Denver Springs

8835 American Way, Englewood, Colorado 80112

Denver Springs

Welcome to your Mental Health Clinical rotation at Denver Springs.

The facility is located off 470; you will turn at the American Warehouse Furniture, and at the end of that street, you will find Denver Springs. There is no gate to enter. Please park furthest away from the facility.

The facility is locked, so you can only gain access if a staff member badges you in. Please do NOT ring the buzzer in the morning since there is no receptionist, and an employee will have to leave the admissions area to let you in. I have access to the building and can open the door.

WiFi is available.
Login: DEN-Guest
Passcode: Guest-4100

WELCOME TO YOUR MENTAL HEALTH CLINICALS AT DENVER SPRINGS

The facility has four different units.
Sunrise
Cedar
Meadows
Willow

- On Sunrise, the age group ranges from 12 years to 17 years old. If a patient is still in high school and 18 years old, the patient can be admitted to Sunrise. Patients will be admitted to the other three units after 18 years of age and no longer in high school.
- On Cedar, the age is 18 and up and are admitted for various acute mental health illnesses.
- On Meadows, patients are at least 18 years old and are admitted for various mental health illnesses. Some of the patients may still be under the influence when first admitted. This unit has a higher risk for seizures and medical emergencies.
- On Willow, patients are at least 18 years old and are admitted for various mental health illnesses. Often the patient population will have a professional background in military, police, fire, EMS, healthcare or emergency dispatcher services.

What to Expect

- On our first day, we will have an orientation discussion and introduction to the facility. Please bring the required **SEVEN** Denver Springs-specific signature-required pages with you. I recommend that you print out your assignment pages as well unless you plan on typing them up and emailing them to me. You do not need to print out your CET. I will create an electronic version of your CET and email it to you at the end of your clinical rotation.
- With the exception of the first day, since we will have orientation, we will arrive in time for you to be present during shift change and report. The report is in each unit's break room at 0700.
- Students are not assigned to nurses. The goal of this clinical is to get comfortable interacting with patients with various mental health challenges and to see different therapeutic communication techniques through group and one-on-one interactions. You can let the nurse know if you would like to be present during the medication pass to observe the process and familiarize yourself with medications; however, students are not allowed to pass medications. Also, if there is a new admission or discharge on your unit, I encourage you to let the nurse know that you would like to observe and assist, if possible. There are care team meetings on the units on most clinical days, and you can attend those as well.
- Please assist the staff with vital signs in the morning - this is an excellent way to meet each unit's patient population and get familiar with names and faces. It is also a great beginning that could potentially lead to a more in-depth conversation (to complete your assignments).
- Each unit has multiple group and activity therapy sessions; you are expected to attend **all** of them. Patients share their stories and concerns during group and activity therapy. **Be present**! Please be on time and do not leave the group or engage in other activities during the group sessions. If you are with a nurse or therapist assisting with an admission/discharge or individualized therapy and miss a group, that is fine. Please do not enter the group halfway through.
- Outside of vital signs and group sessions, there will be plenty of time to converse with patients. It is encouraged to be in the milieu with the patients and interact with them, including playing games and participating in activities on the unit. It is often during those times that patients feel more comfortable having conversations. Weather permitting, please feel free to go outside with patients during their outside time.
- You can keep your mobile phone with you; however, facility and your school **do not allow** phones or other electronic devices to be out at any time while at the nurses station or in the milieu. If needed, you can utilize electronics in the break room.
- Due to safety, students are not allowed into patient's rooms without a staff member.
- Denver Springs has asked us not to use the break room to work on assignments or review charts during staff break/lunchtime. Space is limited in the break room, and the staff would like to be able to eat and enjoy their break/lunch. Each unit has one staff break room.
- Please plan to take your lunch break when there are no group sessions on your unit. Each student group will remain in your assigned units for breaks and lunch.
- Post-conference will be off the unit. Please wrap up conversations/paperwork to attend post-conference.

My first priority is your well-being.

Please communicate with me if you need a break off the unit. The conversations and patient situations are often challenging to hear, and I would never ask you to put yourself in a position that is upsetting to you.

LifePoint Health Mission and Vision

Our mission: Making Communities Healthier

Our vision is to create places where people choose to come for healthcare, physicians, and providers want to practice, and employees want to work.

LifePoint Health Core Values

Champion Patient Care	Do the Right Thing	Embrace Individuality	Act with Kindness	Make Difference Together
• Demonstrate an unwavering passion for delivering high-quality care. • Always look for opportunities to improve the patient and family experience. • Support all providers and caregivers to deliver the best patient outcomes. • Understand how you personally impact care.	• Demonstrate commitment to our mission and all stakeholders, including staff, providers, partners, and communities. • Take personal accountably for your role and actions. • Speak up: See Something, Say Something. • Act with integrity and honesty in everything you do.	• Appreciate and draw upon the diverse skills and perspectives of all people. • Actively listen to understand and act on the unique needs of others. • Make everyone feel welcome and valued. • Seek common ground with peers, patients, and families.	• Approach each day and new challenges with optimism. • Lift up others by making every moment matter. • Act with humility, compassion, and empathy. • Provide meaningful recognition and feedback to others.	• Promote teamwork by building strong relationships and fostering trust. • Collaborate to identify and develop innovative solutions. • Think “We” before “Me”. • Create fun by celebrating all successes.

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Our Facilities

*This map does not reflect our additional 170+ sites of care, including acute rehabilitation units, outpatient centers and post-acute services.

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Your Voice Makes Us Better

Lifepoint Health Ethics And Compliance

The LifePoint Ethics and Compliance team at our Health Support Center is committed to providing relevant education, transparency, and communication to help employees uphold their ethical and legal responsibilities – including required annual compliance training for all employees.

Additionally, the LifePoint Ethics Line is available for confidential reporting of ethics and compliance-related concerns 24/7 by calling 877.508.LIFE or by going to https://appmycompliancreport.com/report?cid=LPH.

Diversity, Equity, and Inclusion

Diversity
In broad terms, diversity is any dimension that can be used to differentiate groups and people from one another. It means respect for and appreciation of differences in ethnicity, gender, age, national origin, disability, sexual orientation, education, and religion.

Inclusion
Inclusion is a state of being valued, respected, and supported. It's about focusing on the needs of every individual and ensuring the right conditions are in place for each person to achieve his or her full potential. Inclusion should be reflected in an organization's culture, practices and relationships that are in place to support a diverse workforce.

Unconscious Biases
Unconscious biases are social stereotypes about certain groups of people that individuals form outside their own conscious awareness. Everyone holds unconscious beliefs about various social and identity groups, and these biases stem from one's tendency to organize social worlds by categorizing.

- A stereotype is an exaggerated belief, image or distorted truth about a person or group-a generalization that allows for little or no individual differences or social variation. Stereotypes are based on images In mass media, or reputations passed on by parents, peers, and other members of society. Stereotypes can be positive or negative.
- A prejudice is an opinion, prejudgment or attitude about a group or its individual members. A prejudice can be positive, but in our usage refers to a negative attitude. Prejudices are often accompanied by ignorance, fear, or hatred. Prejudices are formed by a complex psychological process that begins with attachment to a close circle of acquaintances or an "in-group" such as a family. Prejudice is often aimed at "out-groups."
- Discrimination is behavior that treats people unequally because of their group memberships. Discriminatory behavior, ranging from slights to hate crimes, often begins with negative stereotypes and prejudices.

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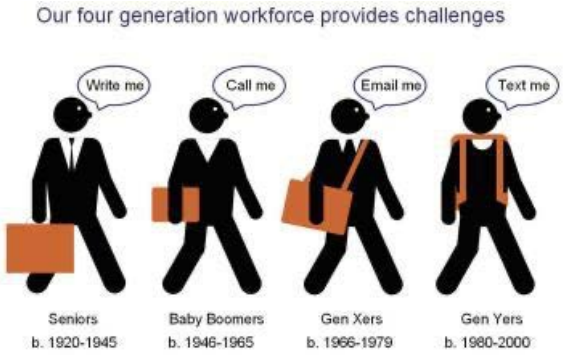
Generational Diversity

What Are the Generations?

