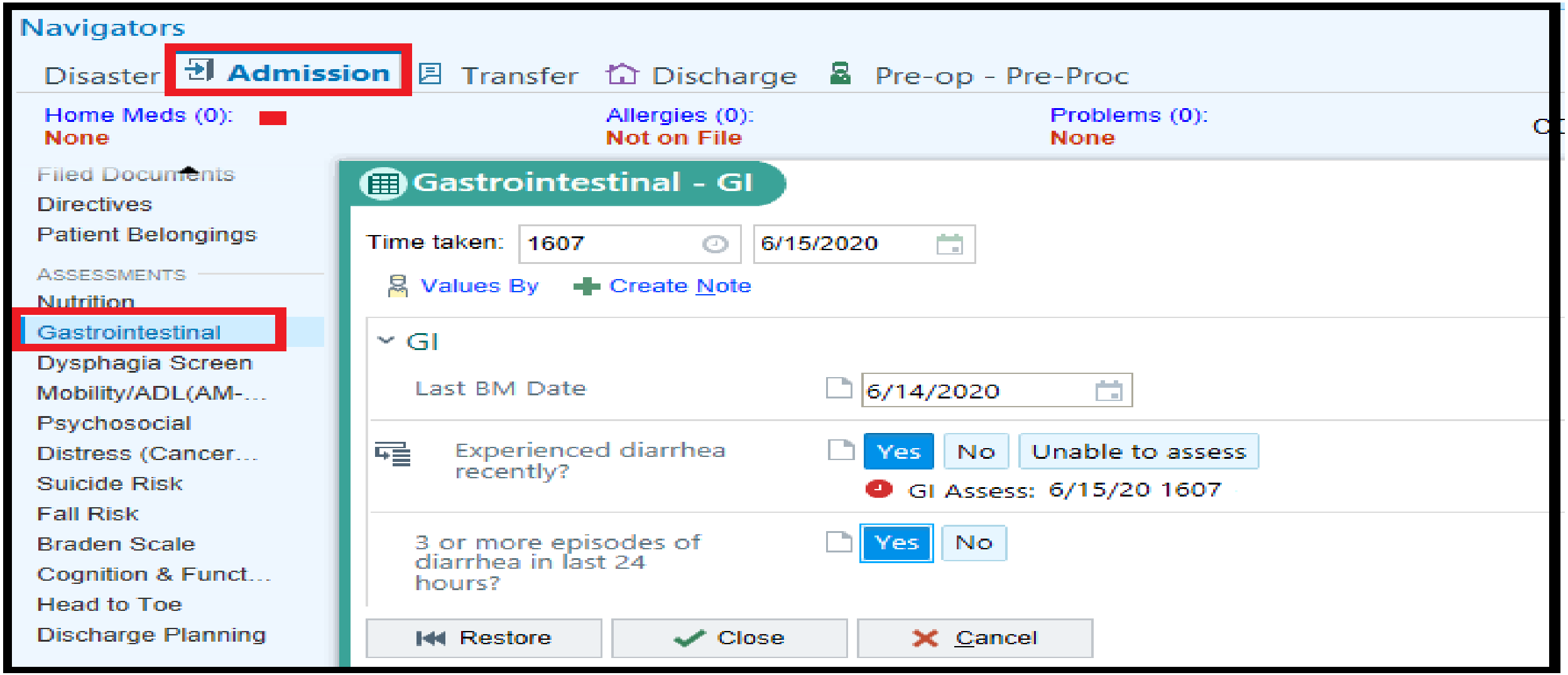
Infection Prevention RN Orientation

Your Commitment to Infection Prevention Protects You, Your Patients, and Your Team

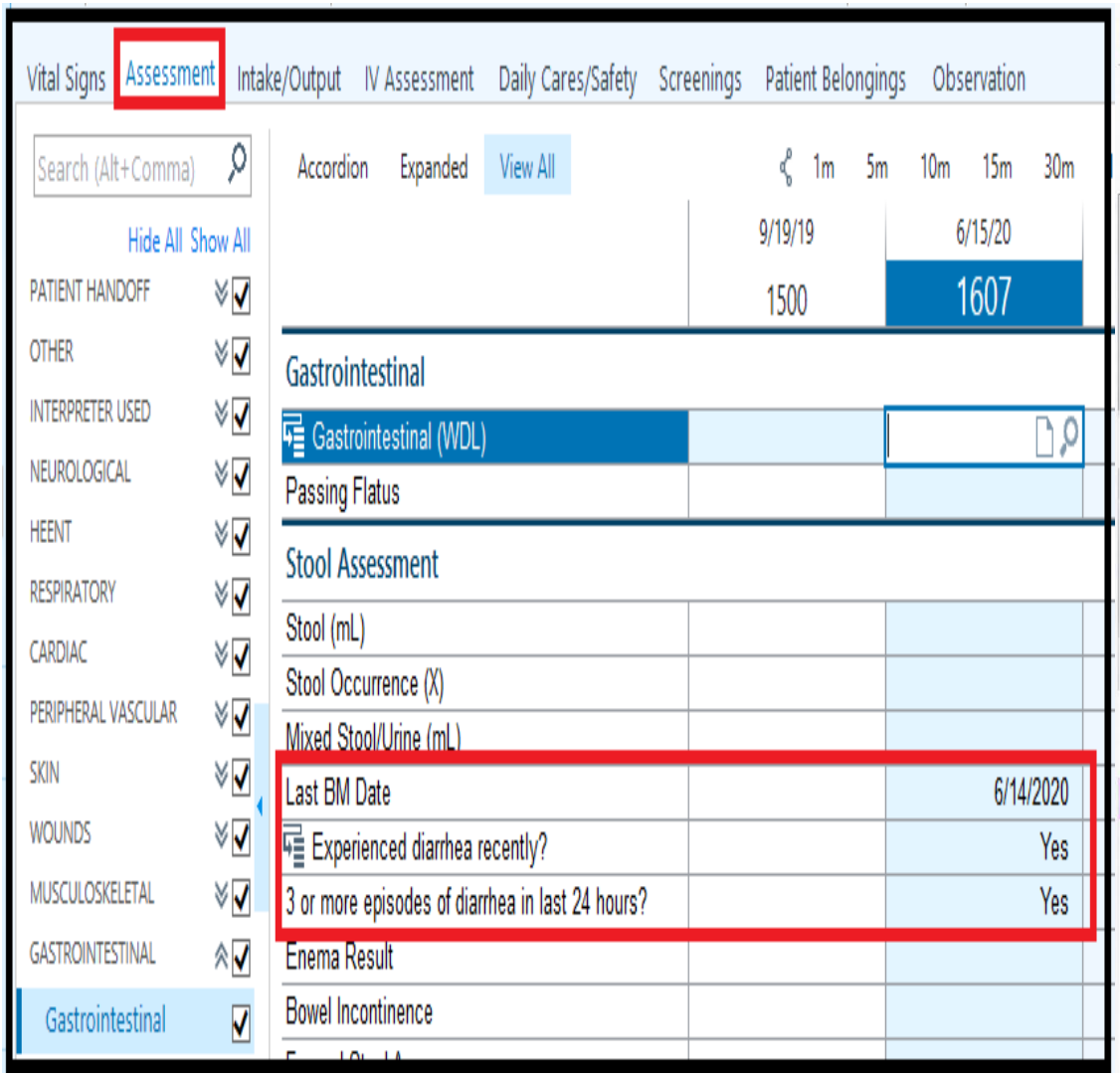
BOSTON MEDICAL CENTER

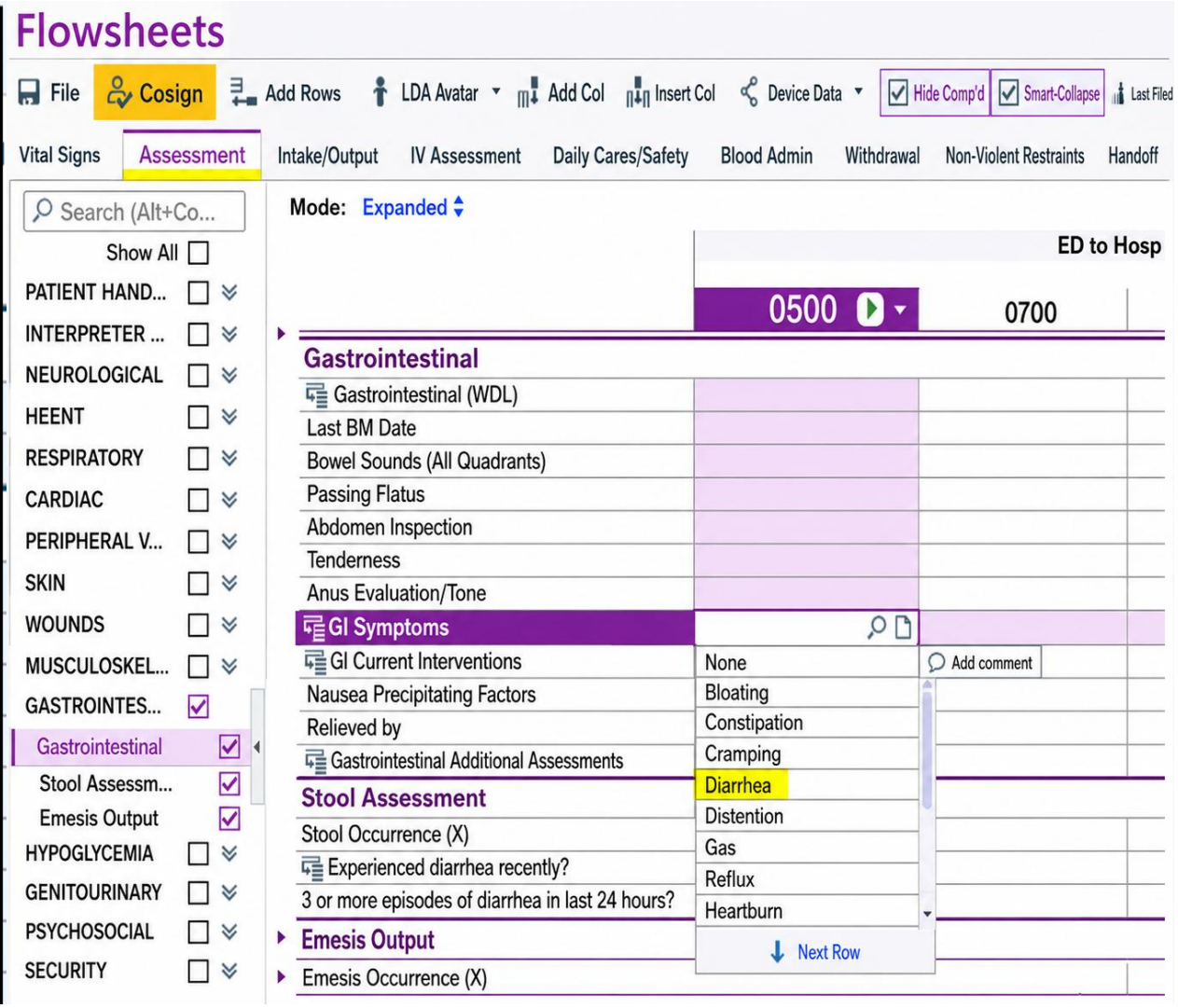
RN Driven Protocol/BPA for C Diff Order for Days 1-3 of admission

Make sure to document on flowsheet. Three or more episodes of diarrhea/loose/watery in 24 hours. BPA will pop up to allow the RN to place order without cosign.

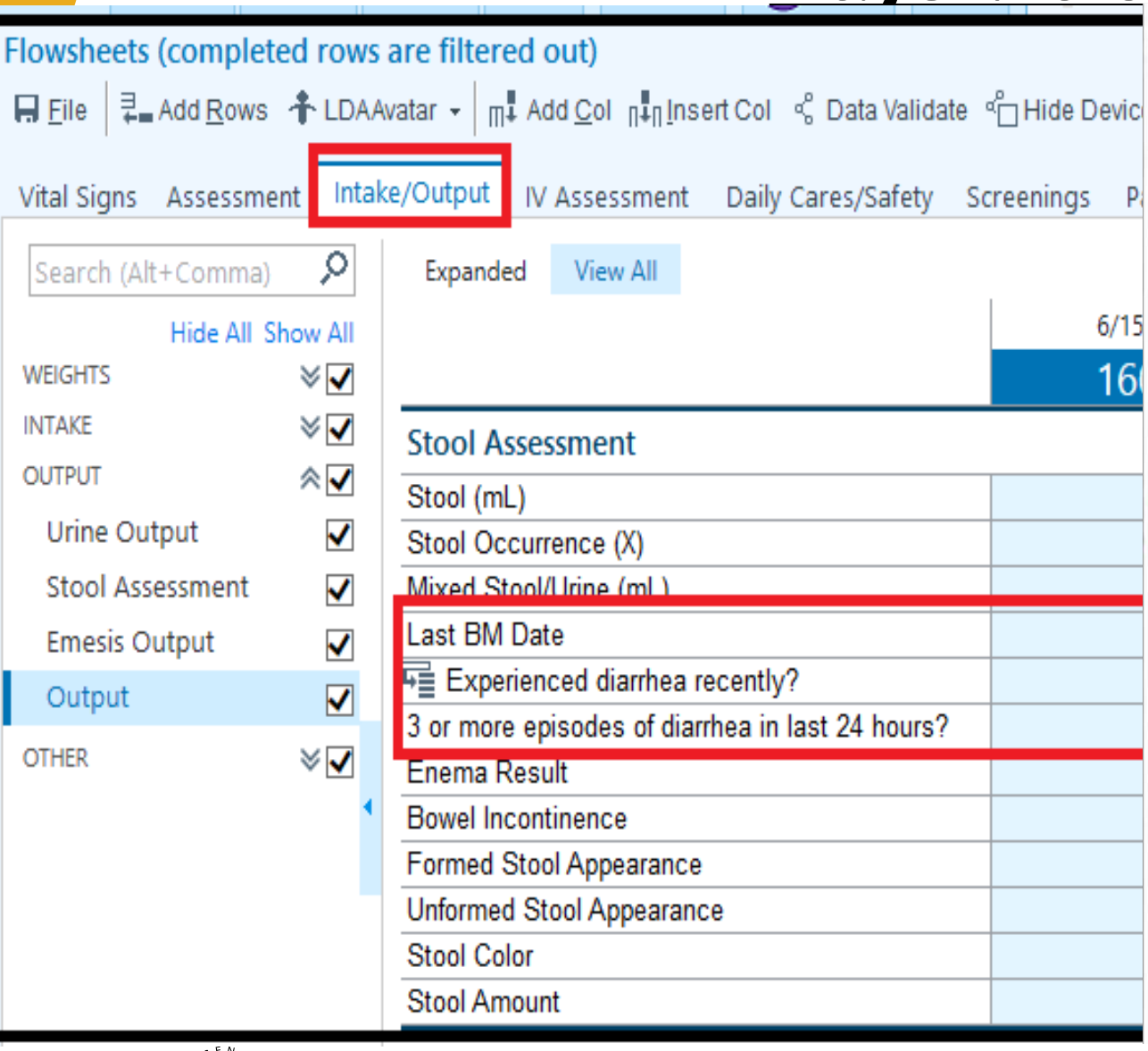


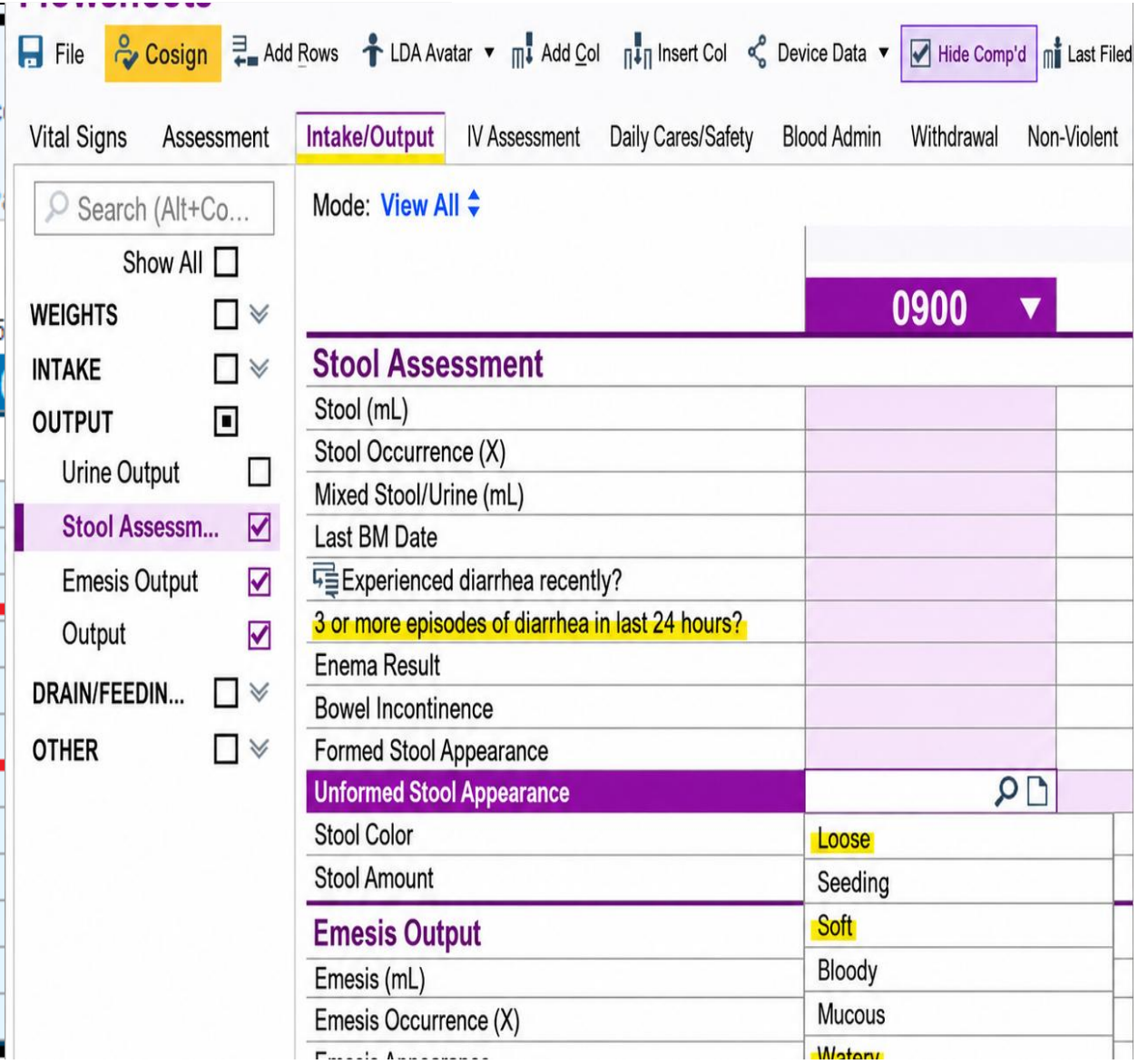
RN Driven Protocol/BPA for C Diff Order
Days 1-3 of admission





