SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

POLICY AND PROCEDURE MANUAL

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Policy 105 – Emergency Services

I. POLICY

It is the policy of Southern Highlands Community Mental Health Center to assure that all persons needing emergency services shall receive it in a timely and effective fashion and that documentation of emergency services shall occur. Twenty-four (24) hour crisis intervention services are directed toward enabling both the consumer and involved family and friends to cope with emergencies while maintaining the consumer as a functioning community member whenever possible. This includes a twenty-four (24) hour crisis line with on-call trained personnel for face-to-face interventions that are available to all persons as needed without regard to income or insurance coverage.

II. DISCUSSION

This policy applies to all persons requesting service on an emergency basis whether by phone or in person. State Health Department Policies shall be adhered to, including the submission of pre-admission information and commitment orders from Circuit Courts and Magistrates for persons admitted to State operated inpatient facilities. Please refer to HIPAA Policy 523 – Right to Restrict Uses and Disclosures of PHI for additional information.

III. PROCEDURES

A. Staff assignments for emergency on-call coverage and consultation will be made by the Crisis Director in Mercer County and by the Clinic Administrators in McDowell and Wyoming Counties. After hours on-call responsibilities will be divided equitably among qualified assigned staff.

B. The consumer's physician and/or family members will be contacted by staff responding to emergencies if the consumer gives his/her written permission. When there is good reason to believe that the consumer's behavior could result in harm to self or others, contacts with the above or others who could assist will be made without the consumer's consent. Case managers of consumers will be contacted at the earliest opportunity.

C. Any emergency calls received by the SHCMHC on-call team from an ACT consumer will be forwarded to the ACT on-call team. The ACT on-call team will assess the consumer, provide assistance, and may request assistance from the SHCMHC on-call team for involuntary hospitalizations.

D. Communication with the nearest emergency medical service, hospital, or police will occur whenever appropriate. For example, staff may make referrals to the local ER due to immediate medical concerns or calls to other inpatient programs for treatment needs with consumer consent. Staff may contact police when executing Duty to Warn only after consultation with supervisor. They may also contact police for a wellness check if they receive a crisis call and the person indicates plan/intent to harm self and they are alone. Or staff may contact 911 in other instances when their clinical judgment deems it necessary to do so due to the immediacy of the person being a harm to self or others. You must always contact supervisor in these situations.

E. Emergency care will be provided only to those persons with observable psychiatric and psychological symptoms; those presenting physical symptoms including acute withdrawal due to substance abuse will be referred to an appropriate medical facility.

F. When emergency services are provided, information shall be gathered and recorded upon first contact with the individual. Documentation will be collected on the Crisis Contact Form in Avatar for all consumers, regardless of admission status or admitted program. All efforts should be made to adhere to the confidentiality guidelines in both the acquisition and sharing of consumer information (see Policy 179). Insofar as available, the information should include:

1. For emergency contact:

a. Identification data relating to the consumer or individual making the contact, such as family, friend, or police.

b. Description of significant clinical data.

c. Response of professional taking the emergency call.

d. Record of recommendations made.

e. Specific instructions given to consumer.

f. **Provisions for follow-up:** If the situation involves a suicidal threat, gesture, or behavior which could result in self harm and the individual is not admitted to the CPST program or hospitalized, there should be documented follow-up contact either face-to-face or by phone within twenty-four (24) hours. The follow-up should be with the consumer or someone who is very familiar with the consumer and their situation (i.e., family, friend, etc., who has been in close contact with the consumer within the twenty-four (24) hour period).

In determining severity of the consumer's threat, good clinical judgment needs to be exercised and follow-up should occur with any whose behavior could be assessed as being high risk in endorsing either suicidal, homicidal, or psychosis to include command hallucinations.

g. Signature of staff taking the call. In situations involving suicidal or harmful behavior, staff will notate supervisory and follow-up review in documentation.