- A generation is a group of people defined by age boundaries- those who were born during a certain era. They share similar experiences growing up and their values and attitudes, particularly about work-related topics, tend to be similar, based on their shared experiences during their formative years.



Gender Diversity

- Gender diversity is equitable or fair representation between genders. Gender diversity most commonly refers to an equitable ratio of men and women but may also include non-binary gender categories.
- Gender equality, also known as sexual equality, is the state of equal ease of access to resources and opportunities regardless of gender, including economic participation and decision-making. and the state of valuing different behaviors, aspirations and needs equally, regardless of gender or gender identity.
- To create an inclusive workplace for all, encourage candidates of all genders to apply for open positions. Having diverse representation on your teams and committees means you benefit from the different points of view and approaches that come from different life experiences. A multiplicity of perspectives can spark creativity and innovation, and help organizations spot and seize new opportunities. It can also encourage organizations to challenge gender stereotypes.

Sexual Orientation and Gender Identity

Sexual Identity And Gender Diversity- LGBTQIA+:

- An umbrella term encompassing people whose gender identity conflicts with the sex they were assigned/designated at birth. Some people may undertake hormone therapy and surgery so that their body accords with their gender identity.

To create an inclusive workplace for LGBTQIA+ employees, employers should consider the following strategy:

- Develop and implement equal opportunity policies that provide diversity training to raise awareness among all employees regarding LGBTQIA+ issues.

Cultural Diversity
Cultural diversity supports the idea that every person can make a unique and positive contribution to the larger society because of, rather than despite, their differences.
To ensure diversity and inclusion:

- Introduce a policy for honoring a variety of cultural and religious practices,
- Observe holidays and celebrations that cross cultural lines,
- Designate a special refrigerator to keep kosher food items separate
- Make the "Christmas" party a nondenominational holiday or year-end party.

Diversity in Patient Care
Stereotypes can be dangerous. Instead ask question to gain understanding

- Do you have any dietary restrictions?
- Do you have any religious or cultural needs you would like to share?
- Anything else you would like us to know to better help us help you?

Employee Resource Groups (ERGs) are aimed at building community, providing support, and contributing to the personal and professional development of its members.

- ERG membership is open to ANY employee. Anyone can be an ally, regardless of their culture, background, or identity.
- Meetings are virtual to allow employees from all locations to attend.
- To sign up for any ERG scan the QR code or go to: https://airtable.com/shrfEdlkAAS4gJgrL
- Offering unconscious bias training to all team members
- Scholarship and tuition assistance programs to ensure ongoing education is available for all staff

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Appearance Policy

- Employees should dress In a manner that is appropriate for their position and work performed.
- Employees should dress in a way that establishes confidence and respect for the Hospital and maintains the health and safety of patients, visitors, and employees.
- Factors that have been taken into consideration in defining the appearance standard include safety, infection control, job responsibilities, professional image, and patient satisfaction.
- If an employee's supervisor finds that an employee's personal appearance is inappropriate, the employee will be asked to leave work and will not be paid.
- Employees should maintain good personal hygiene and are expected to report to work neat and clean in appearance. Body cleanliness, including the use of deodorant and the maintenance of good oral hygiene, is imperative.
- Hair, beards, and moustaches should be clean and well-groomed at all times. The styles of any facial hair should not interfere with the ability of the employee to maintain standard precautions or sterile technique in the work environment
- As recommended by the Centers for Disease Control and Prevention (CDC), only natural fingernails are permitted (artificial nails are prohibited) for caregivers who have direct contact with patients, staff who prepare sterile fluids in pharmacy, all staff involved with cleaning processes, and all staff who prepare products for patients.

Drug Free Workplace Policy

The facility maintains a drug free workplace policy, requiring all employees to report to work in a substance-free condition

- This prohibits the use of intoxicants and illegal drugs in the workplace in compliance with federal and state regulation.
- Certain prescription and over the counter drugs can interfere with an Employee's ability to perform the job.
- Notify the Employee Health Nurse if your medications change while you are employed
- Discuss with your Employee Health Nurse
- Drug and/or alcohol Screening happens upon hire, in a work-related accident, or for reasonable suspicion.

Social Networking/Media Policy

- Employees' use of social media can pose risks to the Facility's confidential and proprietary information and reputation. It can also constitute a violation of the Facility's Code of Conduct, business rules, and anti-harassment/anti-discrimination policies.
- To minimize these business and legal risks, avoid productivity loss and distraction from employee job performance, and to ensure the Facility's Information Systems resources and communications are used only for appropriate business purposes, Facility employees are required to adhere to the following rules regarding the use of social media.

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Social media includes:

- Facebook
- Twitter
- LinkedIn
- Groups
- YouTube
- TikTok
- Personal websites
- Discussion forums
- Blogs (both Facility blogs and external blogs)

Employees are prohibited from using social media to:

- Violate a patient's right to privacy concerning their PHI
- Violate the Facility's information systems
- Violate the Facility's business confidentiality and proprietary rights policies
- Defame or disparage the Facility or its employees, patients, affiliates, vendors, referrals, physicians, business partners, or any other stakeholders
- Harass other employees in any way
- Circumvent policies prohibiting unlawful discrimination against current employees or applicants for employment
- Provide references for stakeholders (co-workers, vendors, business partners, etc.)
- Violate the Facility's privacy policies
- Violate any other laws or ethical standards

Electronic Devices

Employees are not permitted to use their personal electronic device while working within the facility unless it is related to work purposes or with permission of a manager.

- Use of the personal electronic devices is limited to work purposes, such as accessing multi-factor authentication (MFA) or communicating with facility staff regarding patient care using HIPAA compliant means (TEAMS).
- Employees cannot share or permit their personal electronic devices to be used by patients.
- Cameras (including use of a cell phone camera or any electronic device), video (including use of the video feature on a cell phone/Facetime), and audio equipment are strictly prohibited from being used at any time on Facility property.
- Employees must always protect the privacy of our patients and their protected health information (PHI).
- Cell phones in any area with patients could be considered a HIPAA breach and may be cause for termination.

Workplace Violence

The Facility has established a policy that provides ZERO TOLERANCE for actual or threatened violence against visitors, co-workers, or any other persons who are either on our premises or have contact with employees in the course of their duties.

- Workplace violence is defined as any physical assault, threatening behavior, or verbal abuse made in the workplace.
- Violence in any form, physical or verbal, is considered serious.
- Acts of physical violence, threats or intimidation by an employee may result in disciplinary action up to and including termination and notification of proper authorities.
- Employees should never put themselves in danger-notify a member of management immediately.
- Firearms are not allowed.

Email and Computer Use

Company computers and email are for performing the duties of your job

- You may occasionally use the company computer and internet access to conduct personal business
- Only during breaks or meal periods
- NEVER in patient areas
- All other policies apply
- You should have no expectation of privacy
- Process for accessing/monitoring your company emails
- URLs visited are monitored
- Every employee is responsible for checking their email, and as such, responsible for knowing, interpreting and/or responding to all email communications that are sent to your company email.

Risk and Quality Management

Quality Management

- Quality management is focused on the patient (what happens to hi m or her) rather than on the provider (who he or she is), on prevention instead of on inspection, and on process rather than on person (what was done versus who did it).
- Quality management and improvement is a requirement of The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS), and the state.

Performance Improvement

- Performance improvement is geared to increasing the safety of patients and diminishing risks. Our ability to improve safety not only affects the public's view of health care but must also give us the satisfaction of knowing that we are able to do better for patients. That satisfaction in tum leads us to be more satisfied with our work.
- Performance improvement continually and systematically plans, designs, measures, assesses to improve performance of critical focus areas, improve healthcare outcomes, and reduce/prevent healthcare errors.

Risk Management

Risk management involves the analysis of problems and minimization of losses after adverse events. Departments devoted to risk management typically have several functions:

- Define situations that place the system at some financial risk (e.g., medication errors, patient falls)
- Determine the frequency with which these situations occur
- Intervene in and investigate the identified events
- Identify risks and opportunities to improve care

Types of Incidents

Patient Injuries

- Falls
- Contraband
- Medication Variances
- Patient Death
- Suicide
- Gesture/Attempt
- Sharps injury/Exposure
- Elopement/AWOL
- Sexual Assault
- Restraint/ Seclusion
- Employee and/ or patient safety issues
- AMA Discharges
- Patient transfers to a medical facility

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Reporting an Incident

- Who completes the report?
  - The person first aware of the event should complete the report
- When does it need to be done?
  - By the end of the shift the event occurred in
- Where does it go when I'm done?
  - The original goes to the Pl/QA Coordinator, House Supervisor
- Who else do I notify?
  - You notify the shift supervisor and unit nurse; they will take care of other notifications
- NOTE: Employees will need to complete the hospital incident report as well as the state required report (if applicable).