RN Driven Protocol/BPA for C Diff Order
Days 1-3 of admission





BOSTON MEDICAL CENTER

HAI Surveillance – NHSN Definitions

- **CAUTI:** foley for >2 calendar days (day of insertion is day 1) and has at least 1 qualifying symptoms (fever, suprapubic tenderness…) AND a urinary culture >100,000 colonies
  - UA with reflex to UC protocol



- Only send cultures on UA with **WBC>10**
- If UA is positive and foley has been in more than 24 hours → **change Foley catheter prior to obtain urine culture**(foleys get colonized and does not accurately represent a true infection
- Do not send UCs on patients who are asymptomatic
- Urine samples from foley should only be obtained via port using vacutainer

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BMC Perineal Care (peri-care) Protocol for Patients with Urinary Catheters

- Cleanse visible soiling from perineal and inguinal areas with soap and water.
- Always wipe catheter away from urethral meatus
- Females: wipe from front to back
- Males with foreskin: remember to pull back foreskin gently, clean glans, then return foreskin to normal position

Peri-Care (Med/Surg)

- CASTILLE SOAP TOWELETTES
- FEMALE- 5-6 WIPES
- MALE- 3 WIPES



Peri-Care STEPDOWN/ICU

- USE chlorhexidine gluconate (CHG) WIPES for cleansing catheter



Best Practices for Maintaining Indwelling Catheters

Assess IC necessity daily; must meet BMC criteria, consider using alternatives

√ Provide daily catheter (peri) care with wipes or soap & water

√ Always use Foley securing device to secure catheter

√ Use flexiseal (if appropriate) to manage stool incontinence

√ Keep bag below level of bladder to prevent backflow

√ Keep tubing unobstructed and drainage bag off the floor

√ Empty collection bag prior to patient transport to another department, testing or procedural area

√ Use separate collecting container for each patient

√ Do not allow the draining spigot to touch collecting container

BOSTON MEDICAL CENTER

HAI Surveillance – NHSN Definitions

- **CLABSI:** central line in >2 calendar days (day of insertion is day 1) and positive blood culture with no other recognized source (ex: UTI, GI Infection, pneumonia)
  - Some cases meet NHSN definition but are not *true* CLABSIs. Unfortunately, we still need to report if we cannot attribute the bloodstream infection to another source.
  - How can we prevent false-positive CLABSIs? Do *not draw BCs from central line!*
  - Good specimen collection technique!!!
  - Dressing changes and site assessment

Protect your Lines



SwabCaps (Orange)

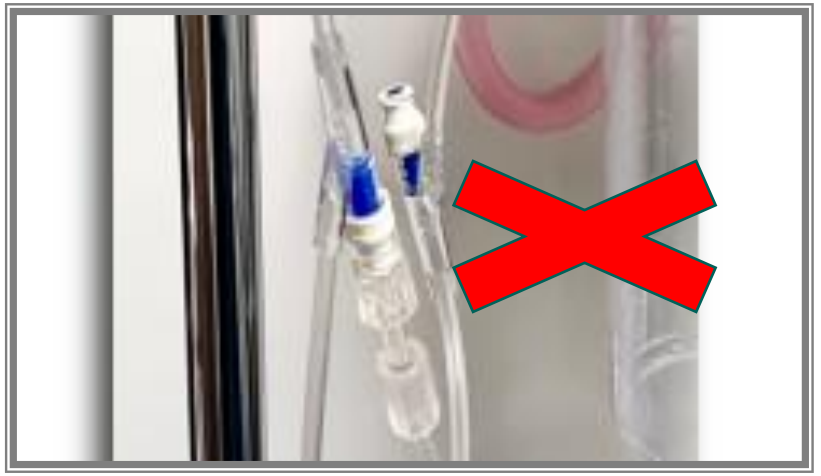
Disinfecting caps for all needle-free connectors and ports



SwabTips(Red)



- Use antiseptic caps on all saline/heparin locked
- Cap all IV tubing
- and line ports when not in use.
- Caps help reduce infection risk.
- **Still scrub the hub** before each access — caps do not replace this step.



NO LOOPING

- A practice of attaching the exposed end of IV Tubing to a port on the same tubing

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CLABSI PREVENTION











CHG WASH

- CHG bath/shower pre-insertion
- Daily CHG baths to every patient with central line and midline
- ICU/stepdown-CHG wipes twice a day

CHG PREP PADS

- **Scrub perimeter** (2-3 cm) of central line dressing for **30 seconds**
- **Scrub** catheter hub & tubing -for **15 seconds**

CATHETER MAINTENANCE

- Scrub the hub with alcohol before each port entry
- Flush each lumen every shift
- Change Dressing every 7 days
- Change IV tubing every 96 hours
- Disinfectant IV caps after use

BOSTON MEDICAL CENTER

DO NOT FLUSH WIPES

Help protect our plumbing and

prevent costly backups

- **Only toilet paper should flushed**
- **All wipes-even those labeled “flushable”- must be disposed of in the trash**

Flushing wipes can cause

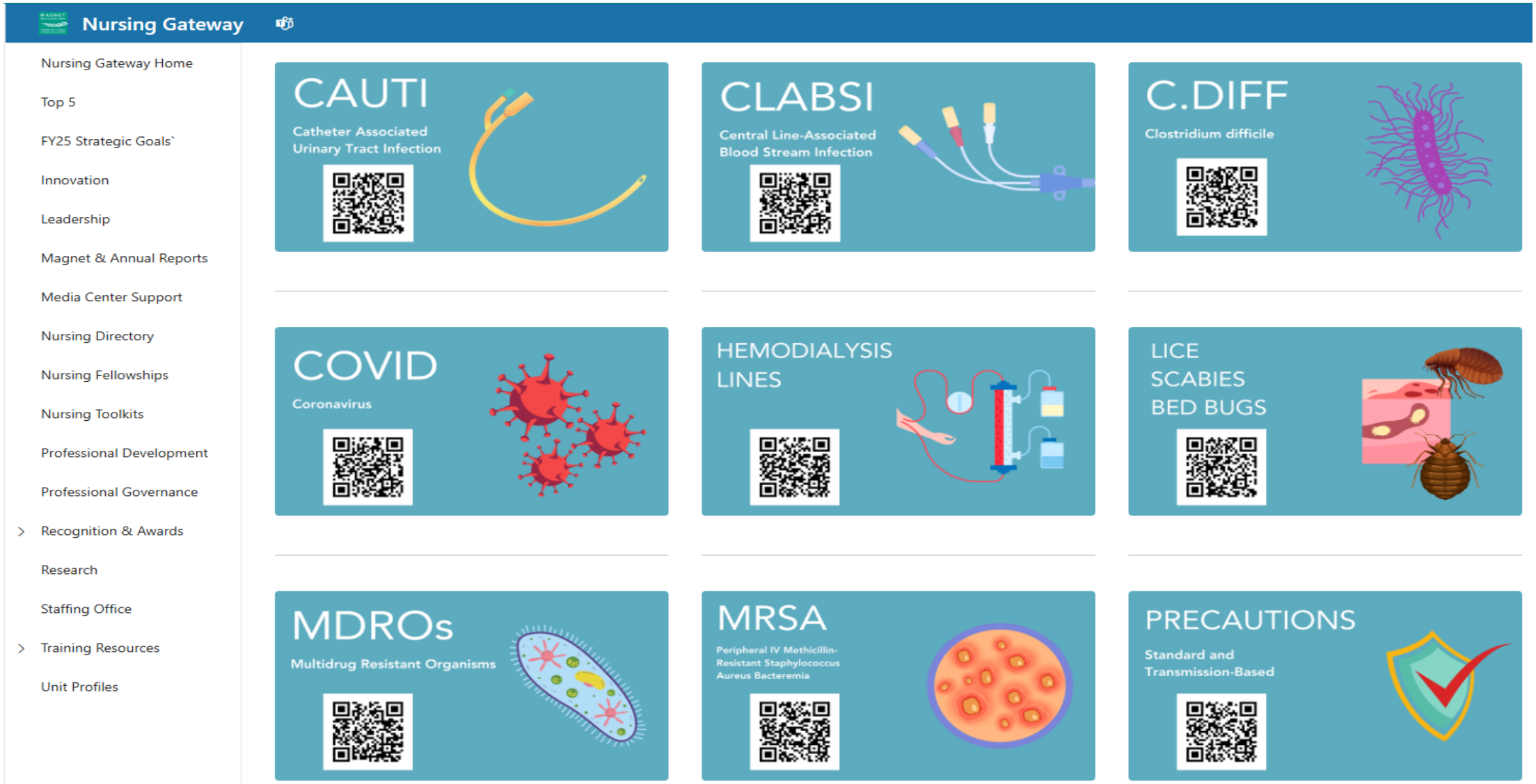
- **Clogged toilets and pipes**
- **Flooding and water damage**
- **Increased repair costs**

Please use the waste bin

Together we can keep our facilities safe, clean and functional

BOSTON MEDICAL CENTER

ONE PAGER TIP SHEET- QR CODES



BOSTON MEDICAL CENTER

Safe Medication Practices

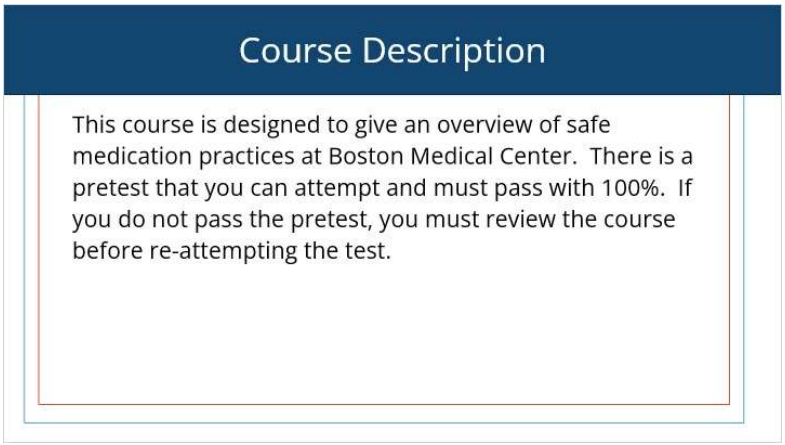
1. Home

1.1 Home



Notes:

1.2 Course Description

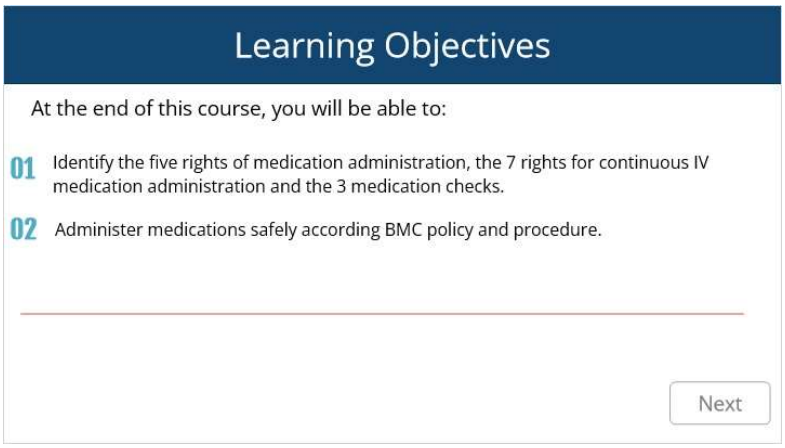


Notes:

1.3 Learning Objectives



Hidepretestlayer (Slide Layer)



1.4 Introduction



1.5 Nursing Practice and Medication Errors

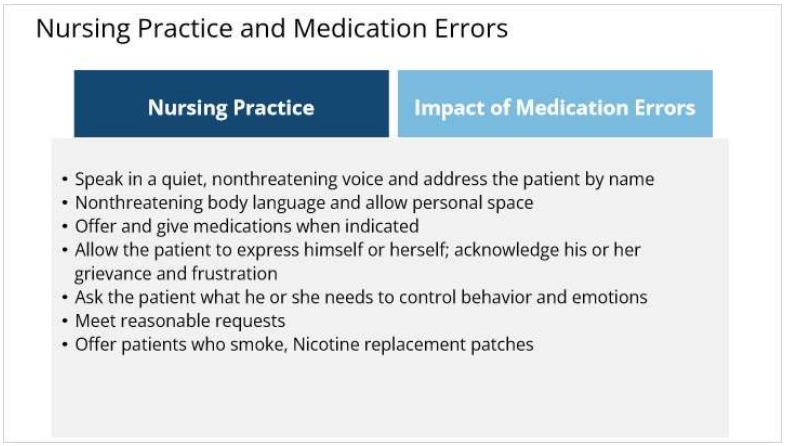


Notes:

Early Signs (Slide Layer)



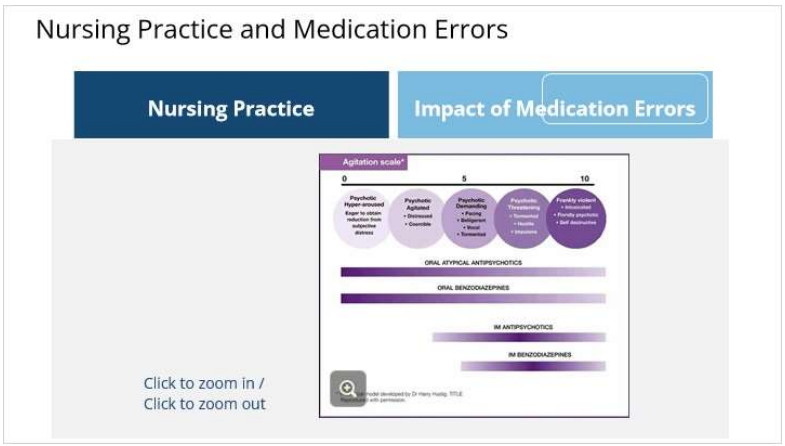
Interventions (Slide Layer)



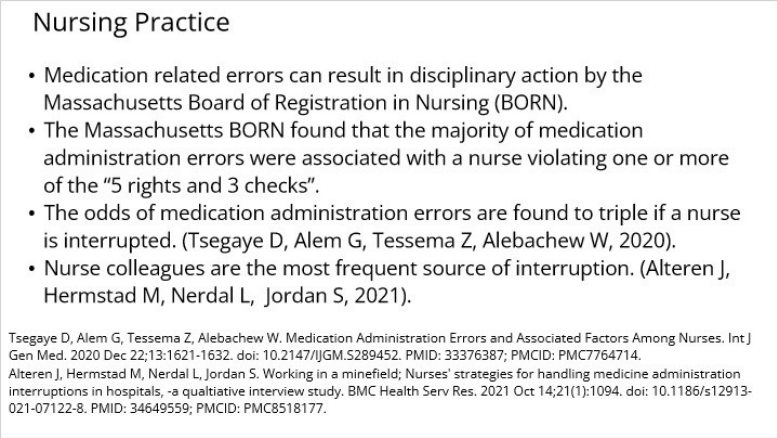
Reminder (Slide Layer)



Agitation Scale (Slide Layer)

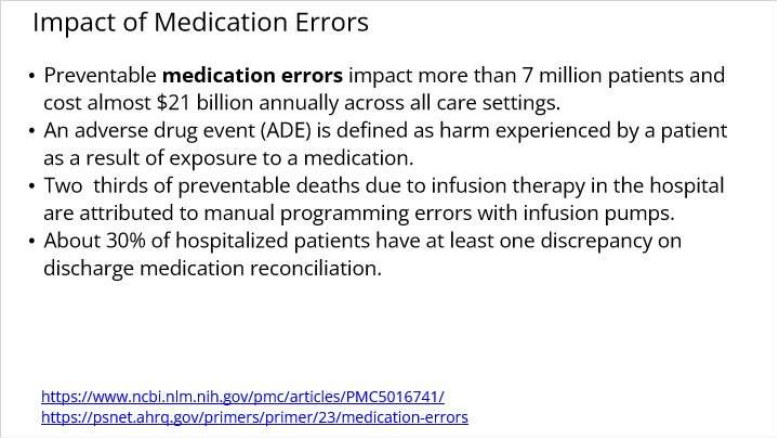


1.6 Nursing Practice



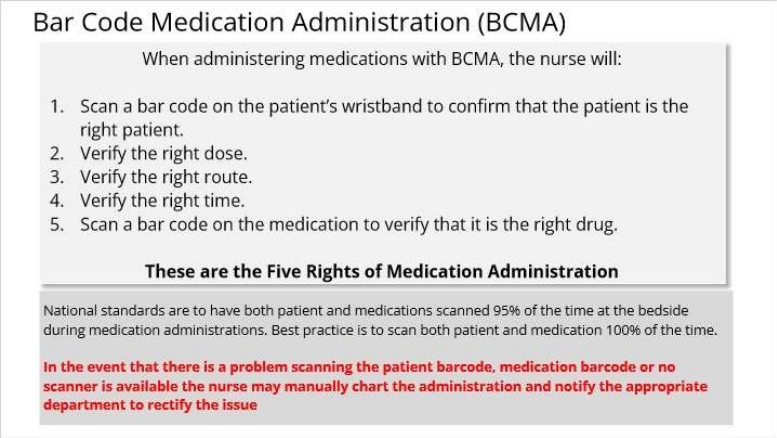
Notes:

1.7 Impact of Medication Errors



Notes:

1.8 Bar Code Medication Administration (BCMA)

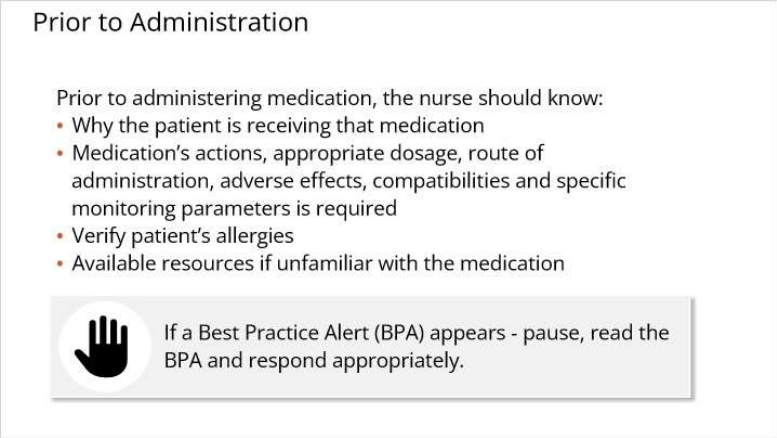


Notes:

1.9 Medication Administration

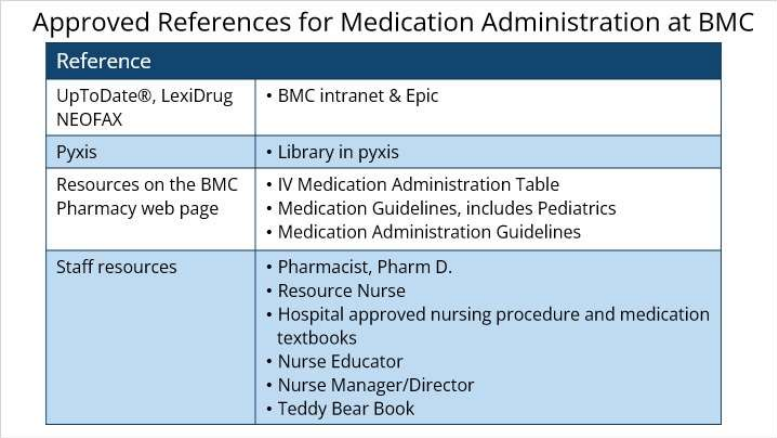


1.10 Prior to Administration



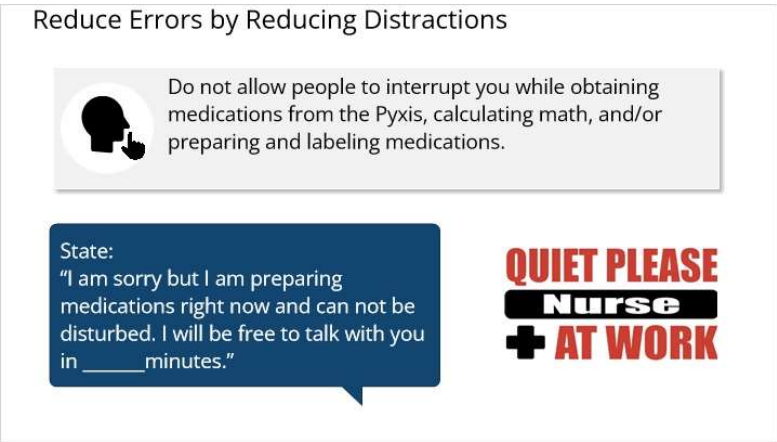
Notes:

1.11 Approved References for Medication Administration at BMC



Notes:

1.12 Reduce Errors by Reducing Distractions



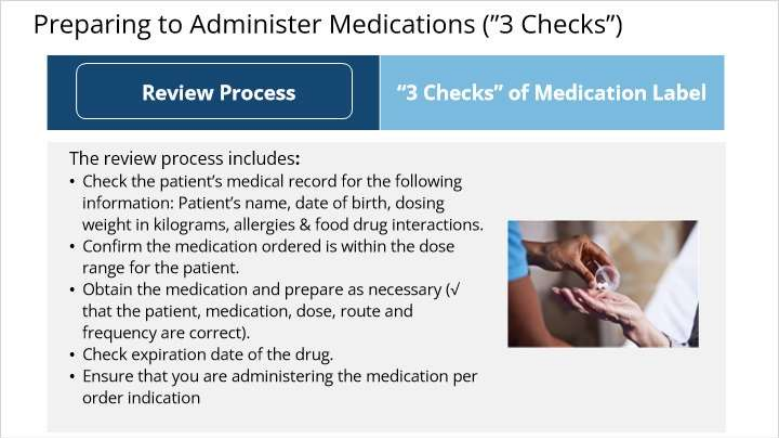
Notes:

1.13 Preparing to Administer Medications ("3 Checks")

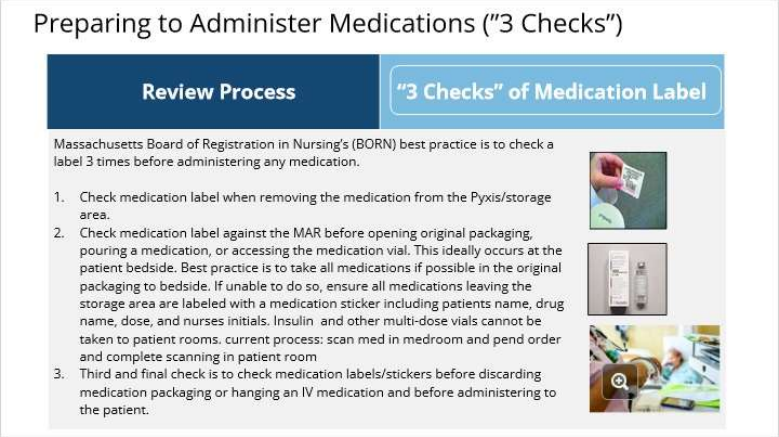


Notes:

Review Process (Slide Layer)



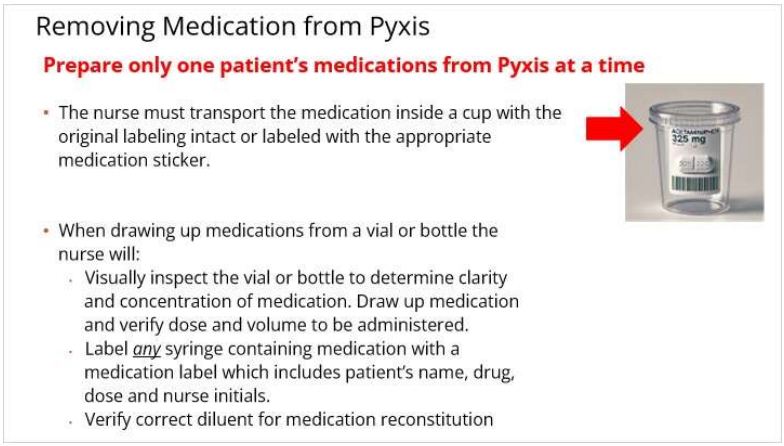
3 Checks (Slide Layer)



Reminder (Slide Layer)

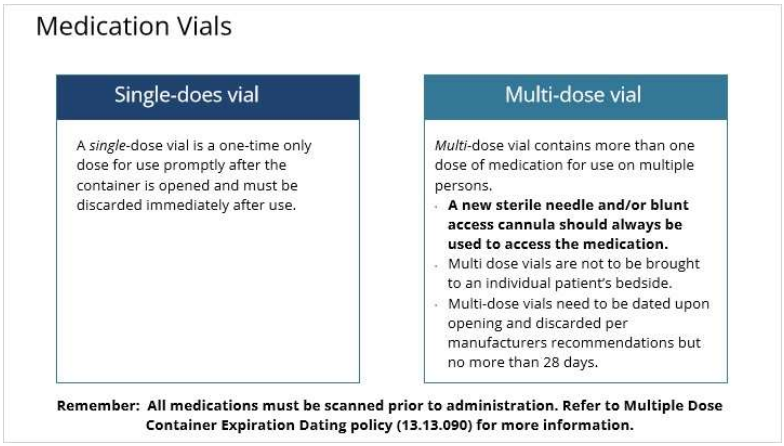


1.14 Removing Medication from Pyxis



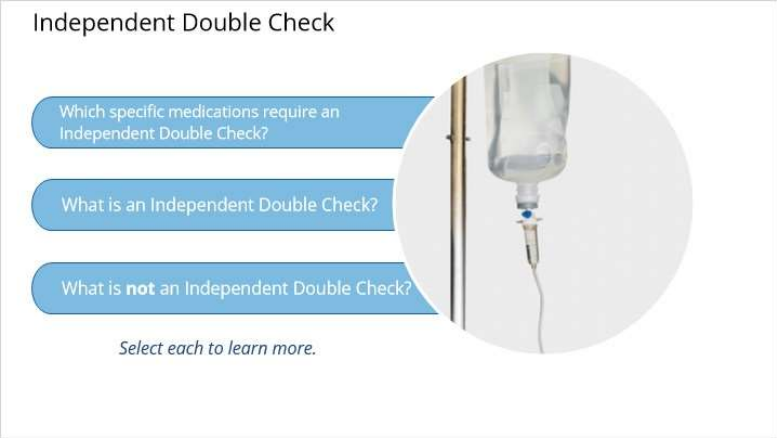
Notes:

1.15 Medication Vials

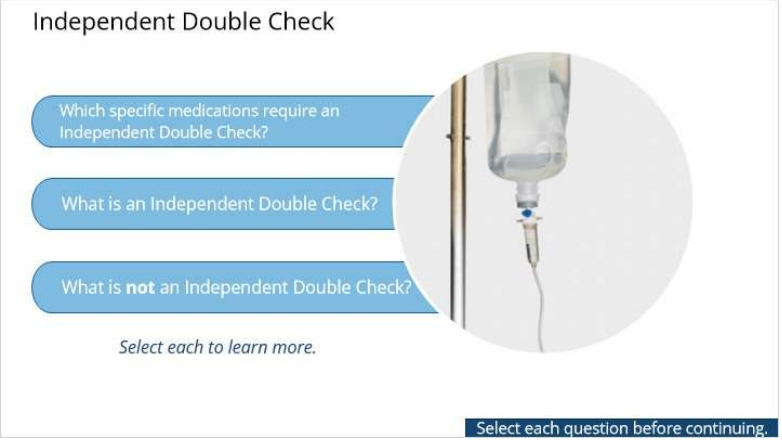


Notes:

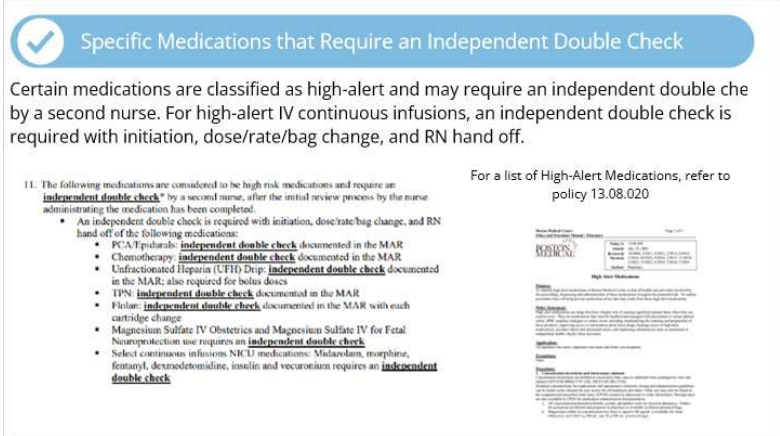
1.16 Independent Double Check



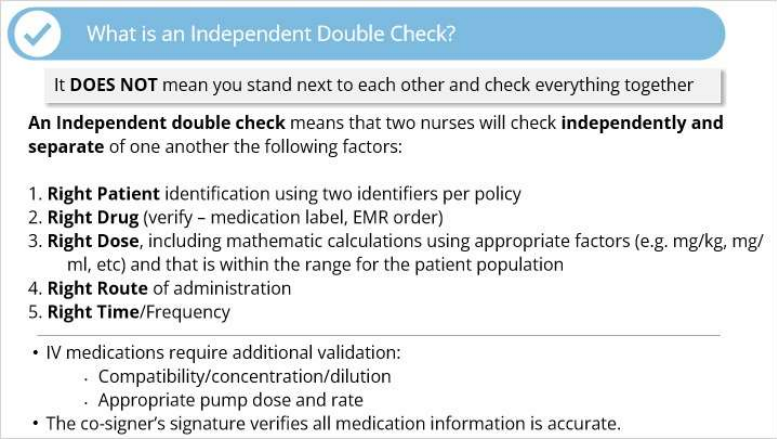
reminder (Slide Layer)



1.17 Specific Medications that Require an Independent Double Check



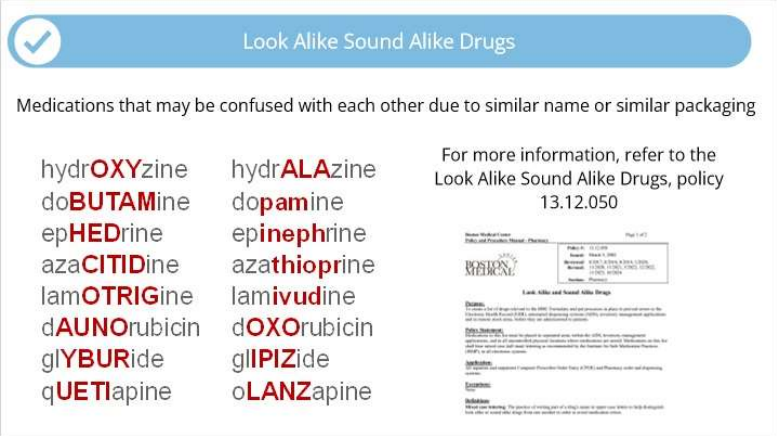
1.18 What is an Independent Double Check?



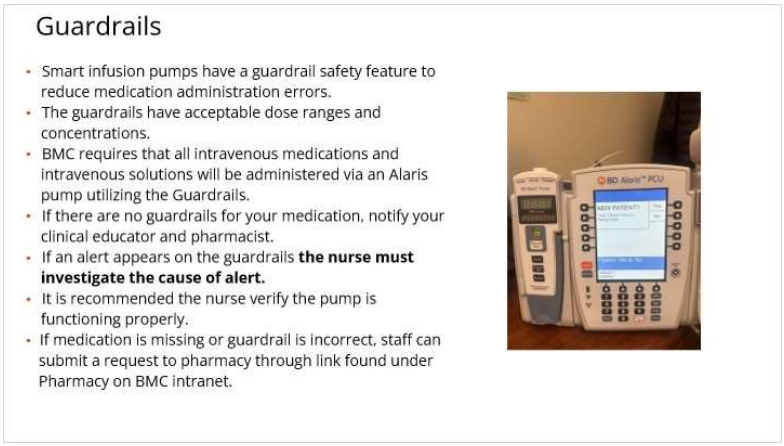
1.19 What is NOT an Independent Double Check?



1.20 Look Alike Sound Alike

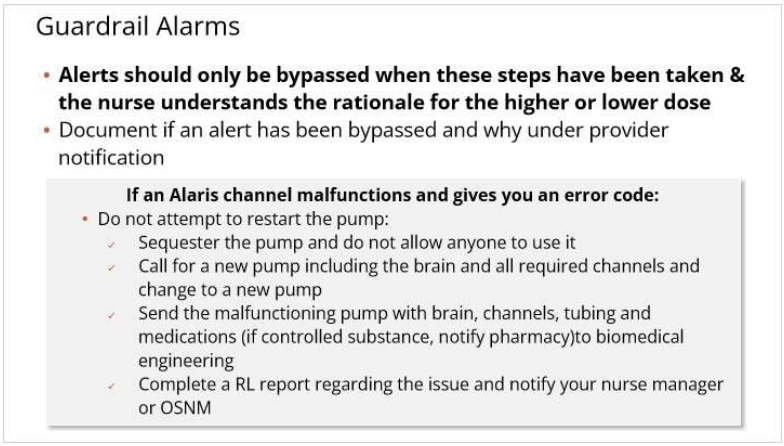


1.21 Guardrails



Notes:

1.22 Guardrail Alarms



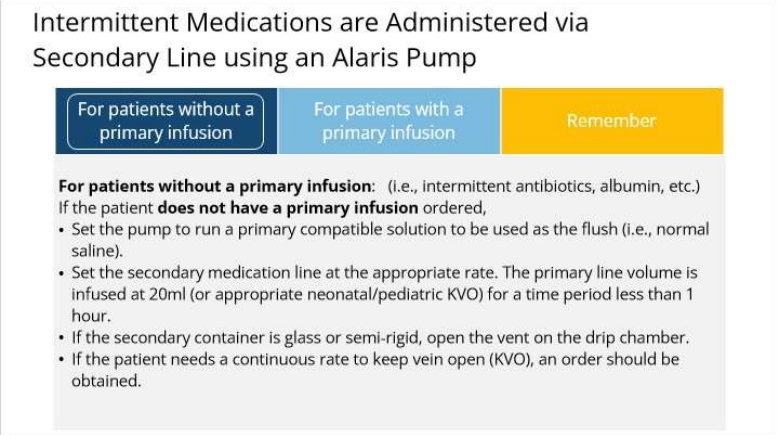
Notes:

1.23 Intermittent Medications are Administered via Secondary Line using an Alaris Pump

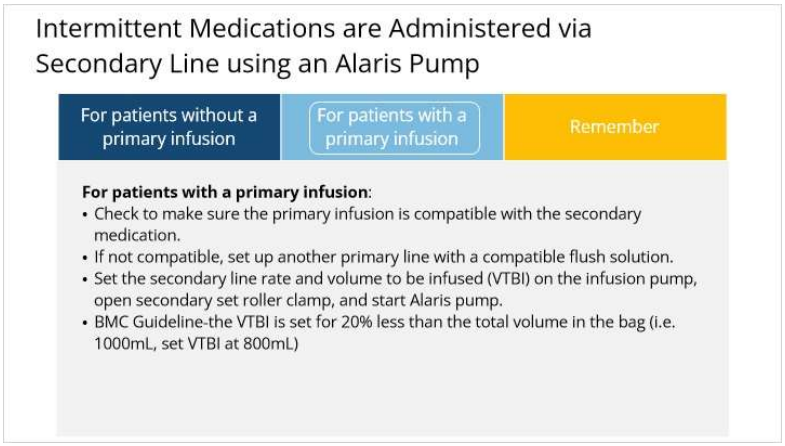


Notes:

For patients w/o (Slide Layer)