2. <u>For walk-in emergencies:</u>

a. Identification data including the consumer's legal status.

b. The time of arrival and the time of discharge from emergency services.

c. Pertinent history including emergency care given upon arrival at the Center or other site.

d. Description of significant clinical data.

e. Treatment Plan if performing crisis intervention services.

f. The condition of the individual on transfer or discharge.

g. Disposition, including instructions given to the individual for follow-up care. In addition to oral instructions given to consumers upon discharge from the emergency service, written instructions shall be given which are dated and signed. Documentation of such instructions to consumer shall be made part of the consumer's record.

G. The record of emergency services shall be incorporated into the consumer's previous record, if one exists.

H. A recipient of emergency behavioral health services shall be referred to other behavioral health services according to his/her needs.

I. State Health Department requirements shall be implemented, according to policy, when individuals are committed to state operated behavioral health facilities.

1. Involuntary Commitment Procedures:

a. We cannot deny anyone the right to file a petition. However, the crisis worker will screen petitions carefully and will work to secure the least restrictive environment possible. Some individuals may need to be referred for other services in lieu of a petition such as to law enforcement if domestic in nature, to CPS/APS, and/or to detox or long term substance abuse treatment when appropriate, etc. For those consumers with substance abuse as primary, options for detox and long term treatment will be considered first before commitment.

b. Assist the petitioner in completing the probable cause petition. If family members or hospital personnel expect the crisis worker to complete the petition, the crisis worker will need to explain that we do not help in that manner. However, there may be instances when the crisis worker feels the consumer should be hospitalized and the consumer refuses and there are no family members or other collaterals to file a petition. In these rare instances, the crisis worker may file a petition if the consumer is voicing suicidal/homicidal ideations or is behaving in such a fashion to suggest that he or she may be dangerous to him or herself or others, but this should be a last resort.

c. Get insurance information and social history, if possible.

d. Have the petition notarized and make a copy of the petition.

e. Check to see if a physician, licensed psychologist or social worker is available.

f. Fax the petition to the Mental Hygiene Commissioner on call. Give the original petition to the Crisis Coordinator. The original petition will be taken to the Circuit Clerk's Office at the courthouse and a copy will be given to medical records.

g. For all court commitments, excluding children, Mildred Mitchell-Bateman Hospital should be contacted for appropriate referrals.

h. Staff is responsible for completing the WV psychiatric pre-admission form, Crisis Contact Form, and such required assessment items that the consumer's condition will allow. If an external physician or licensed psychologist is involved, he/she may need assistance in completing the "Certificate of Physician or Licensed Psychologist" and transportation order.

i. Copies of all the forms are reviewed by the appropriate staff members to insure follow-up by either the case manager or other worker. All consumers not hospitalized will be contacted by the staff person for additional service needs. The names of consumers hospitalized at State institutions will be given to the liaison linkage worker. Case managers of consumers seeking services but not hospitalized will be notified.

j. Give the completed packet to the deputy who will transport the individual to the hospital.

k. Check to see if the individual was sent to the hospital and contact the appropriate admission office.

PROTOCOL FOR COMMITTING A RESIDENTIAL PERSON

The protocol for dealing with residents of residential facilities who require involuntary hospitalization is as follows:

A. On-duty staff should notify:

1. The supervisor of the home or his/her designee.

2. If neither is available:

a. If the consumer is a Mental Health consumer

1) The ACT on call worker

2) The on-call worker, or

3) The Crisis Coordinator

b. If the consumer has a I/DD case manager:

1) The case manager or his/her designee

B. Staff should ensure the physical safety of the resident and others by following procedures outlined in Policy 140 - Management of Inappropriate Behavior, or Policy 141 – Use of Physical Restraints.

C. The residential supervisor and case manager should evaluate the resident and determine the appropriate course of action.

D. If involuntary hospitalization seems appropriate, the coordinator/case manager should follow procedures outlined in this policy.