Do's and Don'ts of Incident Reporting

Do's:

- Report as soon as the incident occurs
- Include facts on what you witnessed
- Include full names of those involved
- Complete separate reports if more than one patient is involved
- Put secondhand information in "quotations" to clearly identify the source
- Include clinical observations in the chart

Don'ts:

- Wait until end of day/next shift
- Speculate or make assumptions
- Prognose the incident
- Include the incident report in the patient chart
- Mention the incident report in the patient record
- State we are at fault or make a statement that we will accept financial responsibility to an Injured patient or visitor
- Use email to send a witness statement or type it on your home personal computer

How is incident report data used?

Used for:

- Identifying problems areas
- Safety
- Security
- Patient Care
- Evaluating Pl Actions
- Getting staff involved in Risk Management

Not Used For:

- Disciplinary purposes
- Scapegoating
- Performance Evaluations

Injury Scoring

- Near Miss: Error or capacity to cause harm was caught by an error detection barrier prior to reaching the patient.
- No Harm: Patient outcomes is asymptomatic. No symptoms are detected, and no treatment is required. Not able to discover or ascertain the existence, presence, or fact of harm, but harm may exist. Insufficient Information is available or unable to determine any harm. Harm may appear later.
- Mild Hann: Patient Outcome symptomatic, symptoms are mild, loss of function or harm Is minimal or intermediate, but short-term, and minimal or no intervention (e.g. extra observation or minor treatment) is required.
- Moderate Harm: Patient Outcome is symptomatic, requiring intervention, (e.g. additional operative procedure, additional therapeutic treatment), an increased length of stay, or causing moderate permanent or temporary harm or loss of function.
- Severe Harm: Patient Outcome Is Symptomatic, requiring life- saving intervention or major medical surgical intervention, shortening life expectancy, or causing major, permanent, or temporary harm or loss of function.
- Death: Unexpected death not related to the natural or expected course of the patient's illness or underlying condition, on balance of probabilities, was caused by or brought forward in the short term by the incident.

Injury Leveling

Level 1: The potential for litigation is thought to be remote
Level 2: The potential for litigation is thought to be minimal
Level 3: The potential for litigation is thought to be prevalent
Level 4: The potential for litigation/government investigation could be Initiated at anytime
Level 3 and 4 indents:

- Must be investigated and leveled within 24 hours by the Director of Quality and Risk Management or their designee.
- Must be reported to LifePoint BH Quality Department as soon as practicable but no later than 24 hours after notification of the event.
- When an Incident Report is leveled a 3 or 4 the incident management system will provide Central Administrative Office leadership immediate notification.
- Additional analysis is needed for these incidents; please refer to the Root Cause Analysis (RCA) and Sentinel Event Policy.

Observation Levels

Level of observation and any precautions are defined as intensified levels of staff awareness and attention to patient safety/security needs, requiring varying levels of observing patients and the initiation of specific protocols and supplemental documentation, when warranted.

- 15-minute Observation
- Line of Sight Observation
- 1:1 Observation
- Q5 Minute Observation

Every 15-minute observation:

- This is moderately restrictive for the patient and involves monitoring every 15 minutes on the Close Observation Sheet.
- Staff members must complete the Close Observation Sheet by noting the patient behaviors and location codes, along with the initials of the staff member who is conducting the observation.
- Staff must make visual contact with the patient at least every 15 minutes. This includes when the patient is toileting and/or showering, in groups, or attending off unit activities
- When using the "Special Bathing" area of the Hospital, staff will be required to monitor the patient inside the "Special Bathing" area at all times.

Line of sight observation:

- This level of observation Is very restrictive and involves continuous visual monitoring at all times.
- Documentation should reflect the need for continued line of sight or improvement in behaviors.
- Staff must be within visual contact of the patient at all times.
- A staff member may observe more than one patient on line-of-sight observation only while those patients remain in an area for scheduled activity (i.e. group therapy, dining, outside break or activity).
- If a staff member is observing more than one patient and one or more of the patients go to separate areas, the staff must transfer responsibility for line of sight to other staff member(s) so that there is continuous observation of all patients on line-of-sight precautions.
- Staff shall maintain a continuous log which indicates the patient's location and behavior every 15 minutes and document throughout each shift.
- When using the "Special Bathing" area of the Hospital, staff will be required to monitor the patient inside the "Special Bathing" area at all times.

1-to-1 Observation at all times:

- This is the most restrictive level of observation for the patient. Staff must be within arms-length to the patient at all times, including toileting and/or showering to continuously monitor patient behavior.
- Documentation should reflect the need for continued 1:1 or improvement in behaviors.
- Staff members must complete the Close Observation Sheet by noting the patient behaviors and location codes, along with the initials of the staff member who is conducting the observation.
- Patients on this level of precaution cannot leave the unit, including going outside for smoke breaks, unless the Provider orders otherwise.
- Based on patient risk level, patient may be moved to a LOS during hours of sleep as long as the Provider provides an order for "1:1 while awake and LOS during hours of sleep".

Q5 Minute Observation:

- This level of observation is only to be used for clinically appropriate patients that are using CIPAP/BIPAP/Oxygen.
- This level of observation requires a Provider's order.

Observation Notes

- Patients on an involuntary status, elopement risk or on a 1:1 observation will not be permitted outdoors unless there is a state statute that allows the patient to go outdoors or are a facility with an internal courtyard. Providers may evaluate the individual face to face and give an order allowing the patient to go outdoors. If an individual is too highly acute to be safe outdoors, the unit nurse may restrict the Individual for any single trip outdoors, and indoor activities will be provided to accommodate the patient's acuity level.

Precautions

- Suicide
- Aggression
- Elopement
- Sexual Acting Out
- Falls
- Seizure

Suicide Precautions

- The patient will be moved to a room closer to the nursing station if a room is available and will be In a room with a roommate unless contraindicated.
- The patient will be on increased observation level if identified as moderate or high risk based on the clinical evaluation, including the Columbia Suicide Severity Rating Scale, and an assessment of risk while within the facility.
- Nursing will complete a suicide risk assessment on the patient every shift. If the patient is determined to be at a higher risk for suicide, the nurse can institute an increased level of observation and/or suicide precautions. For patients currently on Suicide Precautions, the results will be reported dally to the medical provider and the determination will be made if the patient should remain on suicide precautions.
- At the start of each shift, during report. the staff will be made aware of any patient who Is on suicide precautions to increase awareness of safety risks and to be alert for any changes In behavior that might suggest the patient may act on suicidal thoughts.
- The patient will have only supervised use of personal belongings that pose a risk to the patient, such as a hairdryer, safety razor, headphones etc.
- Personal Items that pose a threat to patients will be removed and locked, such as jewelry (except wedding rings), makeup compacts etc.

Aggression Precautions

All patients scoring 3 or higher on the Broset Violence Checklist (BVC) or nursing identifies to be at high risk for aggression/violence must be placed on Aggression Precautions.

- Immediately initiate an order for Aggression Precautions, including required interventions and additional patient-specific individualized interventions.
- As part of Aggression Precautions, the RN can identify additional interventions that will mitigate risk for a specific patient.
- Prior to the creation of an individually specific behavior plan or use of the Clinical Concern Alert, the patient case must be reviewed and discussed by the patient's treatment team.

Elopement Precautions

- At the start of each shift, during report, the staff will be made aware of any patient who is on elopement precautions to increase awareness of safety risks and to be alert for any changes in behavior that might suggest the patient may act on thoughts of elopement. (Such as the patient lingering at doors, watching the coming and going of staff etc.)
- The patient will not be permitted outside to the courtyards for any reason, including to smoke.
- Staff will be mindful when walking though locked doors that patients are not in close proximity and will ensure that doors close and lock behind them when they proceed through doors.
- Patients who request to leave Against Medical Advice (AMA) will be placed on elopement precautions.