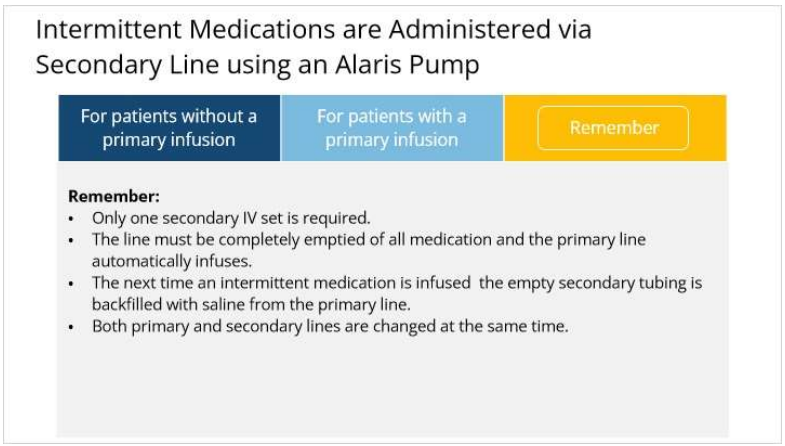
For patients with (Slide Layer)



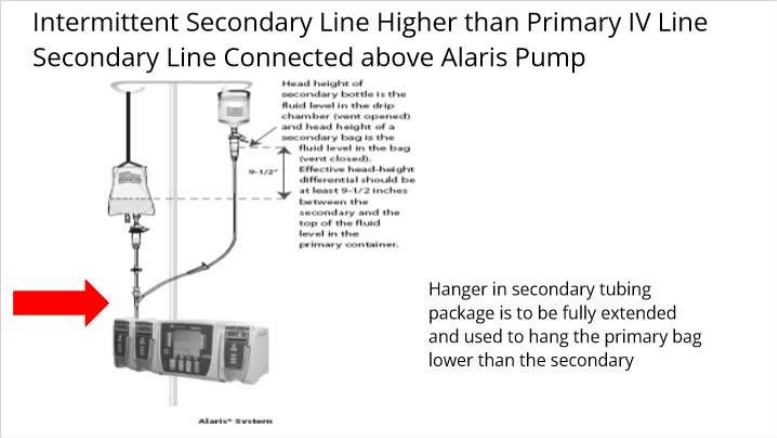
Reminder (Slide Layer)



Remember (Slide Layer)

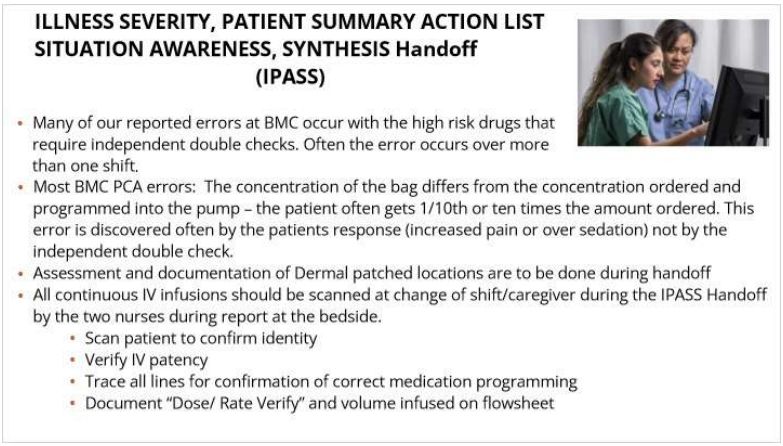


1.24 Intermittent Secondary Line Higher than Primary IV Line



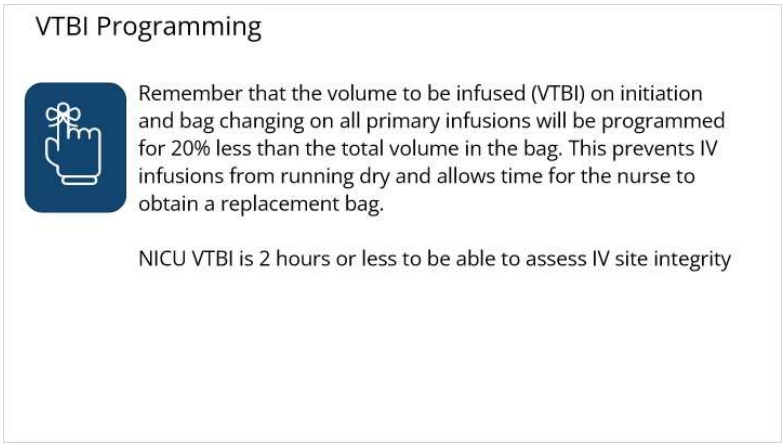
Notes:

1.25 ILLNESS SEVERITY, PATIENT SUMMARY ACTION LIST SITUATION AWARENESS, SYNTHESIS Handoff (IPASS)



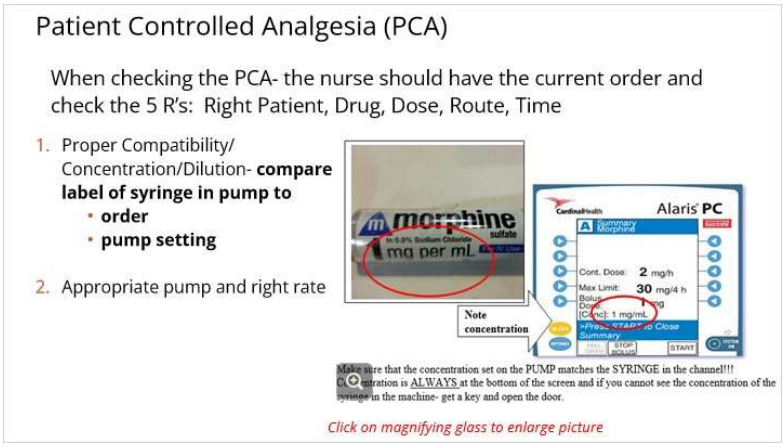
Notes:

1.26 VTBI Programming



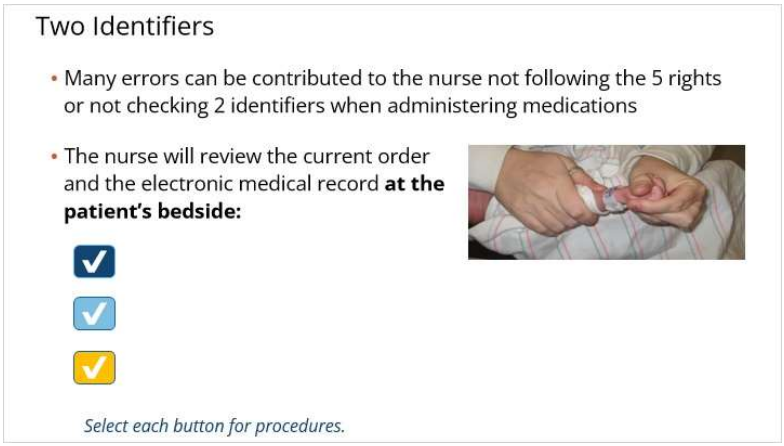
Notes:

1.27 Patient Controlled Analgesia (PCA)



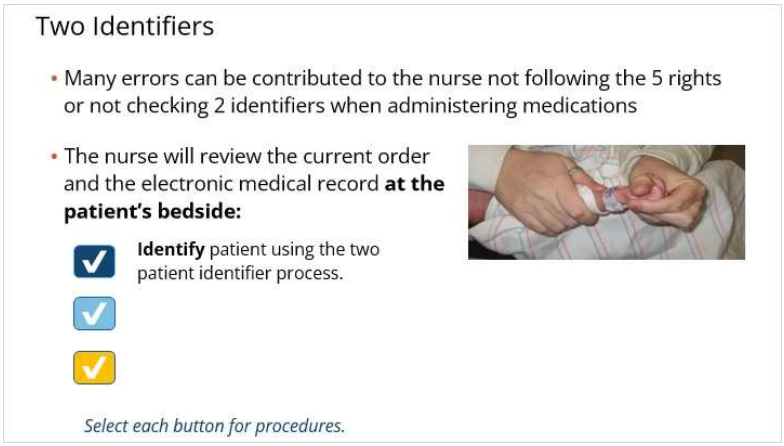
Notes:

1.28 Two Identifiers

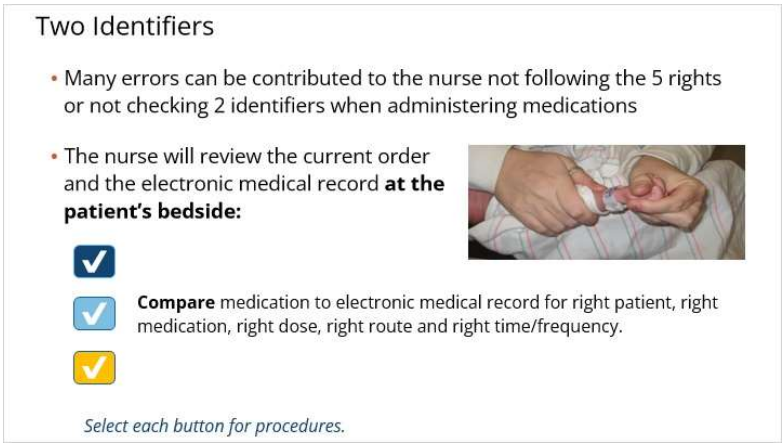


Notes:

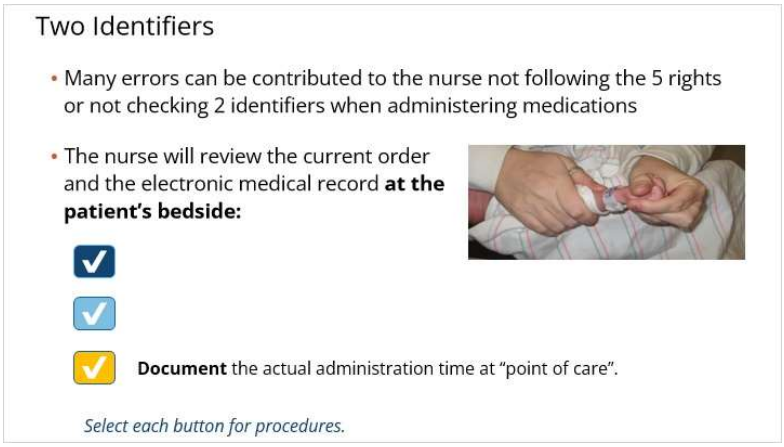
1. identify (Slide Layer)



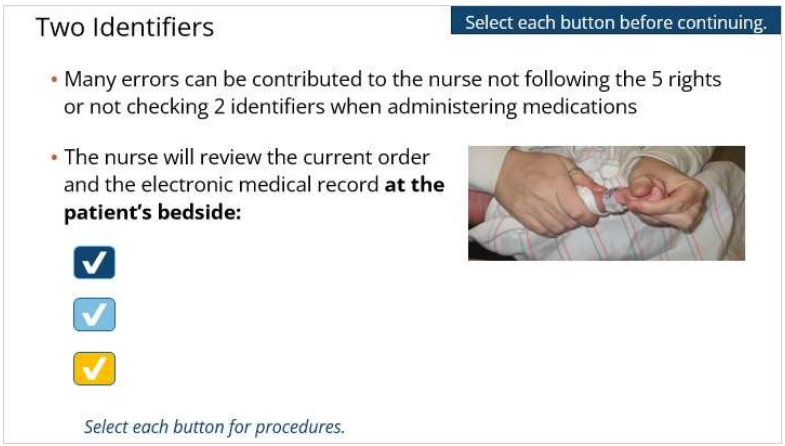
2.Compare (Slide Layer)



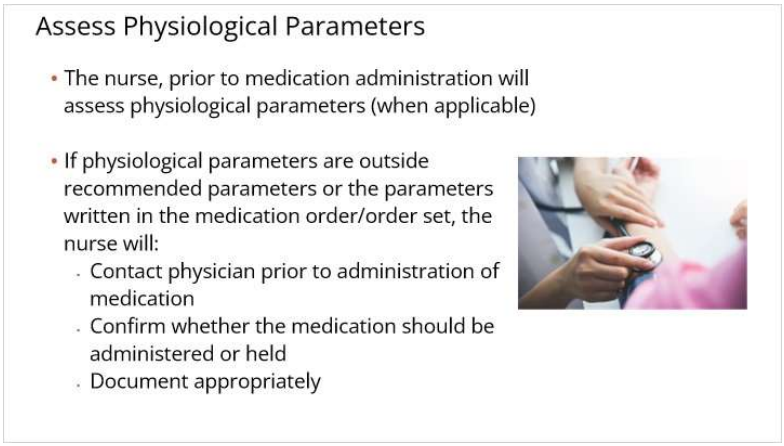
3 document (Slide Layer)



reminder (Slide Layer)

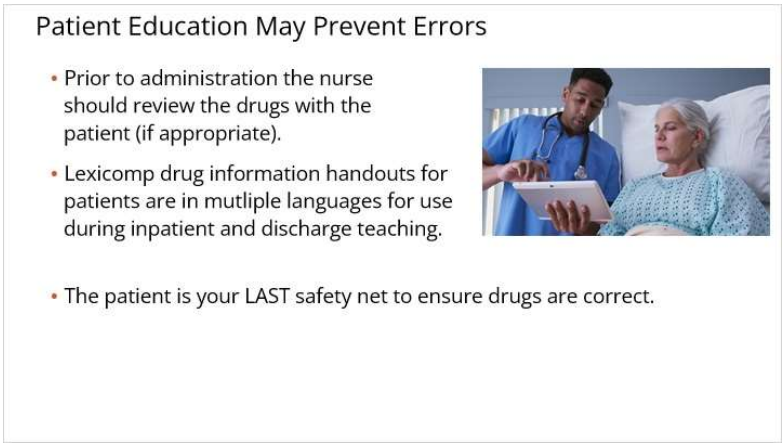


1.29 Assess Physiological Parameters



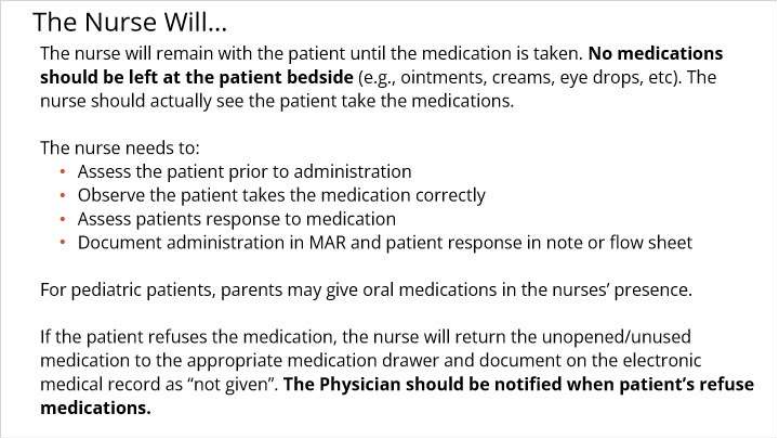
Notes:

1.30 Patient Education May Prevent Errors



Notes:

1.31 The Nurse Will...



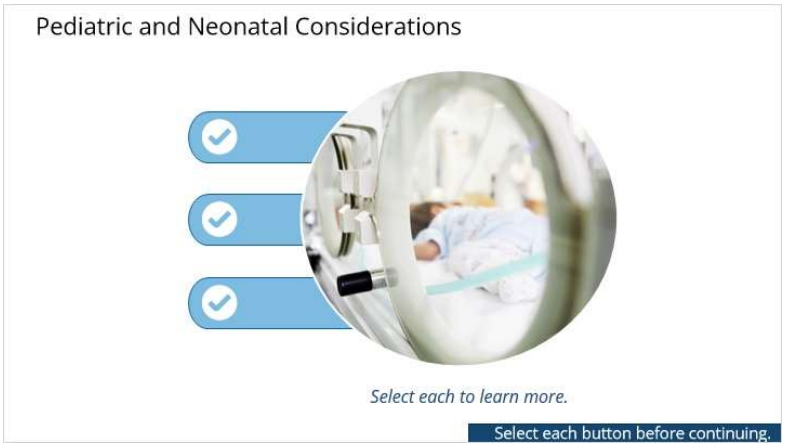
Notes:

1.32 Pediatric and Neonatal Considerations

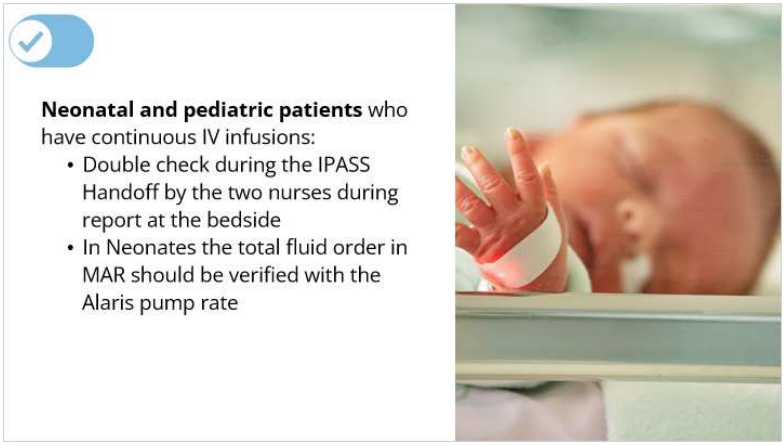


Notes:

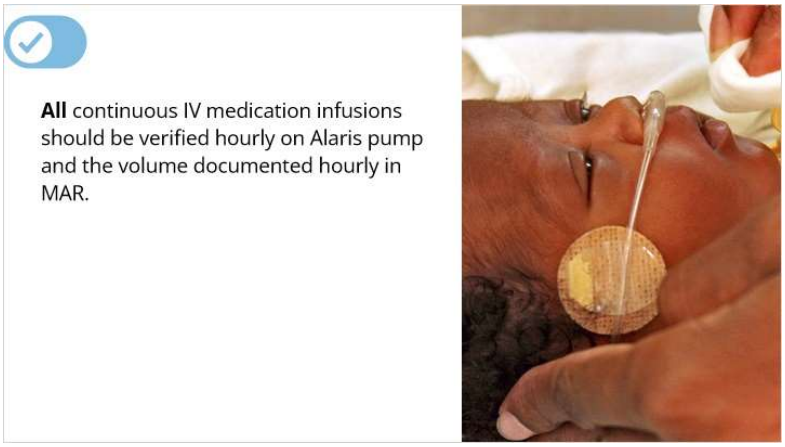
reminder (Slide Layer)



1.33 Neonatal 2



1.34 All continous IV



1.35 Unused Narcotics, Waste, and Disposal of Medications

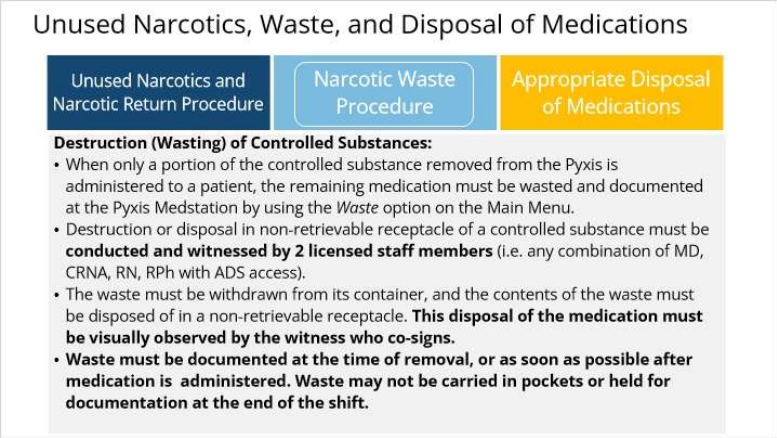


Notes:

Unused (Slide Layer)



Narcotic Waste (Slide Layer)



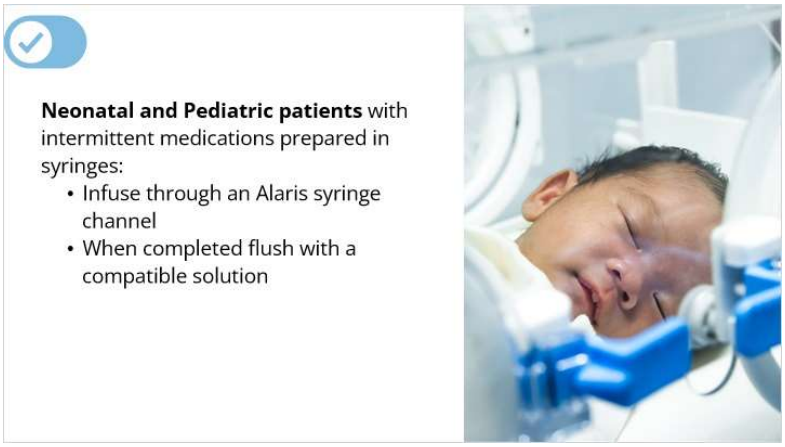
Reminder (Slide Layer)



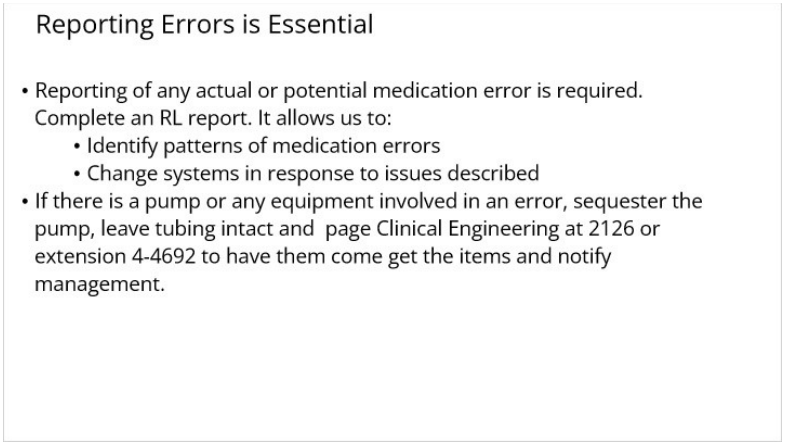
Appropriate Disposal (Slide Layer)



1.36 Neonatal 1



1.37 Reporting Errors is Essential



1.38 Our Patients Thank You



Notes:

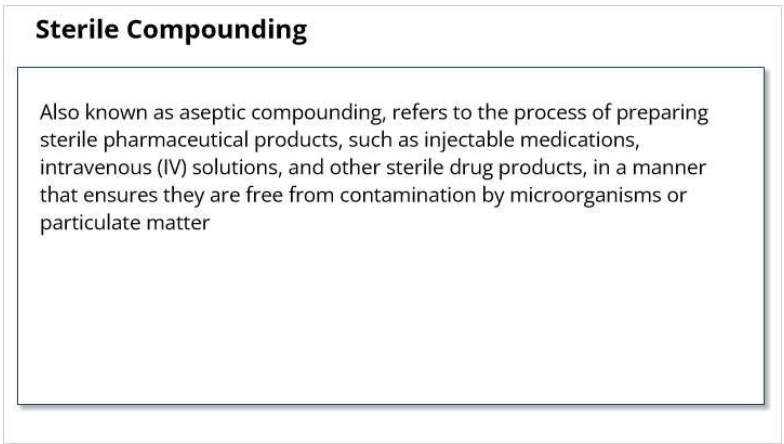
2. IV Sterile Compounding

2.1 IV Sterile Compounding



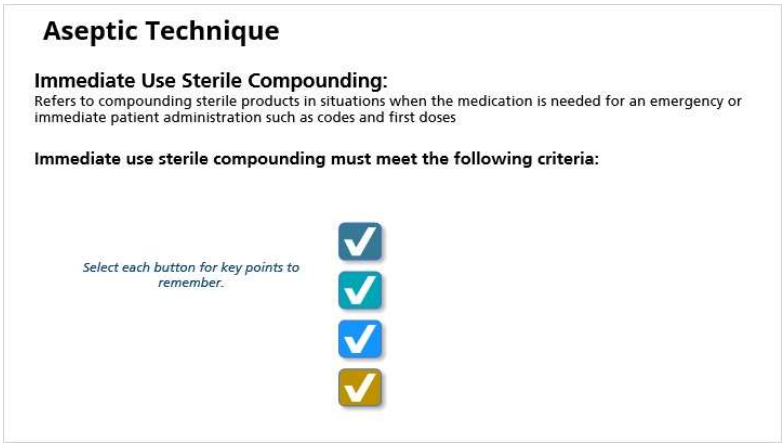
Notes:

2.2 Sterile Compounding



Notes:

2.3 Asptic Technique



Criteria 1 (Slide Layer)

Aseptic technique is followed

Next

Criteria 2 (Slide Layer)

Labeling with all required information

Next

Criteria 3 (Slide Layer)

Administration must begin no later than 4 hours following the start of the preparation of the compounding

- If administration has not begun within 4 hours following the start of preparation, the compounded product ***must*** be discarded

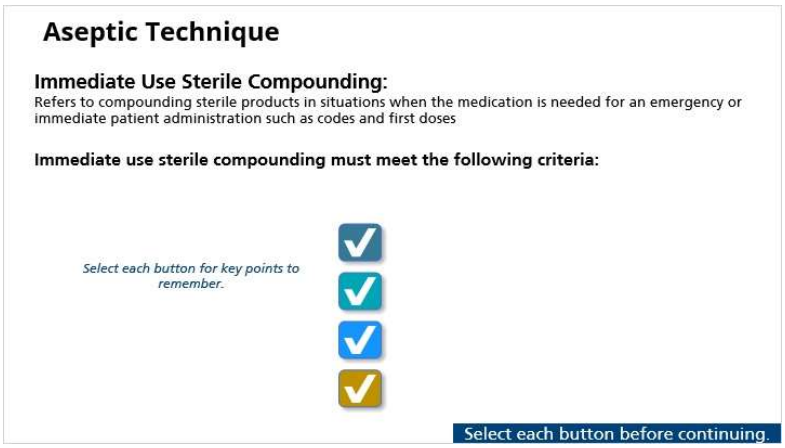
Next

Criteria 4 (Slide Layer)

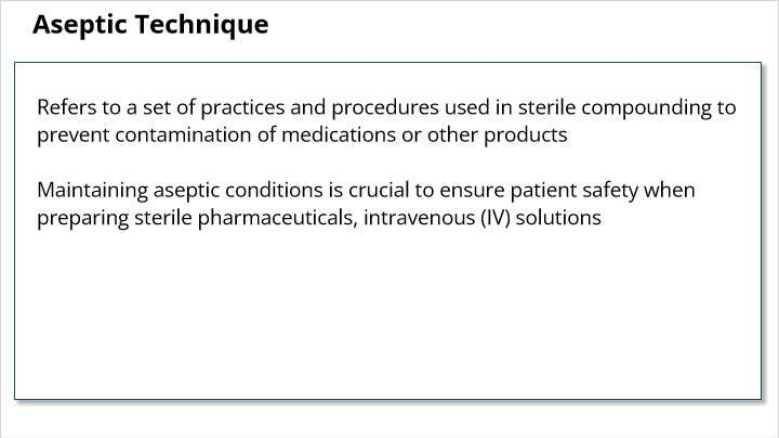
Vials used in preparation must be discarded after use

Next

Reminder (Slide Layer)



2.4 Sterile Compounding



Notes:

2.5 Take Aways

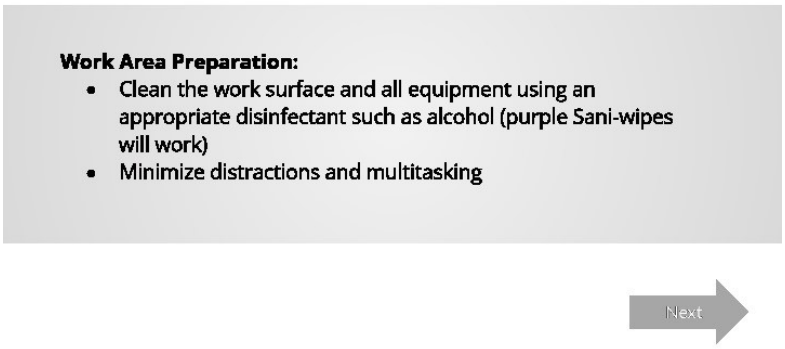


Notes:

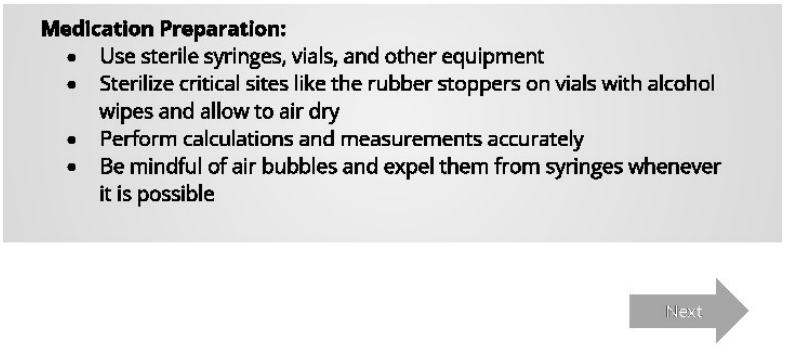
Tab 01 (Slide Layer)



Tab 02 (Slide Layer)



Tab 03 (Slide Layer)



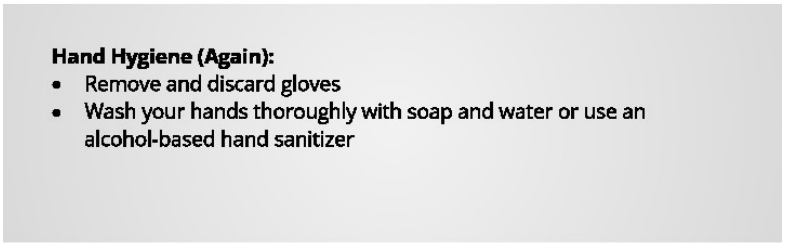
Tab 04 (Slide Layer)



Tab 05 (Slide Layer)



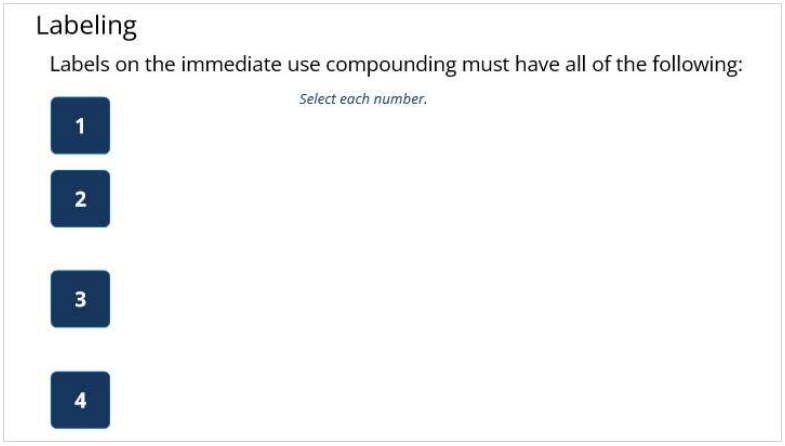
Tab 06 (Slide Layer)



Reminder (Slide Layer)

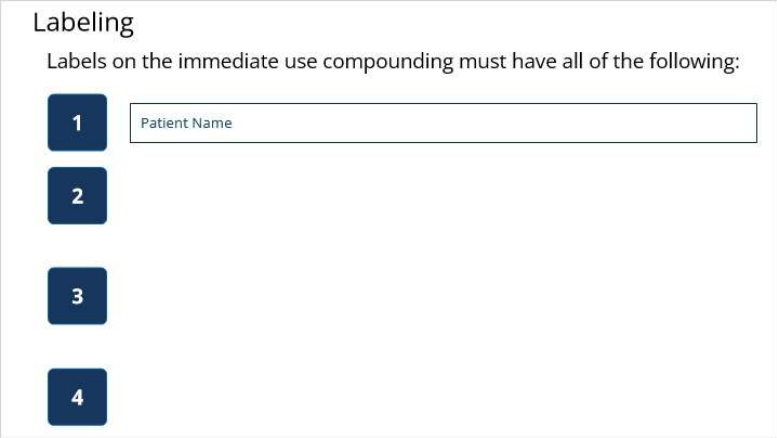


2.6 Labeling

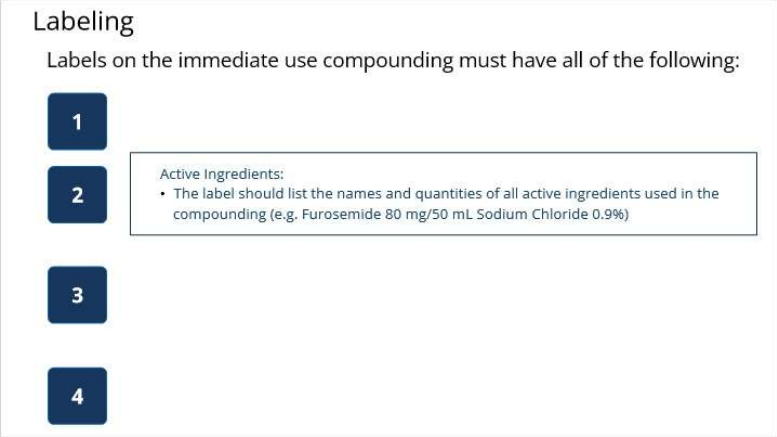


Notes:

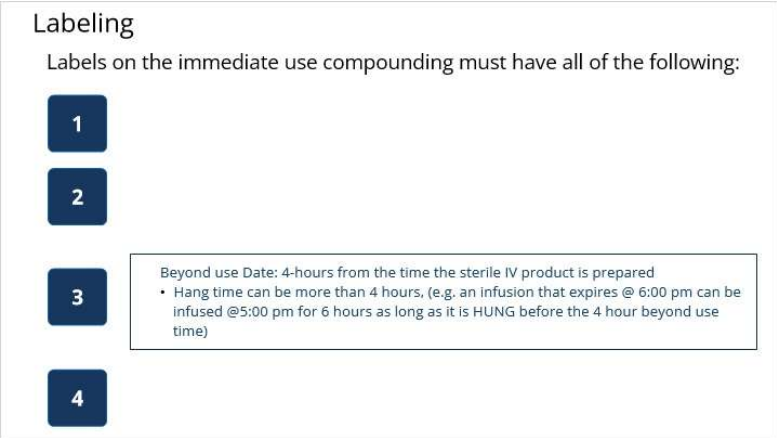
1 (Slide Layer)



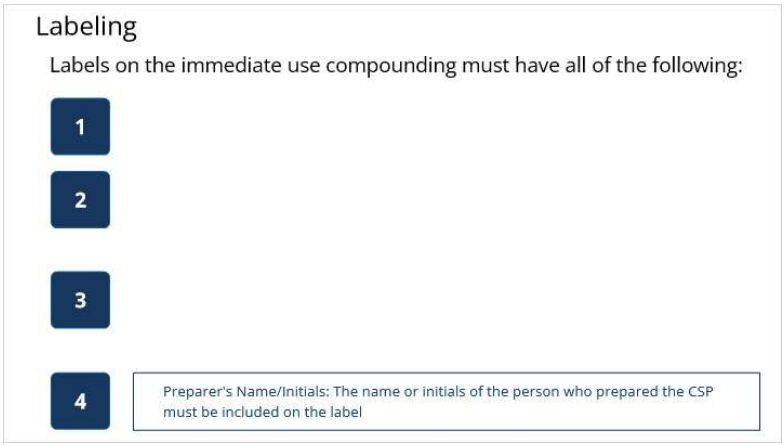
2 (Slide Layer)



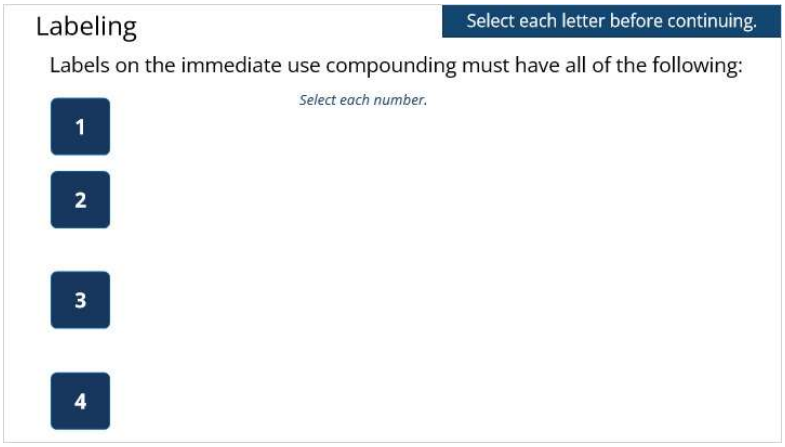
3 (Slide Layer)