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Sexual Acting Out Precaution

- LOS or 1:1 or 15-minute observations based on clinical assessment.
- Assess location of patient rooms based on vulnerability of the patient populations in particular at-risk patients.
- Determine if leveled SAO risk requires that a patient requires his/her patient room.
- Room visible from nurse's station or patient lounge, when possible. Door open when patient in his/her room.
- Communicate plan with patient when SAO precautions are interacted.
- Consider unit restriction-depending on level of SAO; including eating meals separate.
- Ensure all staff members are aware of SAO behavior (including volunteers, students).
- Monitor relationships, interactions, note passing, whispering, etc., among patients.
- Screen reading materials. Ensure appropriate media is viewed on the unit
- Visitor restrictions if appropriate.

Fall Precaution

- An Initial Screen for Fall Precautions will be completed on al Inpatient patients upon admission on the Nursing Admission Assessment.
- Patients that are identified a s a fall risk will be identified in the following ways:
    - Yellow identification armband sticker or yellow identification armband.
    - Yellow stickers stating 'fall risk' on front of patient's medical record.
    - Yellow Falls Risk sign on patients' door.
- Patients identified as a fall risk will be communicated during each change of shift report.
- Patients will be reassessed dally for fall risk potential on the Inpatient unit. Patients will be reassessed following a report of a fall and when patient symptoms indicate an increased risk of fall on the inpatient unit.
- Score 0-6= Low risk. Score 7 or above= High Risk
- When a patient is identified as high risk for falls or has experienced a fall, staff will evaluate the patient for implementation of one or more of the following Interventions. Staff will select Interventions that are clinically appropriate based on the nature of the patient's risk factors and/or patient specific indicators.
- The patient's fall risk and interventions will be added to the patient's treatment plan.
- The nurse will provide patient education on medications that may increase fall risk and document education In the patient chart.
- An Incident Report will be completed and the Nurse Supervisor will be notified of the fall.
- A Fall Risk Reassessment and Post-Fall Documentation will be completed after each patient's report o f a fall.
- The attending Physician will be contacted by the nurse to determine the course of treatment if a fall occurs.
- The patient will be identified as a fall risk after falling, if not done so upon admission.
- When a patient is given any PRN medication that can change sensorium, the RN will determine if the patient is safe for exercise or outside activities.

Seizure Precautions

- A green wristband sticker will be placed on the patient identification wristband to alert nursing staff of seizure precautions.
- Depending on seizure history and room availability, the patient will be placed in a room close to the nursing station to facilitate frequent visual checks and close observation.
- Risk for seizures to be added to the patient treatment plan.
- Seizure Risk to be transcribed on the Close Observation Sheet.
- Seizure Risk identified on the outside of the patient chart.
- Nurse to notify the medical provider if patient is noncompliant with medications.
- Educate patient on the importance of alerting staff of any unusual feelings or "aura" that may indicate a precursor to a seizure.

Managing Grievances/Complaints

What is a complaint?

- Issues that can be resolved promptly
- Typically involve minor issues such as
    - Housekeeping or food preferences
    - Do not involve investigation
    - Verbal

What is a grievance?

- Complaint that is not taken care of on the spot
- Issues presented after discharge always become a grievance.
- Any complaint or issue that is written down automatically becomes a grievance, no matter the topic of the complaint.
    - Usually results from:
        - Concern with patient care
        - Concern with patient rights
        - Concern alleging abuse or neglect

A Grievance is NOT ....

- Issue resolved on the spot by staff present
- Non-Medicare billing issue
- Patient survey response without an attached complaint and request for resolution
- Patient initiated EMTALA and HIPAA complaints

A Grievance is ....

- Concern involving patient care
- Concern alleging abuse or neglect
- Concern pertaining to hospital's compliance with CMS Conditions of Participation (CoPs)
- Medicare beneficiary discharge dispute
- Any concern which a patient requests be handled as a formal complaint.
- Medicare billing/coverage issues
- Patient survey response:
    - with attached complaint and request for resolution
    - with attached concern which would have been considered a grievance

Investigation Time Frames

Time Frame	Grievance Type
Immediately	Situations that endanger the patient (neglect or abuse)
Within 7 days	Most grievances: written response due within 7 days. If grievance will not be resolved within 7 days the extension notice required specifying new time frame.
As soon as possible	All other grievances

Investigation Process

- Interview complainant and patient
- Gather facts
- Identify steps already taken to handle concern
- Research regulations, laws, hospital P & P
- Review patient records
- Make observations

Resolution

- A grievance is resolved when the patient is satisfied with the actions taken on their behalf.
- A grievance may be considered closed when the hospital has taken appropriate and reasonable actions on the patient's behalf, yet the patient remains dissatisfied.

Quality Assurance Program

- Each grievance should be taken seriously regardless of the nature of the grievance.
- The hospital should make sure that it is responding to the substance of each grievance while identifying, investigating, and resolving any deeper, systemic problems indicated by the grievance.

Make sure results are part of QA/Pl program

- Surveyors may ask:
    - Does the hospital share what it learns from the grievance as part of its continuous quality improvement activities?
    - Is the grievance process reviewed and analyzed through the hospital's
    - Quality Assurance Process Improvement (QAPI) process?

Lifepoint Health

Patient Rights

- The patient has the right to formulate advance directives and to have hospital staff &practitioners who provide care in the hospital comply with these directives
- Receive treatment in a safe environment free from abuse and harassment, and to be assisted in accessing Protective Services and/or Advocacy Services as appropriate
    - All patients have rights when they are receiving treatment
    - Patients must be informed of their rights upon admission
    - Patient or patient's representative is offered a written copy
    - Patient rights are conspicuously posted in each lobby and unit
    - A patient must be provided with a copy of their rights if they ask

The Patient has a right to:

- Be informed of their rights within 24 hours of admission
- Be free from restraints and seclusion of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff
- Participate in the development & implementation of his or her plan of care
- The patient or his or her representative has the right to make informed decisions regarding his or her care
- To be informed of his or her health status
- Confidentiality of their medical records
- Sufficient safeguards to ensure access to all information
- Need for authorization for release
- Make and receive phone calls
- Exercise their religious beliefs
- Refuse medication without a specific court order
- Refuse therapeutic activities
- Protection of privacy and confidentiality
- Make a complaint about services/care

Organizational Philosophy

Restraints

Our organization does NOT use mechanical restraints.

- Physical holds, seclusion are used as a last resort. The key is early detection & intervention.
- All direct care staff will receive Crisis Prevention Intervention training during orientation and annual refreshers thereafter.

Definitions

- Physical Abuse - Allegation of staff action directed toward a patient of hitting, slapping, pinching, kicking, or controlling behavior through corporal punishment or any other form of physical abuse.
- Sexual Abuse - Allegation of staff action directed toward a patient where there is sexual contact or sexual conduct with the patient, any act where staff cause one or more other persons to have sexual contact or sexual conduct with the patient, or sexual comments directed toward a patient Sexual conduct and sexual contact have the same meanings.
- Neglect- The failure to provide care or services necessary to maintain the mental or physical health and wellbeing of the patient.
- Exploitation- The use of a patient's person or properly for another's profit or advantage or breech of a fiduciary relationship through improper use of a client's person or property including situations where an individual obtains money, property, or services from a patient from undue influence, harassment, deception, or fraud.

Abuse of Adults and Children

- The law provides protection of adults and children who may be suffering from abuse, neglect, or exploitation.
- Perpetrator could be family, care providers, agency staff or team members.
- If you suspect: You must report immediately.

What is Abuse?

- The infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury.
- Infliction of injury
    - Sexual abuse
    - Physical abuse
    - Emotional abuse
    - Unreasonable confinement
    - Intimidation
    - Corporal punishment

Verbal Abuse

- Examples:
  - Threats: "If you don't stop that, you won't discharge tomorrow"
  - Humiliation/Teasing: "You're back again? Weren't you just here ??n
  - Tone and Rudeness: "You don't need to know that" or "I just answered you, can't you see I'm busy?"

What is Neglect?

- Adult is unable to perform or obtain for himself the goods or services that are necessary to maintain his health or welfare, including self-neglect.
- Deprivation of services by a caretaker that are necessary to maintain the health.

What is Exploitation?

- Improper use of an adult/child's resources for the profit or advantage of the caretaker or other person

Your Responsibility

- Familiarize yourself with all of the patient rights
- Intervene when you think a right is being violated
- Report it immediately
- Advocate for the patient
- Empower yourself to assist in resolving a patient's complaint that a right has not been honored
- Any suspected cases of abuse must be reported to your manager or charge person immediately.
- Licensed health care professionals may be fined for failure to report.
- Your job doesn't end after reporting to manager. If you see action has not been taken you have to ensure patient is safe and report up the chain of command.

Quality Indicators

- Monthly Quality Indicators for each department in the Quality Report
    - Examples:
        - Treatment plan (per state standards)
        - Quarterly fire drills
        - Emergency cart supplies checked daily
        - Every assessment is signed, dated, and timed by assessor at completion of assessment
        - Food temps on serving line within required parameters
        - 15 min checks completed
- A plan of correction for any area that falls below the expected threshold
    - Example:
        - 15-minute checks uses a sample of 10 charts or loo king at the video monitors, threshold is 90% compliance

HIPAA

- HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.
- The standards for privacy of individually identifiable health information (HIPAA), which applies to healthcare plans, healthcare clearinghouses and healthcare providers who transmit specific transactions electronically, established an individual's right to access and amend their information in all but a limited number of situations.
- All staff members, medical staff, interns, volunteers, or other individuals having access to patient information have a responsibility to protect and preserve confidentiality for all patients.

Protected Health Information (PHI)

- Individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. PHI does not include individually identifiable health information In employment records by hospital/facility in its role as employer.

Statement of Confidentiality

- All individuals involved in the collection, handling, and dissemination of patient information should be specifically informed of their responsibility to protect patient data and the penalty for violation of confidentiality. This policy should be made known to all employees upon hire and each employee should indicate understanding of this policy through a signed statement of confidentiality at the time of employment, retained in the employee's personnel file. This responsibility will not cease with termination of employment
- A breach of confidentiality may result in disciplinary action up to, and including, termination. In addition, students, interns, and other non-employed individuals providing services within the Facility should be educated about confidentiality laws and sign a statement of confidentiality.

Confidentiality of Medical Records

- Patient medical records are confidential documents and are kept for the mutual benefit of the patient, Physician, treatment team and Facility in accordance with legal accrediting and regulatory agency requirements. They are the property of the Facility and it is the Facility's responsibility, as custodian, to safeguard patient information, the patient record, and its contents against access, loss, defacement, tampering and use by unauthorized individuals. Review of the medical record by the Facility personnel should be restricted to the clinical staff requiring information from the medical record in order to carry out hospital duties.
- No medical record information that is obtained from another hospital, healthcare provider or treatment hospital is to be re-released for any reason by any member of the Facility.
- To ensure consistency, requests for patient information such as verbal or written inquiries from attorneys, insurance agencies or other persons requesting copies of the records should be referred to the Health Information Department for processing.

Patient Confidential Code Numbers

- In order to protect patient confidentiality, every patient is assigned a confidentiality code number for each admission. Upon admission, the patient will be informed of his or her code number and it is his or her responsibility to give it to individuals he or she deems appropriate. This code should be communicated to the nursing units and the switchboard.
- No acknowledgement of a patient's current or former presence at the Facility will be given to anyone without the correct code number. (This includes speaking to patients or visiting by p hone or in person, accepting personal items or flowers at the reception desk, telephone inquiries about patient, etc.) Even when the correct code number is given, specific information with regard to the patient's care and treatment cannot be communicated to anyone without the written consent of the patient or individual authorized to give consent, as noted above.

Release of Information

The medical records department will be responsible for all release of information requests

- Mental health records will only be disclosed upon written consent from the patient utilizing a valid Release of Information Form.
- A patient is entitled to inspect a copy of the patients own medical record in the presence of the administrator or designee and be given the opportunity to request amendments or corrections however, if upon advice from the physician, the information requested could be detrimental to the physical or mental health of the patient, or it is likely to cause the patient to harm the patient or any other person, the physician may withhold the information from the patient as described above and will be released as soon as the physician deems safe.

Cameras/Tape Recorders/Video Recorders

- No cameras, tape recorders or video recorders should be allowed inside the Facility without authorization from administration. No photographs, voice or video recording may be made without prior written consent from the patient.

Paging

- The Facility's paging system is to be utilized in a professional manner by authorized personnel in order to facilitate the flow of communication throughout the Facility. In order to be consistent, each page should be clearly stated using first name and last initial as well as instruction of where the paged person it to call or report. Each page should also be repeated twice. In order to protect confidentiality, patients will not be paged on the overhead paging system, nor will their full name be posted within the view of other patients or visitors.

Telephone Requests for Information

- Telephone requests for patient information should be carefully screened. Patient Information can only be released via prior written consent by the patient, except in very limited circumstances.

Lifepoint Health

Emergency Codes

Code Red	*FIRE*
Code Black	*Bad Weather*
Code Orange	*Weapon or Hostage*
Code Blue	*Medical Emergency*
Code 100	*Need Assistance*
Code Amber	*Missing Child*
Code Green	*Disaster*
Code Yellow	*Bomb Thread*
Code Brown	*Eloping Patient*
Code Lavender	*Lockdown*

Fire Alarm Pull Stations

Pull stations are generally located at egress path doors.

- Pull stations will automatically initiate the fire alarm systems.
- Pull stations activation will also immediately open the fire door to the exterior – or interior egress doors.
    - Remember – once a fire alarm is activated - ALL doors are open and patients must be protected from elopement risk.
- The Fire Alarm Pull Station is protected with a keyed cover that will alarm if tampered.
- Every staff member must always have the correct key at all times

Mental Health Report & Shift Change

Welcome to your mental health clinical rotations. During report, you might hear some abbreviations that are specific to mental health.

Please utilize this to assist you in clarifying the most common abbreviations. If you come across one that is not covered here, please ask the staff to assist you.

AUD	Alcohol Use Disorder
AD	Adjustment Disorder
ADHD	Attention Deficit Disorder
AP	Aggression Precautions
CBT	Cognitive Behavioral Therapy
CIWA	Clinical Institute Withdrawal Assessment (to score Alcohol withdrawal)
COWS	Clinical Opiate Withdrawal Scale (to score Opiate withdrawal)
CP	Chest Pain
DNMS	Developmental Needs Meeting Strategy (Therapy)
DT	Delirium Tremors
ED	Eating Disorder
EMDR	Eye Movement Desensitization and Reprocessing (Therapy)
E-Meds	Medications given under emergency circumstances without a court order
EP	Elopement Precautions
ESTC	Extended Short-Term Certification (after STC, can add additional 90 days)
Fall	Fall Precautions
GAD	Generalized Anxiety Disorder
HI	Homicidal Ideations
I-Meds	Involuntary Medications given with a court order
IOP	Intensive Outpatient Program
LOS	Line-of-sight
LTC	Long Term Certification (up to 180 days)
MDD	Major Depressive Disorder
M1	Mental Health Hold (involuntary hold lasting up to 72 hours)
ODD	Oppositional Defiant Disorder
OUD	Opiate Use Disorder
RTU	Restricted to Unit
SI	Suicidal Ideations
SIB	Self-Injurious Behavior
STC	Short Term Certification (up to 90 days)
SZ	Seizure precautions

Therapeutic Communication Definitions

Review: All communication (verbal, non-verbal) techniques prior to beginning IPR. This will make it easier for you to log the communication and recognize strengths and weaknesses of your communication process.
Communication: Transaction between sender and receiver
Non-verbal: Physical appearance/dress, body movement & posture, touch, facial expressions, eye movements, vocal cues