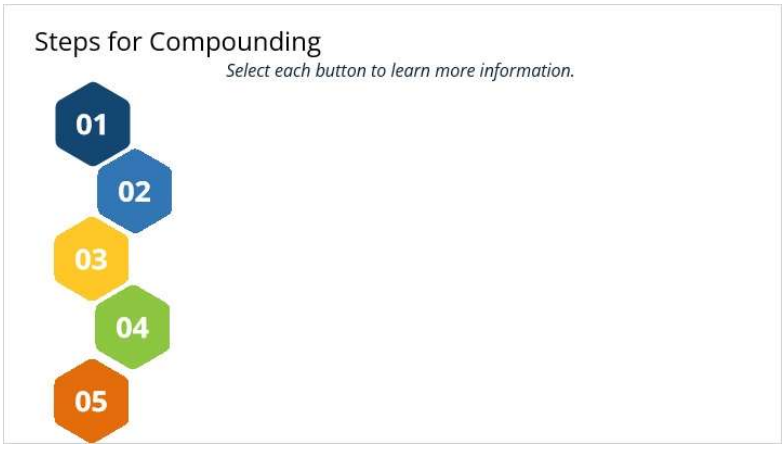
4 (Slide Layer)



reminder (Slide Layer)

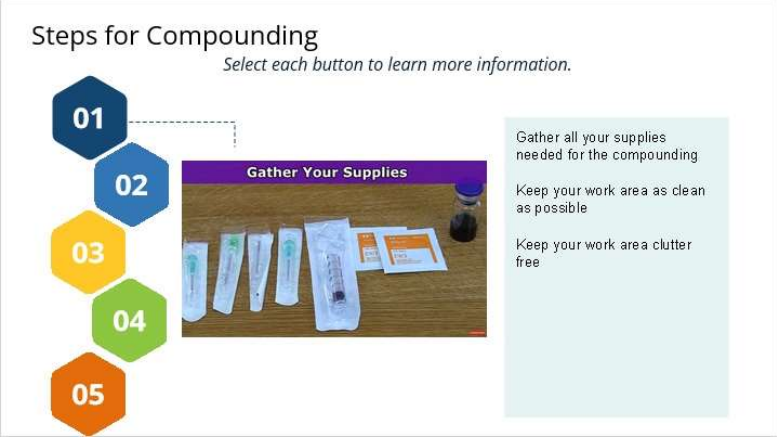


2.7 Steps for Compounding



Notes:

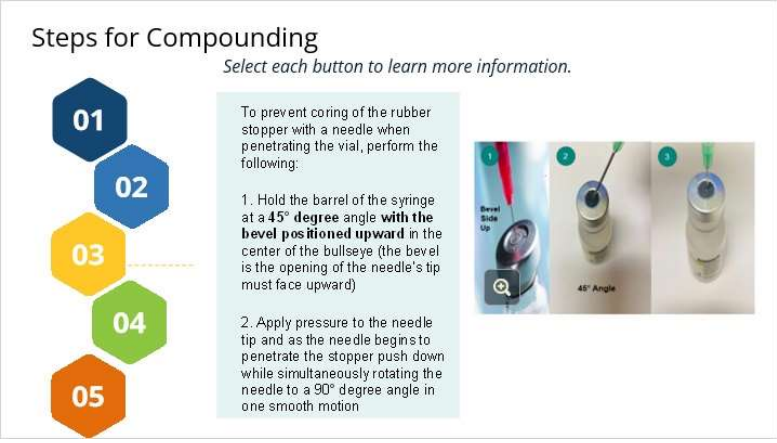
Layer 01 (Slide Layer)



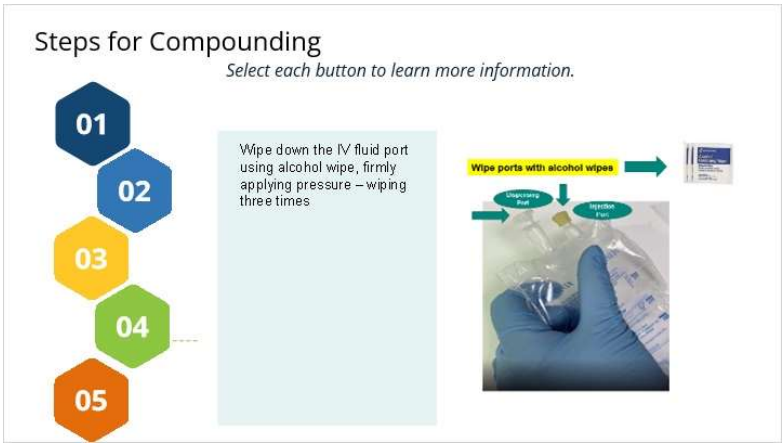
Layer 02 (Slide Layer)



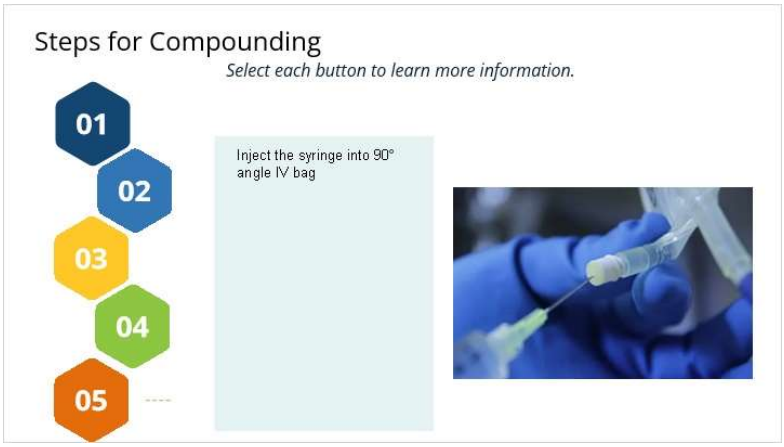
Layer 03 (Slide Layer)



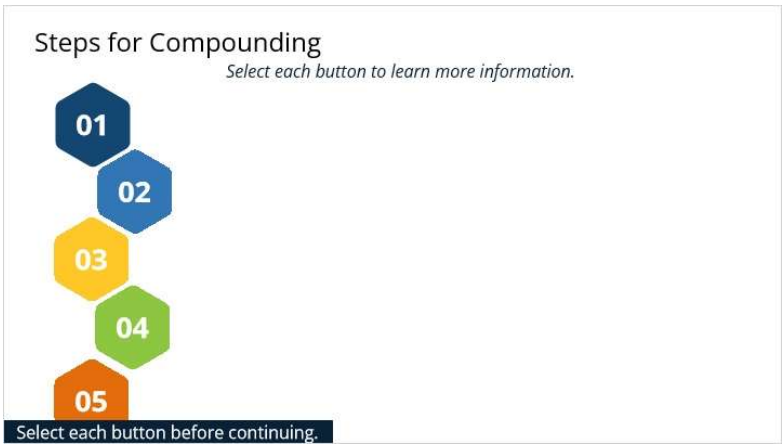
Layer 04 (Slide Layer)



Layer 05 (Slide Layer)

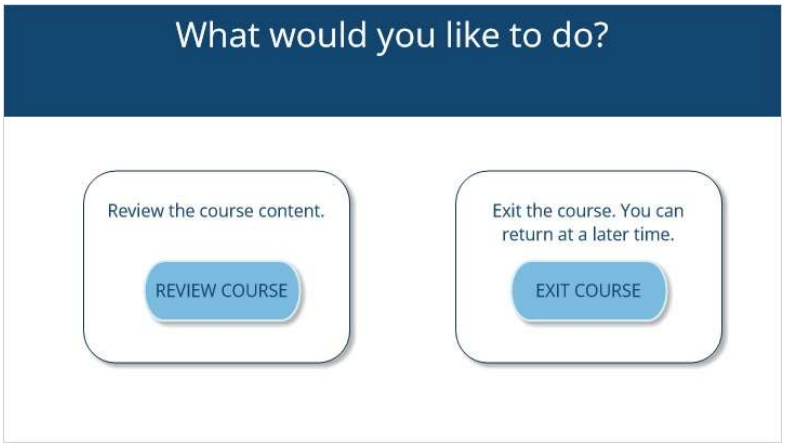


Reminder (Slide Layer)



3. Untitled Scene

3.1 Thank you



Notes:

Comprehensive Stroke Center Education for New Hire RNs - 2025

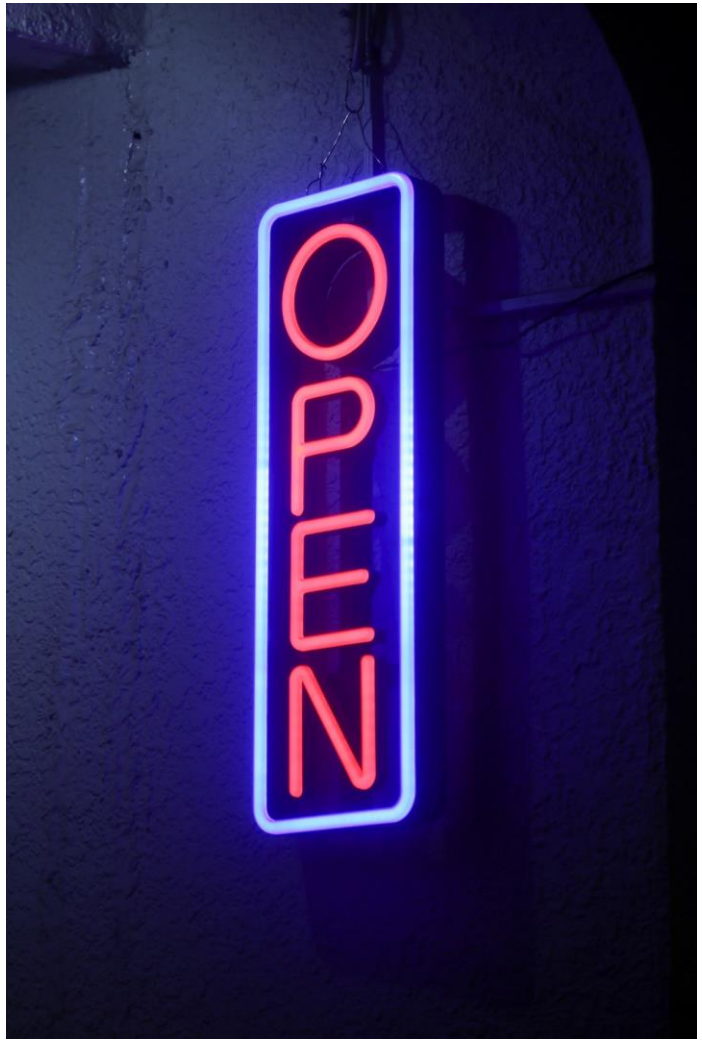
Boston Medical Center
HEALTH SYSTEM

Introduction & Objectives

- ✓ Understand the role of the Comprehensive Stroke Center
- ✓ Understand common types of Stroke, signs & symptoms, and risk factors
- ✓ Understand how to call a Code Stroke
- ✓ Understand the treatment options for Stroke
- ✓ Understand the importance of documentation
- ✓ Understand how Stroke affects quality of life and the challenges a Stroke presents
- ✓ Understand the importance of patient-specific, disease-specific education and stroke prevention in our patient population

What is a Comprehensive Stroke Center?

	Primary Stroke Centers	Comprehensive Stroke Centers
PATIENT CARE	Stabilize and treat most cases of acute ischemic stroke.	Cares for all types of stroke patients, both ischemic and hemorrhagic and including complex cases requiring advanced technology, specialized diagnosis and higher levels of treatment.
ADVANCED IMAGING	No advanced imaging (such as CT angiography, CT perfusion or transcranial doppler) required.	24/7 access to advanced imaging including CT angiography, CT perfusion, or transcranial doppler required.
ENDOVASCULAR INTERVENTION	Not required.	24/7 access to endovascular interventions such as mechanical thrombectomy for acute ischemic stroke, aneurysm coiling, and arteriovenous malformation embolization.
NEUROCRITICAL CARE	No requirement for a separate neuroscience ICU.	Dedicated neuroscience intensive care unit staffed 24/7 with neurocritical care experts.
NEUROSURGERY	Access to neurosurgery within 2 hours.	On-site neurosurgical providers available 24/7 to perform complex neurovascular procedures, such as aneurysm clipping, AVM resection, and carotid endarterectomy.
PATIENT TRANSFERS	Sends complex patients and those who require advanced intervention to CSC.	Receives patients from Primary Stroke Centers following stabilization.



Certifications and Program Overview

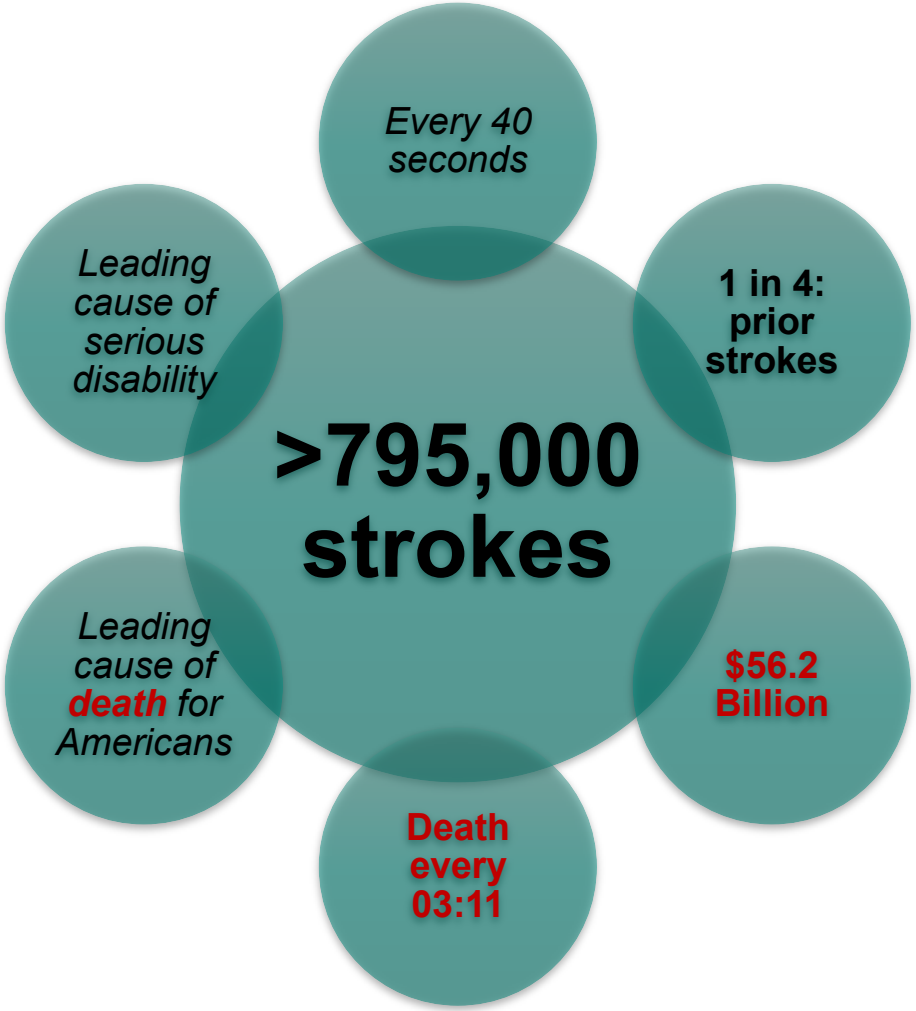
- Joint Commission Certified Comprehensive Stroke Center
- MA DPH/CDC Coverdell Stroke Performance Improvement Pilot
- American Heart Association Get With the Guidelines – Stroke
- Framingham Heart Study
- Clinical Trials
  - ASPIRE, DISCOVERY, CAPTIVA, STEP, Escape Me-VO, and many more!
- Stroke Neurology Team
  - Stroke Directors/Attendings
  - Stroke Fellows and Residents
  - Stroke NPs
  - Stroke Research Team
  - Stroke Nurse Coordinator/Nurse Manager
  - Stroke Nurse Navigator



Why Do You Need to Know About Strokes?

Boston Medical Center
HEALTH SYSTEM

Annual Stroke Statistics: United States



Stroke Risk Factors

Modifiable

- High Blood Pressure: 3.5x
- Atrial Fibrillation: 4-10x
- Physical Inactivity
- Overweight/Obesity: 1.5x
- High Cholesterol: 1.5x
- Tobacco Exposure: 2x
- Alcohol and Drug Abuse
- Diabetes: 2x

Non-Modifiable

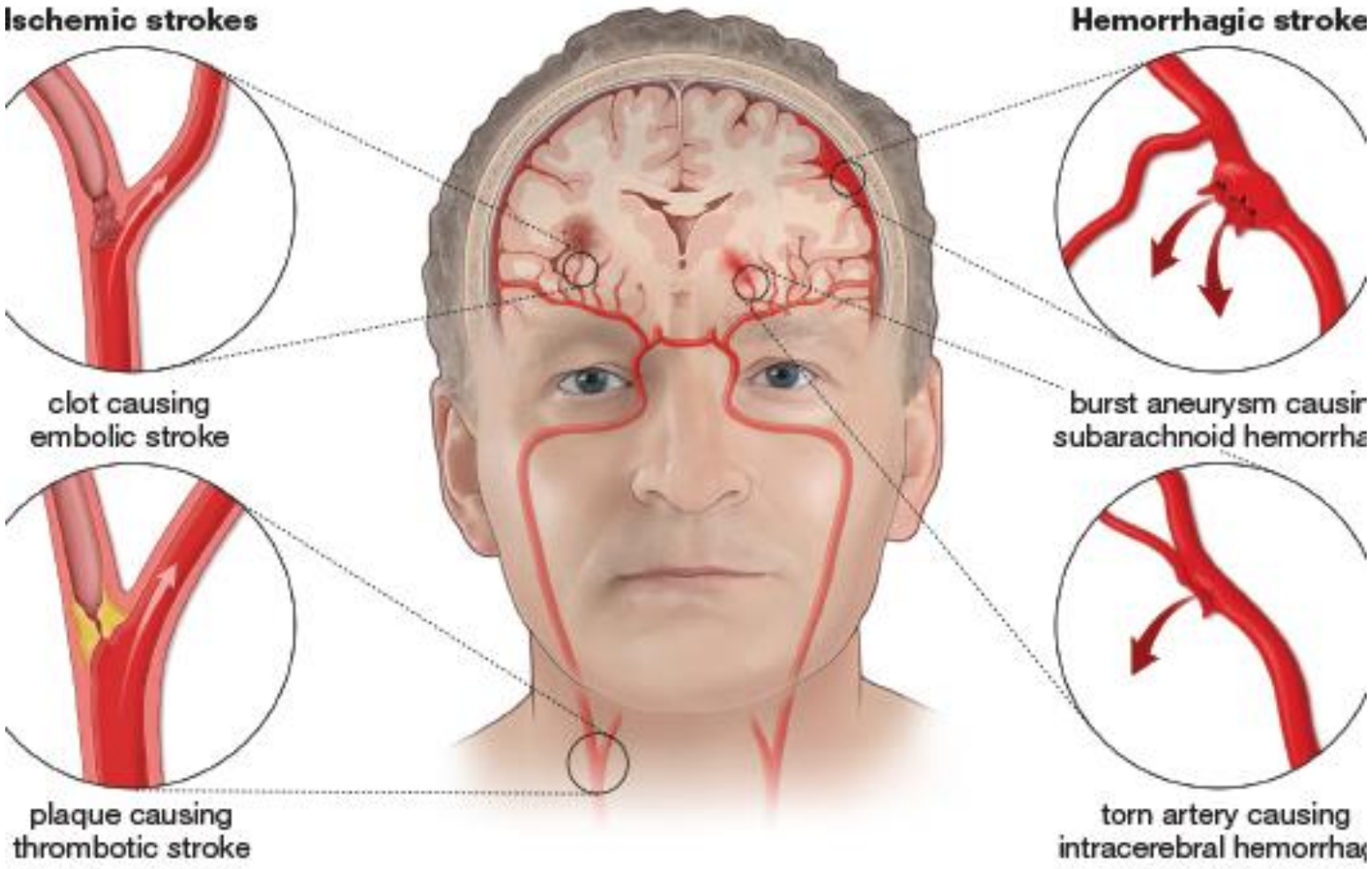
- Previous Stroke or TIA
- Age
- Gender
- Race
- Family History