Therapeutic Communication Techniques

Silence: give time to collect thoughts, consider other concerns
Accepting: conveys attitude of reception and regard
Giving Recognition: acknowledge and indicate awareness (commend strengths)
Offering Self: making oneself available on unconditional basis (increases self-worth)
Broad Openings: allows patient initiative to introduce topic of concern (patient role)
Offer General Leads: offers patient the encouragement to continue
Placing the Event in Time or Sequence: clarifies event in time perspective
Making Observations: verbalizing what is observed or perceived (patient behavior)
Encouraging Perception Description: ask patient to verbalize what perceived hallucination
Encourage Comparison: ask patient to compare similarity and difference-reoccur/change
Restate: repeat main idea of what patient said (patient can clarify or continue on)
Reflect: questions and feelings referred back to patient to recognize/accept own view
Focusing: taking notice of a single idea or word (don't use if patient is anxious)
Exploring: delve further into subject (helpful if patient tends to be superficial in communication)
Seek Clarification/Validation: strive to explain the vague or incomprehensible
Present Reality: when patient has misperception, nurse indicates perception of situation
Voicing Doubt: expressing uncertainty of reality of patient's perception (delusions)
Verbalizing the Implied: put into words what patient has implied or said indirectly
Attempt to Translate Words into Feelings: find clues to feelings expressed indirectly
Formulate Plan of Action: when patient has a plan of action for stressful situation, it may prevent anger or anxiety form escalating into unmanageable level
Active Listening: sit facing patient, open posture, lean forward, eye contact, relax
Feedback: descriptive of behavior, specific rather than general, directed toward what can be changed, impart information not advice, well-timed (early after behavior)

Non-Therapeutic Communication Techniques (Blocks)

- Agreeing/disagreeing
- Belittling Feelings
- Defending
- Giving approval/disapproval
- Giving advice
- Giving reassurance
- Indicating Existence of an External Power
- Interpreting
- Introducing an Unrelated Topic
- Probing
- Rejecting
- Requesting an Explanation
- Stereotype Comments
- Using Denial

Interaction Process Recording (IPR) Instructions

The purpose of the Interactive Process Recording (IPR) is to demonstrate the student's skills in understanding and refining therapeutic interactions as part of the nurse-patient relationship if noticed. The analysis of interactions with the patient promotes the student's ability to use the key therapeutic tool, the use of self, to facilitate growth in the nurse-patient relationship. The IPR assists the student to recognize personal feelings, actions, and interactions throughout the orientation, working, and termination phases of the relationship and to identify areas needing improvement.

Dialogue/Analysis

1. Place all verbal statements and nonverbal communications in the appropriate columns. Statements by the student and patient are to be recorded verbatim
2. Student analysis column
   a. Enter the type of therapeutic technique used e.g., Silence, and whether it was Therapeutic (T) or Non-therapeutic (N).
   b. Student rationale – "to allow the patient more time to think about the death of his mother" – and your thoughts about the patient's response. For example: *Patient seemed close to tears and I felt uncomfortable that I may have made the patient cry. I did well not talking – I wanted to say something like I felt sad when my grandmother died, but I didn't – I allowed patient the time patient needed to process his feelings.*
   c. If applicable, write alternative statement(s) and for each (N) response.
3. Patient analysis column
   a. Analysis of patient's thoughts, feelings, and response.
   b. Anxiety level – rate none, mild, moderate, severe, or panic. May also use 0, +1, +2, +3, +4.
   c. Labile defense mechanisms. If none, state none seen.

General Suggestions

1. Be direct in asking the patient to talk with you. Nurse counseling is a legitimate role and nurses should be comfortable with it.
2. Use **who, what**, **where, and when** to follow up patient statements as appropriate.
3. Avoid use of **why and how** statements.
4. Avoid jargon, euphemisms, slang, and figures of speech; may be misunderstood.
5. Do not over-sympathize with the patient about problems
6. When the patient uses psychiatric terms, ask what they mean by them.
7. Avoid close-ended questions.
8. Do not tell the patient how to feel.
9. Do not spend time discussing a patient's diagnosis.
10. Do not give advice.
11. If the patient talks about things patient would not do, ask what patient would do or did.
12. Do not defend the staff or hospital.
13. Do not share information about yourself, students, or staff. Divert the questions by saying "This is your time to talk about you."
14. If your patient is crying or emotional at the end of a session, stay with them. Ask if they are feeling OK and if they have someone to talk to. Do not just leave them.
15. If concerning statements were made by patient, always report what patient told you to staff before leaving the unit.

MENTAL STATUS EXAMINATION

The mental status examination is a process wherein a clinician systematically examines an individual's mental functioning. Each area of function is considered separately.

Appearance

This category covers the physical aspects of the individuals. Include: Physical appearance, height, and weight, how patient is dressed and groomed, dominant attitude during interview, such as degree of poise or comfort, degree of anxiety, and how anxiety is expressed.

Behavior

How does the patient move and the position in which the patient holds body? Note abnormal tics, movement disorders, and degree of movement.

Speech

Separate speech from content of thought. Note volume, rate, and flow of speech (fast, slow, halting, extremely loud). Include mannerisms, accent, stress or lack of it, hesitations, stuttering. Use descriptive words like garrulous, monotonous, loud, or emotional.

Mood/Affect

Affect is the outward show of emotion. Can vary thru depression, elation, anger, and normality, but if the overall sense from the examination is depressed, depressed is the word to describe the mood. Mood is the general pervasive emotional state as reported by patient. Range describes if the patient shows a full or even expanded range or if the affect is blunted or restricted. Include cultural considerations. Consider appropriateness of affect – is the emotion consistent with the topic being discussed. A patient with inappropriate affect may cry when talking about a parking ticket and show little or no emotion when discussing the death of a loved one.

Thought

Thought is divided into process (the way a patient thinks) and content (what the patient thinks).

Process: The rate of thoughts, how they flow and are connected. A formal thought disorder comprises processes such as pressured thoughts, (excessively rapid), flight of ideas, thought blocking (speech is halted), disconnected thoughts (loosening of association, derailment), tangentiality, circumstantial thoughts (over inclusive and slow to get to the point), word salad (nonsensical responses), punning (talking in riddles), poverty of speech (limited content).

Content: Includes those things discussed in the interview and the patient's beliefs. May have preoccupying thoughts – ideas of reference, obsessions, ruminations, or phobias. The patient may have delusions of control, thought insertion, broadcast, or delusions – persecutory, grandiose, religious, reference, somatic, morbid jealousy. For example, a depressed patient may have delusions of hopelessness, helplessness, or worthlessness.

Perceptions

Covers sensory areas and describes distortions such as illusions, delusions, or hallucinations. Describe the nature of the experience in detail. Auditory hallucinations (hearing voices) are more common in schizophrenics, visual disturbances are more common in organic problems. In addition, there are gustatory, olfactory, tactile, somatic, and kinesthetic hallucinations.

Ask "do you hear voices when no one else is around?" "Do you see things such as ghosts, spirits, or angels?" Ask if the voices are commanding the patient to do anything, particularly homicidal or suicidal acts. Hallucinations can be in the form of a running commentary. If the voices command a patient to do something,

does the patient obey the instructions or ignore them. Sometimes hallucinations are not well-formed voices or objects – patients may hear bells ringing, knocking at the door, banging sounds in his ears, or see vague things like halos or colors which are difficult to describe.

Note how patients cope with the hallucinations and whether they are pleasant, unpleasant, or terrifying. Comment on the hallucinatory behavior, such as patient looking back repeatedly, gesturing, or engaged in self-talk. To determine if the patient is having delusions, ask do you feel you have some special power or abilities? Does the radio or TV give them special messages? Does the patient have thoughts that other people think are strange?

Obsessions and compulsions: Is the patient afraid of dirt/germs? Does patient wash his hands frequently or wash hands repeatedly?
Phobias: Does the patient have any fear, such as animals, heights, snakes, crowds, etc.
Preoccupations: Ask about ideas about the patient's body: Patient may believe he or she is changing or has changed, that his elimination functions, sexual functions, or digestive functions work in different or bizarre ways.

Cognition
Look at areas of abstract thought which declines or is absent in several conditions such as schizophrenia or dementia, level of general education and intelligence, degree of concentration.

Consciousness
Level of conscious state is assessed whether it is steady, fluctuating, cloudy or clear.
Rating: 1=coma 2=stuporous 3=lethargic/evidence of drowsiness 4=alert.