Common Types of Strokes

Boston Medical Center
HEALTH SYSTEM

Three Types of Stroke

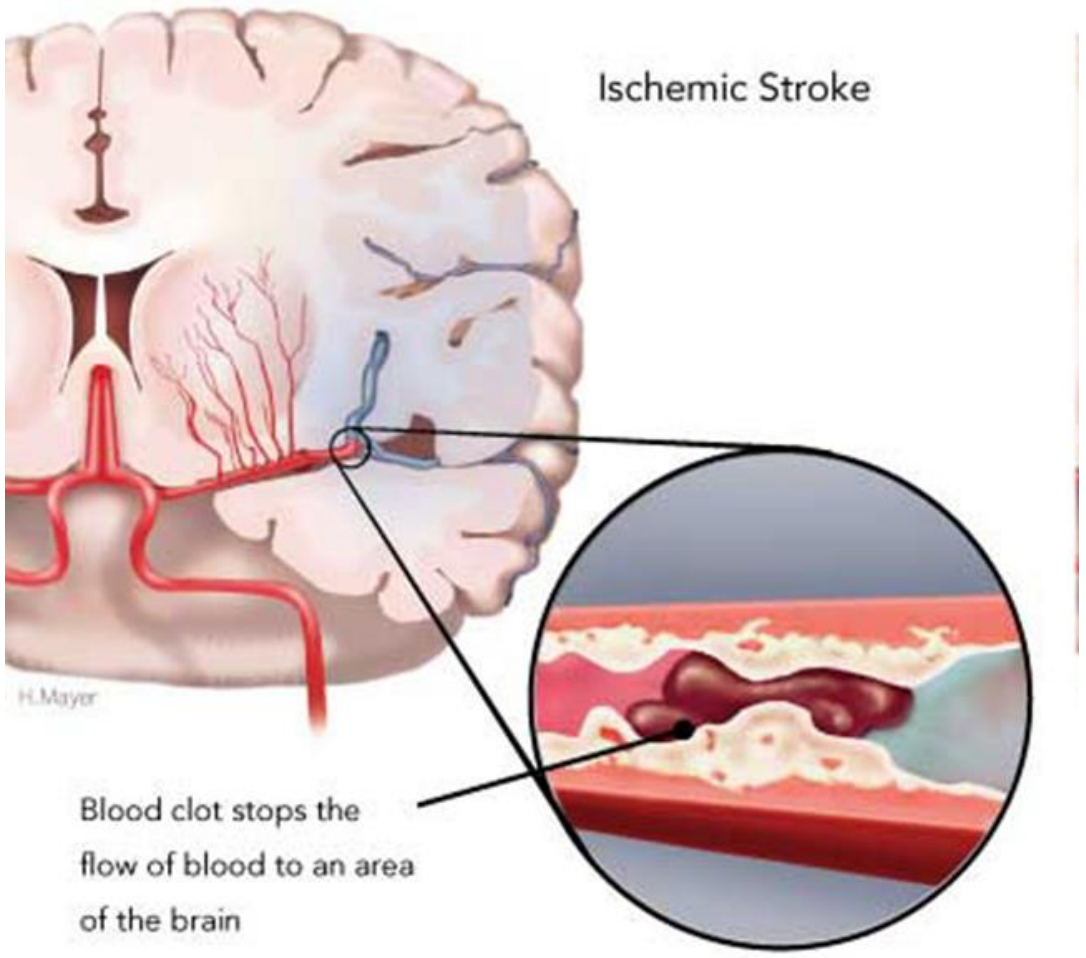
1. Ischemic
2. Hemorrhagic
3. Transient Ischemic Attack (TIA)



Ischemic Stroke: 87% of Strokes

When blood flow through the artery that supplies oxygen-rich blood to the brain becomes blocked.

- Thrombotic
  - Blood clot blocks artery
  - Usually seen in older patients with HTN, high cholesterol and atherosclerosis
- Embolic
  - Embolus (blood clot or cholesterol plaque) travels to artery in brain
  - Atrial fibrillation
- Lacunar
  - Blockage of arterioles
  - Very small ends of arteries penetrate deep in brain

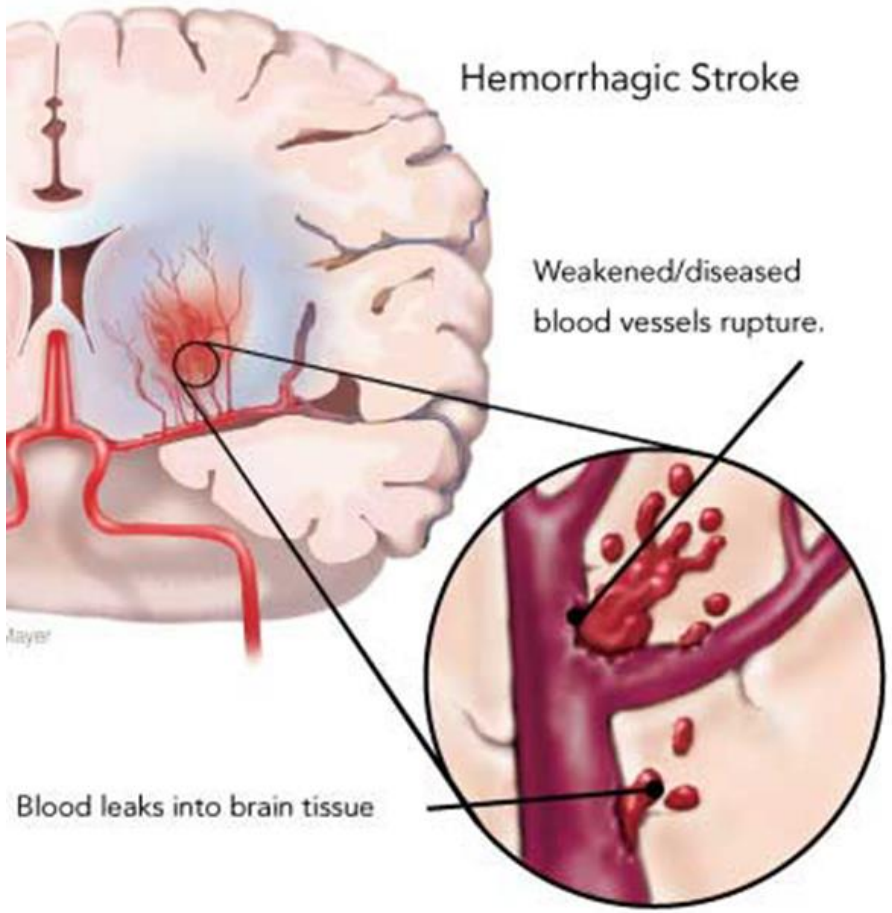


Hemorrhagic Strokes: 13% of Strokes

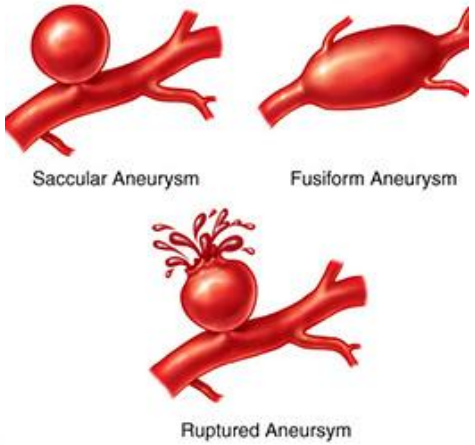
Blood Vessel Ruptures

When an artery in the brain leaks blood or ruptures. The leaked blood puts too much pressure on brain cells, which damages them

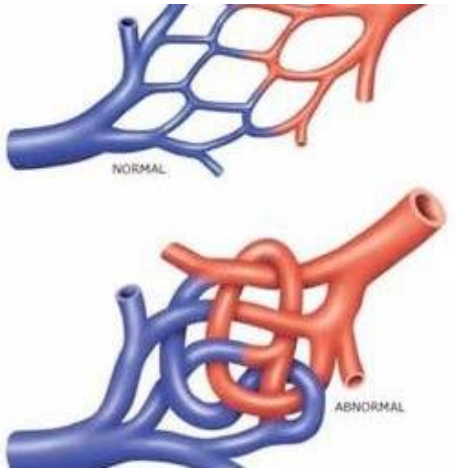
- Intracerebral (ICH)
- Subarachnoid (SAH)



Weakened Blood Vessels



Aneurysms



Arteriovenous Malformation (AVM)

Transient Ischemic Attack (TIA)

- Blood flow to the brain is blocked for only a short time – a few minutes to a few hours
- TIA is a medical emergency and a warning sign; it presents an opportunity to make timely changes that can help save lives in the future



American Heart Association/American Stroke Association. January 2025

NIH Stroke Scale

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NIHSS: National Institute of Health Stroke Scale



- A measure of **stroke severity** with a range of 0 – 42
- The higher the number, the greater the impairment
- NIHSS is done rapidly as initial assessment by Neuro Resident, NP or Fellow and as follow up to assess improvement/decline
- Score ≥12 has 91% predictive positive value of central LVO stroke

0 - 1 Normal

1 - 4 Minor Stroke

5 - 15 Moderate Stroke

15 - 20 Moderately Severe Stroke

> 20 Severe Stroke



The NIHSS is not perfect! A low (1) NIHSS doesn't mean the absence of Stroke! The scale may not capture all stroke signs such as nausea, headache, vertigo or truncal ataxia (disequilibrium)

NIHSS: The Scale

The Scale

1. LOC
2. Best Gaze
3. Visual fields
4. Facial palsy
5. Motor Arm
6. Motor Leg
7. Limb ataxia
8. Sensory
9. Best Language
10. Dysarthria
11. Extinction & Inattention

Visuals Used (New for 2024)



Words & Phrases

You know how.	MAMA
Down to earth.	TIP – TOP
I got home from work.	FIFTY – FIFTY
Near the table in the dining room.	THANKS
They heard him speak on the radio last night.	HUCKLEBERRY
	BASEBALL PLAYER

Stroke Treatments

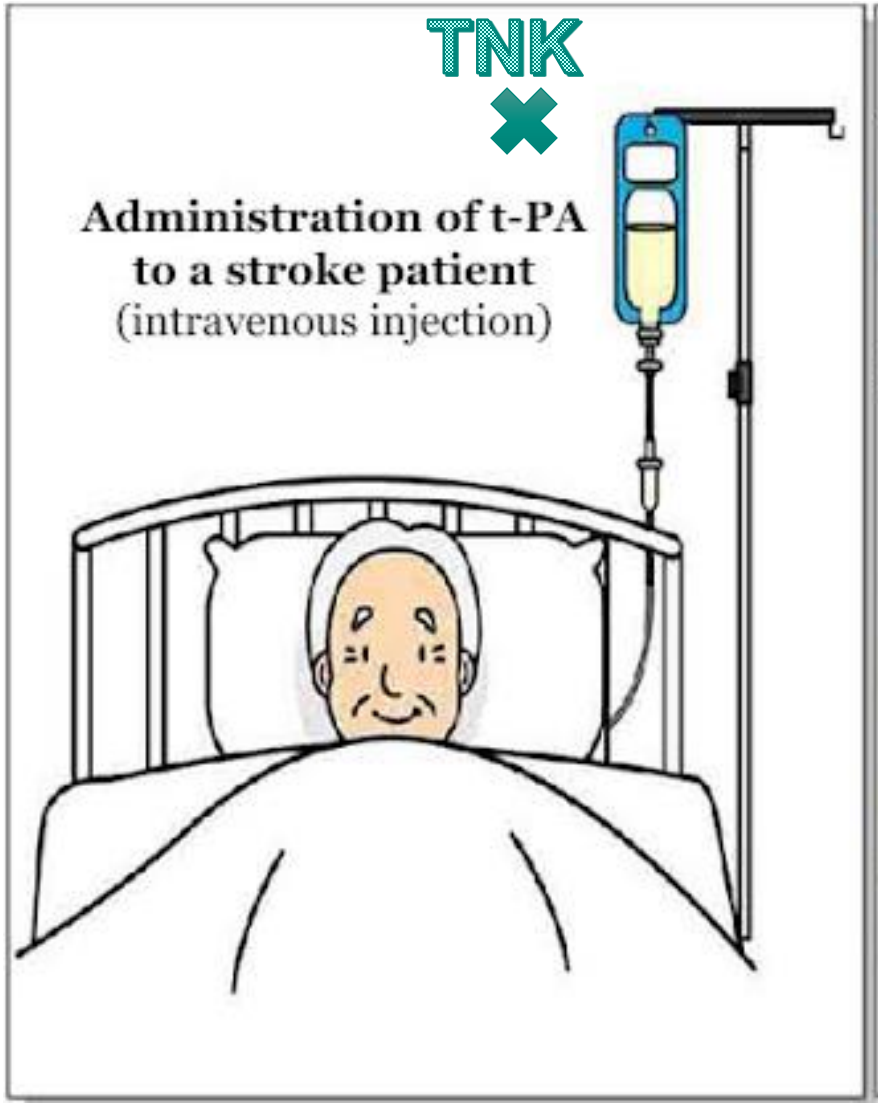
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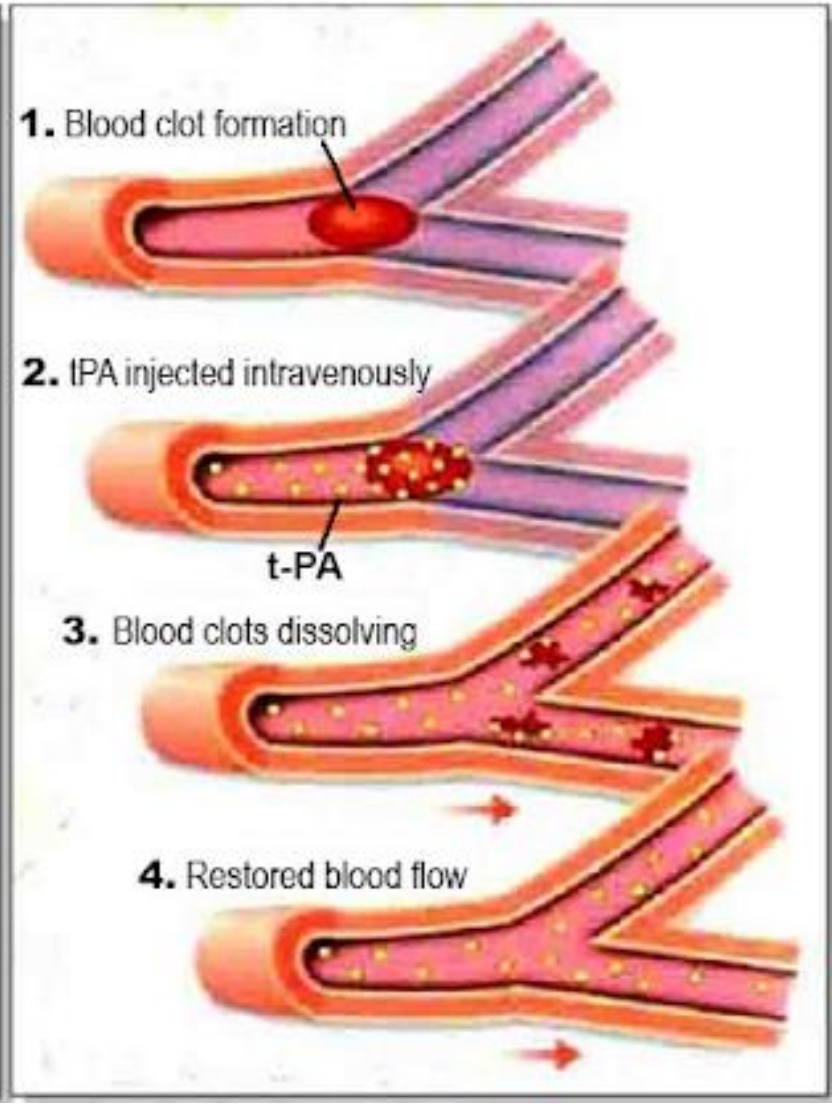
BMC Time Goals

Emergency Department Stroke Care Process Measure Assessment Tool	
Activity	**Time Targets**
Door to notification of Acute Stroke Team (AST), i.e., making the call to the team*	within 5 minutes of arrival
ED physician assesses acute stroke patient	within 5 minutes
Time from notification of AST to response of team member by phone or at patient bedside to assess patient*	within 5 minutes of being called
Pt leaves Trauma Bay to Radiology	within 10 minutes
Door to CT scan or MRI scan	within 15 minutes
Door to CT result	within 25 minutes
Door to completion of chest X-Ray and interpretation – if ordered	within 45 minutes
Door completion of ECG and interpretation- not to delay CT Head	within 45 minutes
Door to completion of labs and results/interpretation	within 25 minutes
Results (labs, CT) to tenecteplase decision time*	Within 5 minutes
ED door-to-needle time for IV thrombolytic (tenecteplase) treatment	within 30 minutes
Neurointerventional/ Neurosurgical intervention	as needed urgently
Door to Puncture for Thrombectomy	60 minutes for tranfers 90 minutes for ED patients

* AHA/DPH stroke care recommendations modified for BMC.