Orientation
Ask if the patient knows the time and date, place, patient (who the patient is), and the situation the patient is in.

Memory
Memory is tested by looking for immediate recall. Give the patient 3 unrelated words (yellow, fox, Chicago) and ask patient to repeat them. In 5 minutes ask the patient to repeat them again. Do not tell the patient that you will ask them to repeat them in 5 minutes. (You might want to write them down, so you remember.)

Recent recall: What did the patient eat two meals ago?
Remote memory: When and where was the patient born? Where did patient go to high school?
Confabulation: Patients may do this if they cannot remember – if this occurs, just note it. You might have to check information with outside sources for verification. You can test for confabulation by asking if the patient has seen you before – the patient who confabulates may fabricate details of a meeting which did not take place.

Concentration and Attention
May be impaired for a variety of reasons: cognitive disorder, anxiety, depression, internal stimuli. Ask the patient to subtract 7 from 100 and keep subtracting 7 from the answer (serial 7s). Average time to complete is 90 seconds. Note the patient's response to the task: irritability, frequent hesitation, or questioning. Four or more errors is considered marginal; 7 or more indicates a poor performance. If the patient cannot begin the task, start at 50 and subtract 3s. If patient is unable to do that, have patient count backward from 10. Patient is not to use paper to complete the task.

Others

Dreams: Are there dreams, how often, how vivid, any repetitive dreams, nightmares? What is the content of dreams?

Déjà vu: Sensation of having been in situations like the present one.

Presence of suicidal/homicidal thoughts. Must inquire about specific plans, suicide notes, impulse control. If positive, will patient contract for safety?

Ask if patient has any thoughts of wanting to hurt anyone, wishing someone were dead? If yes, ask about specific plans.

Intellectual Functioning

General knowledge:

- Who is the President, name 5 last presidents?
- What is happening in the world? (war, economy).
- Name 5 major US cities.
- If you go to McDonalds and buy 2 hamburgers for 70 cents each and pay $2, how much change will you get back?
- Or how much is a quarter, dime, nickel, and penny?

Math calculations:

-Ask basic math problems: 4+6 or 13-8.
-Complex: Add 14+17.

Ability to abstract:

Determine similarities-

- How are an orange and a pear alike? Good answer = fruit, Poor answer = round.
- How are a fly and a tree alike? Good answer = alive, Poor answer = nothing
- How are a train and car alike? Good answer = modes of transportation, Poor answer = both have wheels

Proverbs-

- Ask "what does it mean to say: Don't count your chickens before they are hatched?" Good answer = Do not plan on future gains before they happen. Poor answer = chickens are little.

Judgment and Insight

Evaluate judgment with patient's response to: "What would you do if you were in a crowded theatre and smelled smoke?" "What would you do if you found an addressed, stamped envelope lying in the street?"

Insight: How does the patient perceive his present problem? "How did things come to be this way?

Mental Health Nursing Assessment Definitions

Emotions

Mood

Anxious	Feelings of fear or apprehension; can result from a tension caused by conflicting ideas or motivations.
Depressed	Feeling profound and persistent sadness
Despairing	Feelings of loss of all hope
Elated	Feeling ecstatically happy
Euphoric	Feeling intense excitement or happiness
Fearful	Feeling afraid
Guilty	Feeling culpable or responsible for a specified wrongdoing
Irritable	Feeling easily annoyed or angered
Labile	Feelings characterized by emotions that are easily aroused or freely expressed, and that tend to alter quickly and spontaneously; emotionally unstable.
Sad	Feeling depressed

Affect

Appropriate	When an individual reacts with the proper and expected emotion for the situation.
Blunted	Occurs when an individual's emotions or expressions are less reactive to stimuli than average.
Broad	Also known as full affect, describes the typical affect expected of the average person. An individual exhibiting broad affect shows the emotion that they are feeling.
Congruence with mood	Is the consistency between a person's emotional state with the broader situations and circumstances being experienced by the persons at that time
Flat	Occurs when an individual has a complete lack of expression, feeling, or emotion, regardless of the level of stimuli.
Inappropriate	Display of reactions that do not match the situation that you are in or possibly even your internal state.
Incongruence	Occurs when the individual's reactions or emotional state appear to be in conflict with the situation.

Labile	Occurs when a person's expressions shift unpredictably, frequently, and excessively.
Restricted	Also known as constricted affect, describes a small reduction in affect. An individual experiencing restricted affect may have dulled feelings or emotions but will still be relatively close to broad affect.

Thought Processes

	Form of thought
Able to concentrate	Being able to focus on a single thought or task.
Associative looseness	Characterized by a lack of connection between ideas. Associative looseness often results in vague and confusing speech, in which the individual will frequently jump from one idea to an unrelated one.
Attention span	Ability to attend to a stimulus or object over a period of time. This ability is also known as sustained attention or vigilance.
Circumstantiality	convoluted and non-direct thinking or speech that digresses from the main point of a conversation.
Clang associations:	Is a reflection of disorganized thought processes. Instead of a person's thinking and speech being directed based on meaning, in clang association, a person's thinking and speech is driven by the sound of words.
Concrete thinking:	Is reasoning that's based on what you can see, hear, feel, and experience in the here and now. It's sometimes called literal thinking, because it's reasoning that focuses on physical objects, immediate experiences, and exact interpretations.
Echolalia	Is a psychiatric disorder that makes someone meaninglessly repeat what another person says.
Flight of ideas:	Occurs when someone talks quickly and erratically, jumping rapidly between ideas and thoughts. Flight of ideas is not a medical condition in itself. It is a symptom that may occur as part of mania, psychosis, and some neurodevelopmental conditions.
Mutism	is a severe anxiety disorder where a person is unable to speak in certain social situations
Neologisms	Is the creation of words which only have meaning to the person who uses them.
Perseveration	Is the repetition of a particular response (such as a word, phrase, or gesture) regardless of the absence or cessation of a stimulus
Poverty of Speech	Is when there is reduced spontaneity and productivity of thought as evidenced by speech that is vague or full of simple or meaningless repetitions or stereotyped phrases.
Tangentiality	Is the train of thought of the speaker wanders and shows a lack of focus,

	never returning to the initial topic of the conversation.
Thought Blocking	Is a sudden cessation in the middle of a sentence at which point a patient cannot recover what has been said
Word salad	Are random words or phrases linked together in an often-unintelligible manner.
	Content of thought
Compulsions	Are repetitive stereotyped behaviors that the patient feels impelled to perform ritualistically, even though he or she recognizes the irrationality and absurdity of the behaviors. Although no pleasure is derived from performing the act, there is a temporary sense of relief of tension when it is completed. These are usually associated with obsessions.
Control	is a person's ability or perception of their ability to affect themselves, others, their conditions, their environment, or some other circumstance. Control over oneself or others can extend to the regulation of emotions, thoughts, actions, impulses, memory, attention, or experiences.
Delusions	false fixed beliefs that have no rational basis in reality, being deemed unacceptable by the patient's culture
Grandiose	Is a false or unusual belief about one's greatness.
Homicidal Ideas	Is a thought pattern characterized by the desire to kill another person or persons, along with a mental plan for a method of doing it.
Ideas of Influence	The patient may believe that somehow, they caused an unrelated event to happen
Ideas of Reference	are erroneous beliefs that an unrelated event in fact pertains to an individual.
Magical thinking	The belief that one's ideas, thoughts, actions, words, or use of symbols can influence the course of events in the material world.
Nihilistic	Is the belief that all values are baseless and that nothing can be known or communicated.
Obsessions	are repetitive, unwelcome, irrational thoughts that impose themselves on the patient's consciousness over which he or she has no apparent control.
Paranoia/suspiciousness:	Are intense anxious or fearful feelings and thoughts often related to persecution, threat, or conspiracy
Persecutory	Patient believes, erroneously, that another person or group of persons it trying to do harm to the patient.
Phobias	Is an overwhelming and debilitating fear of an object, place, situation, feeling or animal.
Poverty of content:	Is a person talks a lot but does not say anything substantive, or says much more than is necessary to convey a message.

Reference	false beliefs that random or irrelevant occurrences in the world directly relate to a person.
Religiosity	Is when a patient experiences intense religious beliefs or episodes that interfere with normal functioning
Somatic	Is when a person feels extreme, exaggerated anxiety about physical symptoms.
Suicidal Ideas	having thoughts, ideas, or ruminations about the possibility of ending one's own life.

Perceptual Disturbances

Hallucinations

Auditory	Are the sensory perceptions of hearing noises without an external stimulus.
Gustatory	Are tastes that are often strange or unpleasant. Gustatory hallucinations are often metallic taste.
Olfactory	Are false perception of odors, which are usually unpleasant or repulsive, such as poison gas or decaying flesh.
Tactile	Are an abnormal or false sensation of touch or perception of movement on the skin or inside the body
Visual	Is the visual perception in the absence of any external stimulus.

Illusions

Depersonalization	Are a patients' feelings that he or she is not himself, that he or she is strange, or that there is something different about himself that he or she cannot account for
Derealization	Is a patients' feeling that the environment is somehow different or strange, but patient cannot account for these changes.

Sensory and Cognitive Ability

Memory

Capacity for abstract thought	The ability to understand concepts that are real, such as freedom or vulnerability, but which are not directly tied to concrete physical objects and experiences.
Confabulation	Filling in memory lapses by guessing or making up events.

Recent	Is the temporary storage of information that is used in managing cognitive tasks, like learning, reasoning, and comprehension.
Remote	Refers to memory for the distant past, measured on the order of years or even decades.

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ Blood pressure:_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION -- Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total **CIWA-Ar** Score _____
Rater's Initials _____
Maximum Possible Score 67

*The **CIWA-Ar** is not* copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.

Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms for opiate withdrawals over a period of time.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date: _____

Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

Times: _____ _____ _____ _____

Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness *Observation during assessmen*t 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

GI Upset: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting				
Tremor *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection				
Total scores **with observer's initials**				

Score:
5-12 = mild;
13-24 = moderate;
25-36 = moderately severe;
more than 36 = severe withdrawal

Lifepoint Behavioral Health

Policies and Procedures, Code of Conduct, and Handbook Acknowledgement

I agree to abide by the Lifepoint and/or Springstone Code of Conduct, Employee Handbook, and Policies and Procedures. I understand that the Code of Conduct, Employee Handbook, and Policies and Procedures are readily available via PolicyStat. I understand that Lifepoint / Springstone has a right to change the Code of Conduct, Employee Handbook, and Policies and Procedures at any time and the changes will be communicated via normal communication channels.

I understand that this acknowledgement does not constitute an employment relationship, and further understand that Lifepoint / Springstone may terminate my student/intern assignment at any time if I'm in violation of any standard within the Code of Conduct, Employee Handbook, or Policy or Procedure.

_____

Student/Intern Name

_____ _____

Student/Intern Signature Date

_____ _____

Witness Signature Date

Lifepoint Behavioral Health

Video Release Agreement

I hereby give the Facility and its legal representatives and assigns, consent to record, videotape, and photograph my image and/or voice to be used for any legal purpose.
I understand this consent will last the duration of my contract agreement and following my contract termination, should that occur. I understand that I have no rights to the recordings, videotapes, and photographs.

I further understand that no special compensation will be provided to me for use of my image and that I may not be informed in advance of the specific use of my image. I waive any right to inspect or approve the finished photograph, advertising copy, and/or printed matter.

I release the Facility, its officers, employees, and agents, from all claims of harm and liability as a result of any distortion, blurring, or alteration, optical illusion, or use in composite form, either intentionally or otherwise which may occur from making, showing, using or distributing these photographs/videos.

I have read this release and consent form before signing below, and I understand and agree to its terms. I understand that signing this form is voluntary and will not affect my student/intern status.

_____
Student/Intern Name

_____ _____
Student/Intern Signature Date

_____ _____
Witness Signature Date

Attestation of Understanding – Modified New Employee Orientation

I have read and understand the PowerPoint presentation provided by Denver Springs for Modified Orientation. I understand that I am able to ask questions about any of the material covered and have been given the opportunity to do so.

I understand the following covered concepts:

- **Human Resources Concepts**
- **Review of the Following Policies**: Attendance, Appearance, Drug Free Workplace, Social Networking/Media, Performance Monitoring, Meal and Break Periods.
- **Review of Systems:** HealthStream, Email/Computer Usage, and IT.
- **Risk and Quality Management:** Incident Reporting, Observation Levels, Precautions, Managing Grievances/Complaints, Patient Rights, and HIPAA.
- **EOC:** Alarm Pull Stations, RACE, PASS, Emergency Codes, Own the Door, Smoking Policy, Biohazard Disposal, Chemical Safety, and Terminal Cleaning.
- **Infection Control Concepts:** Hand Hygiene, PPE, Precautions, MRSA, Hepatitis C, Tuberculosis, COVID-19, MDROs, Antimicrobial Stewardship, and Reporting.

Should I have questions, I am comfortable and competent in finding policies on the above concepts or ask my direct supervisor for help.

By signing below, I agree that I understand the information covered with the Modified Orientation PowerPoint provided and will follow the guidance issued in this PowerPoint when performing my daily job duties. Please return to Human Resources.

Name: _____ Date: _____

Signature: _____

DS 09.2024

Lifepoint Behavioral Health

Confidentiality and Security Agreement

I understand that the facility or business entity named below (the "Company") in which or for whom I work, Student/Intern or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with individually identifiable health information and protected health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will not use company systems to access patient information if it is not necessary to perform my job-related duties. This includes NOT accessing my own health information or that of my child or persons for which I am personal representative via the company systems. The Company's Privacy and Security Policies are available through the Company, copies of which will be provided upon request. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation, even if the patient's name is not used. I will make every reasonable attempt to refrain from practices that might lend itself to unintended breach of patient confidentiality.
4. I will not make any unauthorized transmissions, inquiries, modifications, or deletions of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Company's Privacy and Security Policies at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of Company employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up electronic media devices when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
    a. Use only my officially assigned User-ID and password (and/or token (e.g., Multi-Factor Authentication "MFA").
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
15. I will never:
    a. Share/disclose user-IDs, passwords or MFA.
    b. Use tools or techniques to break/exploit security measures.
    c. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Facility Information Security Officer, or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.
18. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information and will ensure that any such employee will execute their own Confidentiality and Security Agreement.
19. I understand that the Company may, at its sole reasonable discretion, rescind any person's access to any information system at any time. I further understand that if I am a member of the medical staff, any violation of the terms contemplated herein or of the facility's rules and regulations, may subject me to disciplinary action pursuant to the facility's medical staff bylaws.

_____
Student/Intern Name

_____ _____
Student/Intern Signature Date

_____ _____
Facility Name Facility Code

04.2024

Vital Sign Competency

Assessment S = Satisfactory, NI = Needs Improvement/Supervision, U = Unsatisfactory				
Validation Method O = Observed, D = Demonstrated, W = Written				
Process	**Assessment**	**Validation Method**	**Date**	**Initials**
Collect supplies (stethoscope, blood pressure cuff, thermometer, pulse oximeter)				
Choose the correct cuff size				
Accurately obtain the patient's blood pressure (diastolic & systolic)				
Accurately obtain the patient's pulse				
Accurately obtain the patient's O2 level				
Accurately obtain the patient's temperature				

Employee/Student Signature: _____Date: _____

Employee/Student Name (Printed): _____

Supervisor's Name: _____Date: _____

Infection Control Competency CheckList

Assessment: S = Satisfactory, NI = Not Improvement, NS = Needs Supervision

Validation Method: O = Observation, V = Verbalized, D = Demonstrated

Components	Assessment	Validation Method	Trainer Initials
Gloves:			
Staff can articulate how-to put-on gloves and dispose of the gloves correctly (behind nursing station)			
Staff can article why there is only one set of gloves used for patient contact			
Staff can articulate the process of cleaning the vital machine equipment in between each patient use			

By signing this document, you acknowledge and will abide by this education during your working hours.

Staff/Student Name Printed: _____

Signature: _____

Date: _____ Time: _____

Trainer's Name Printed: _____

Date: _____ Time: _____

Student Nurse Acknowledgement

By signing this you acknowledge your role as a Student Nurse related to code response.

Signature: _____

Print Name: _____

Date: _____

Name of Nursing School: _____