Ischemic Stroke Treatment: IV Tenecteplase (TNK)



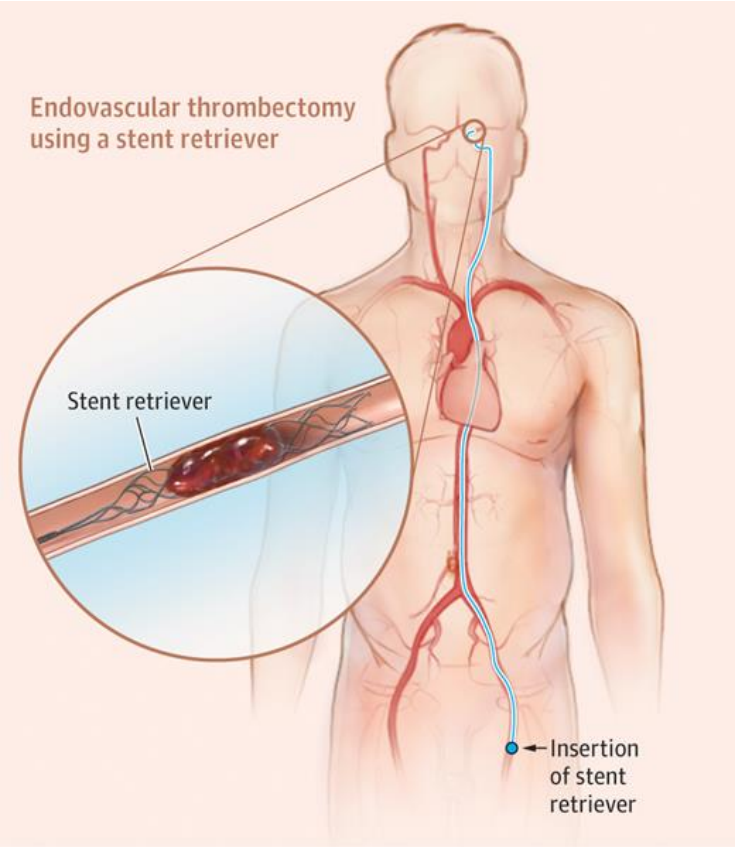


Ischemic Stroke Treatment: IV Tenecteplase (TNK)

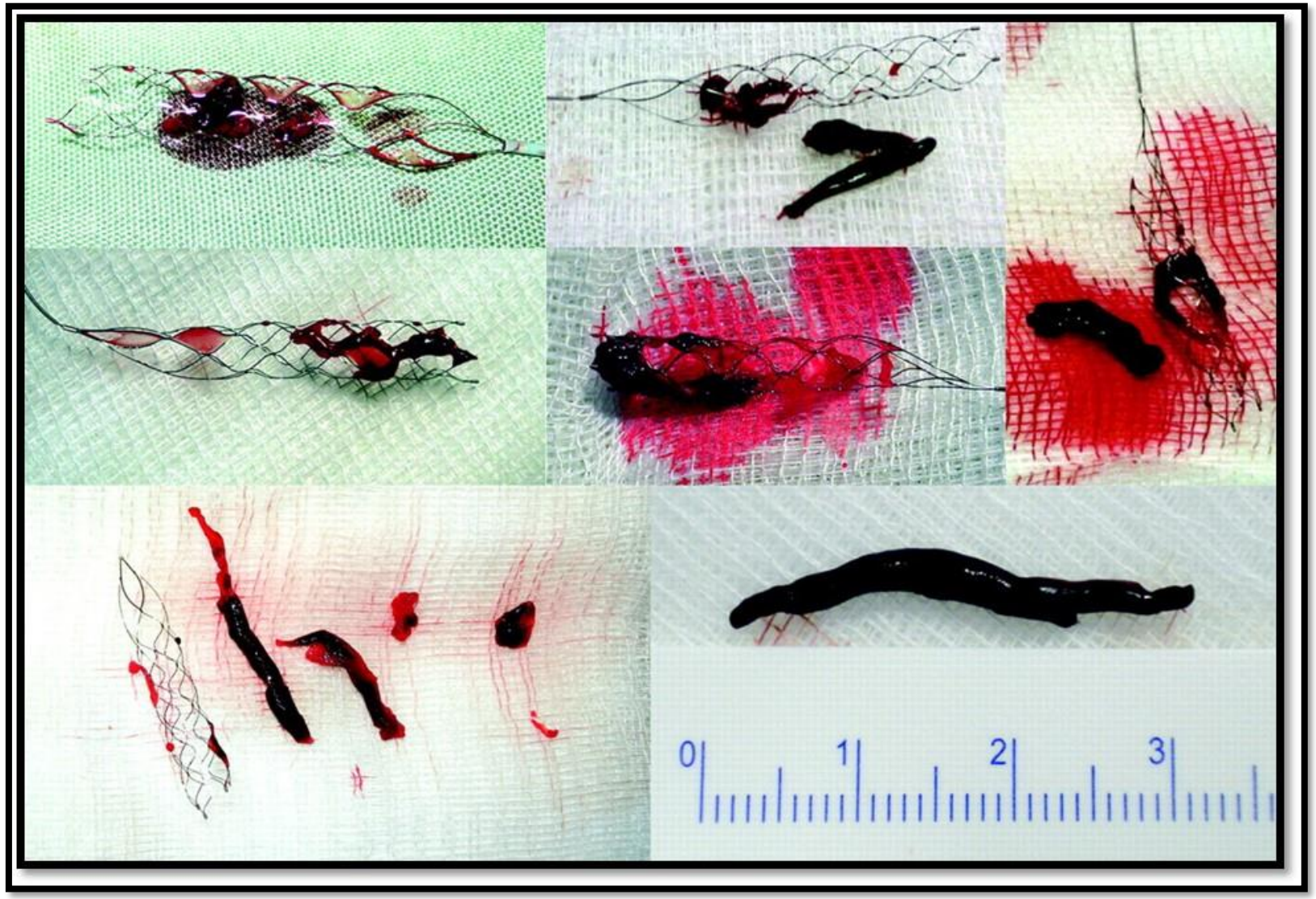
- Genetically modified form of wild-type tPa (alteplase) that has a longer half life and greater fibrin specificity
- Administered as a **single bolus**, given over 5 seconds
- **Same inclusion/exclusion criteria and post-administration monitoring as tPA (alteplase):**
  - **Inclusion: Ischemic Stroke with Last Known Well (LKW) 3-4.5 hours, >/= 18yo**
  - **Exclusion: bleeding, recent stroke, uncontrolled HTN, recent major surgery or significant head trauma; NIHSS 25 and history of stroke AND diabetes (only for 3-4.5h window)**
  - **Monitor in SNICU x24h; no punctures/catheter placements/antithrombotic drugs x24h unless life-saving**
- Blood pressure:
  - Below 185/110 before administration; Maintained < 180/105mmHg for at least 24 hours after
  - For patients not treated with thrombolytic therapy, BP should not be treated acutely unless the hypertension is extreme (systolic BP>220 mmHg or diastolic BP >120 mmHg); BP lowered slowly over several hours/sometimes days

Endovascular Ischemic Stroke Treatment: Mechanical Thrombectomy (MT)

- Indication: For Large Vessel Occlusions (LVO) that fail to open with TNK/tPA alone
- Inclusion Criteria
  - ✓ Minimal pre-stroke disability
  - ✓ Large vessel occlusion
  - ✓ ≥18yo
  - ✓ NIHSS ≥6
  - ✓ ASPECT ≥6
  - ✓ **6-24 hours of Last Known Well**
- Post MT, patients are transferred from Neuro IR to SNICU
- How Endovascular Stroke Treatment Works - YouTube



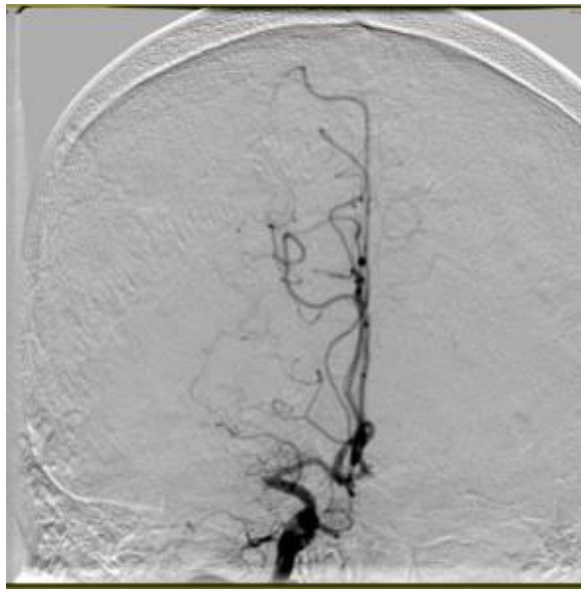
Endovascular Ischemic Stroke Treatment: Mechanical Thrombectomy (MT)



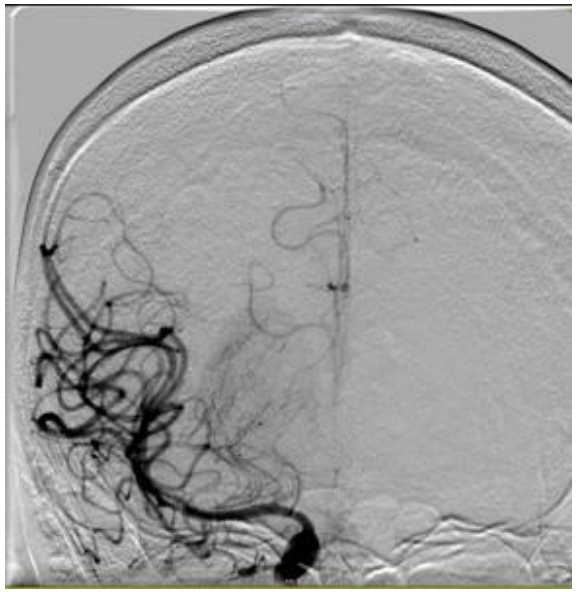
TICI Score for Reperfusion: Thrombolysis In Cerebral Infarction Scale

TICI Scale
TICI 0: complete occlusion. Absence of contrast passage through occluded vessel
TICI 1: filiform passage of contrast with virtually complete distal branches
TICI 2: passage of contrast filling distal branches of the treated vessel. It is subdivided into:
2a: Reperfused less than two thirds of distal branches
2b: Reperfused more than two-thirds but not complete
TICI 3: complete recanalization

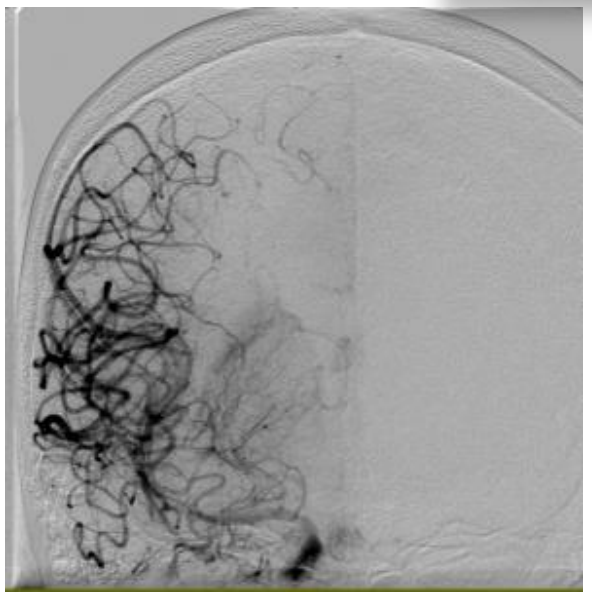
> **Successful recanalization**



TICI 0



TICI 2a



TICI 2b

Stroke Signs & Symptoms

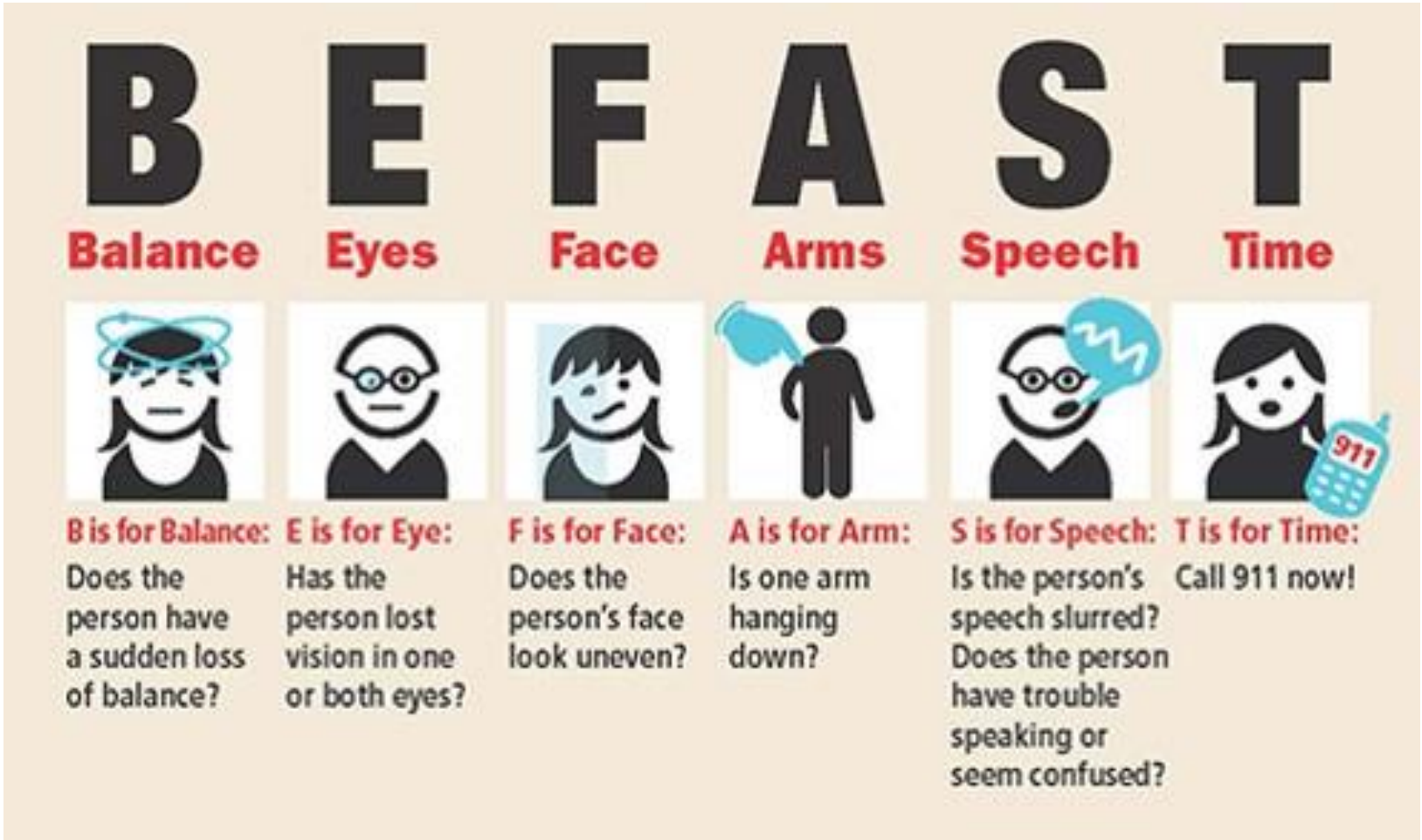
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Stroke Signs & Symptoms: The “Suddens”

- **Sudden** weakness or numbness of the body, especially on one side
- **Sudden** vision changes in one or both eyes
- **Sudden** severe headache with unknown cause
- **Sudden** dizziness, difficulty walking or imbalance
- **Sudden** confusion, difficulty speaking or understanding others

Stroke Signs & Symptoms: BEFAST

- Expanding on the FAST acronym, BEFAST includes balance and vision



What Do You Do If You Suspect A Stroke?

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Do you suspect a STROKE?

- If you suspect a stroke - don't hesitate to call
- BMC South – Call x5555; BMC Brighton call x666
- Time is of the essence
- Last known well- when were they last normal?
- Blood Pressure
- Stat finger stick (glucose)
- Place on monitor (DASH)
- Validate IV access (preferably on Right)
- **Keep patient NPO**
- Pertinent current medication- anticoagulation
- PMH
- Current vitals
- **Stay with the patient**: someone needs to **communicate** to the Stroke Team **why the Code Stroke was called**

Caring for the Stroke Patient

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Care of the Stroke Patient

Stroke Consideration	Nursing Intervention
Altered neuro status	Neuro checks as ordered – what is the patient's baseline? Have there been any changes?
Risk for aspiration	Dysphagia screen! Documented passing screen for ALL patients who present with stroke signs/symptoms and/or are being ruled out for a stroke prior to ANY PO intake
High fall risk: ~70% fall in 1st 6 months post-stroke	Fall risk precautions, close to nursing station, don't leave unattended in bathroom, declutter rooms, **communicate** to team
VTE prophylaxis	Sequential Compression Devices (SCDs), heparin, etc
Blood pressure goals	Know your patient's parameters
Risk for another stroke	Educate: patient-specific, disease-specific education that patient and/or caregiver can understand (language, reading level, etc)

Assess, Intervene and Document!!!

Dysphagia Screening: “3 oz water swallow challenge”

All patients with new stroke signs/symptoms, or who are being ruled out for a stroke, need a documented passing dysphagia screening prior to ANY PO intake

- ✓ Assess mental status, Facial Status, Breathing, Oral Secretions, Cough and Voice.
- ✓ Ask patient to say AHHH for 3 seconds.
- ✓ If patient passes all above criteria, give 3oz water
- ✓ If patient has no sign of aspiration, can finish the entire 3oz of water, and can say AHHH for 3 seconds again, they have passed the screen
- ✓ If patient fails screen, a speech and swallow screen needs to be placed
- ✓ Keep Patient NPO: no liquids, no medications, no food
- ✓ Speech Language Pathology (SLP) prioritizes stroke patients, and most times will see them within 24 hours



Time Is Brain!!!

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Time is Brain!

- This is the most important thing to remember when it comes to suspected stroke!
- Every minute that passes causes significant damage to the patient and reduces their chance for recovery and a good outcome!
- Early recognition of stroke signs and symptoms are imperative

	Brain Cells Lost	Number of Years the Brain Ages
Per Stroke	1.2 billion	36 yrs
Per Hour	120 million	3.6 yrs
Per Minute	1.9 million	3.1 weeks
Per Second	32,000	8.7 hrs

Progression of an Infarct

