SECTION - PATIENT RIGHTS
POLICY NO. 16.10

Effective Date: 6/11/14

TITLE: ORGANIZATION ETHICS

This policy replaces policy #16.10, dated 11/9/11.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to address ethical concerns of patients, staff and family members as they relate to patient safety and care.

CMHIP recognizes the role each employee plays as part of the team providing quality patient care and considers it the responsibility of all employees to appropriately address ethical issues as they arise.

Ethical concerns in the context of this policy must be related to patient care, and should be patient specific. Referrals include, but are not limited to:

- The rights of a patient versus the standard of medical practice.
- The ethics of different treatment approaches involved in a patient's treatment.
- The ethics of a medical professional versus the requirements of the law.
- Medical treatment considerations versus fiscal or systemic limitations.
- Conflict of interest issues regarding referrals for services.
- Conflicting patient rights, e.g., right to life versus right to be free of suffering.

Questions or concerns that arise due to a conflict that does not involve patient care shall be referred to the immediate supervisor or the appointing authority. Examples include interpersonal conflicts between staff, fiscal limitations or resource availability that might improve working conditions, staff disciplinary issues/grievances, etc.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all CMHIP staff and the CMHIP Ethics Committee.

III. PROCEDURE

A. Procedure for Referring a Concern

1. When a patient, staff member or family member has an ethical concern, the concern shall be submitted in writing to the Ethics Committee chairperson. All referrals are handled in the strictest of confidence with full regard of HIPAA rules and regulations.

2. If staff is making the referral, they shall indicate whether an immediate response is needed for patient treatment planning and interventions.

3. In the event the concern requires immediate action and occurs after normal business hours, the employee with the concern shall contact the hospital's

Administrator on Call. The Administrator on Call will consult with at least one member from the hospital's Executive Committee, and one member from the division management team (Division Director, Clinical Team Leader, Lead Nurse, Division Chief Psychiatrist, Division Chief Nurse), if available. The Administrator on Call will issue guidance/direction for temporary implementation of a resolution until the next meeting of the hospital's Executive Committee, hospital's Leadership, or the next meeting of the Ethics Committee.

4. The Ethics Committee chairperson shall notify committee members of the submission of an ethical concern and schedule a meeting at the earliest possible time, but no longer than 30 days from receipt of the referral. The chairperson will acknowledge receipt of the ethical concern and inform the referring party that a meeting has been scheduled. If the referring party wishes to attend the meeting, he/she may do so with details coordinated by the chairperson.

5. The Ethics Committee will evaluate each referral to decide whether the issue is an ethical concern or if it should be referred to another evaluating party. If more than 30 days is needed to provide a final recommendation, the person submitting the concern shall be advised during the interim regarding progress.

6. The Committee will request additional information as needed to make their determination. The Ethics Committee may refer issues for consideration or resolution to:

   a. CMHIP Executive Committee
   b. Physician Peer Review Committees
   c. Executive Committee of the Medical Staff
   d. Nurse Executive Committee
   e. Patient Representative
   f. Chaplain
   g. Other

B. Leadership and Employee Roles

1. CMHIP provides information on organizational ethics to all new employees as part of orientation.

2. As a condition of employment, prospective and current employees of CMHIP shall sign a copy of the Code of Ethics. The original signed copy will be kept in the employee's personnel file in the Southern District Human Resources office.

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Birgit M. Fisher, PhD Date
Interim Superintendent

COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO

CODE OF ETHICS

Employees, consultants, students and volunteers shall conduct business at CMHIP in a manner consistent with the mission of the hospital. You agree to follow these guidelines while affiliated with the Institute:

Conduct business relationships with other health care providers, educational institutions and payers in accordance with this Code of Ethics.

Conduct all activities in compliance with applicable laws and regulations.

Follow accepted standards of business ethics and integrity, representing CMHIP accurately and honestly. Do not engage in any activity intended to defraud anyone of money, property or services.

Maintain confidentiality of patient information and protect confidential and proprietary information about employees and the organization.

Treat patients, employees, students, volunteers, family, visitors and representatives of community agencies with courtesy and respect.

Involve patients, significant others, guardians and appropriate community resources in the patient care decision-making process, to the extent possible.

Follow accepted standards of integrity in research and educational activities.

Engage only in professional relationships with patients and families during and after patients' hospitalization. Make known to supervisors or the administrative staff, any pre-existing relationship with patients of the Institute.

Provide an accurate account of current services provided in all CMHIP marketing materials, including brochures, videos, and the like.

Base the continuum of service on patient needs, legal status and established standards of practice. Address in discharge planning patients' ongoing requirements for transition to community living.

Render services to all patients regardless of ability to pay. Understand that at any time patients may seek to resolve conflicts associated with billing issues.

Expect competency and integrity of individual practitioners and the organization as a whole.

When a patient is assigned work at Colorado Department of Human Services as part of their hospitalization, the work must be therapeutically appropriate, the patient must be compensated and it must be done of his or her own free will.

______________________________________ ____________________

Printed Name Position Number

______________________________________ ____________________

Signature Date

Colorado Mental Health Institute at Pueblo POLICY MANUAL

SECTION - PATIENT RIGHTS
POLICY NO. 16.11

Effective Date: 4/11/12

TITLE: UNANTICIPATED OUTCOMES

This replaces policy 16.11, dated 3/30/11.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to inform patients and, when appropriate, families or guardians about outcomes of care, including unanticipated outcomes.

The purpose of this policy is to define circumstances in which such notification is required and how notification shall occur. Any outcome that, in the opinion of the attending physician, differs significantly from the one anticipated shall be reported to the patient or surrogate decision maker (when appropriate and with patient consent), by the attending physician or his/her designee. Such outcomes would generally result in temporary or permanent harm to the patient and necessitate additional treatments, interventions or transfer to a higher level of care. Circumstances that could constitute unanticipated outcomes include but are not limited to:

1. Significant outcome related to medication errors (e.g., wrong patient, wrong medication or dose, etc.)
2. Adverse Drug Reactions determined severe and definite or severe and probable
3. Incorrect or misdiagnosis for Axis III only which resulted in harmful tests, procedures or treatment
4. Medical equipment or device failure
5. Technical errors (e.g., miscalculation of medication dose, incorrect use of equipment, etc.)

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include physicians and clinical staff.

III. PROCEDURE

In the event of a significant outcome in the course of patient care, the following shall occur:

1. The outcome shall be factually documented in the medical record in the progress note section.

2. The physician or designee will discuss the outcome with the patient and document that interaction, including the patient's response, in the progress note section of the medical record.

3. If it is established that authorization for release of patient information allows contact (see CMHIP policy 14.46, Authorization for Disclosure-HIPAA), the physician will discuss the unanticipated outcome with the patient's family or guardian and document that interaction in the medical record in the progress note section. Unsuccessful attempts to contact a family or guardian shall also be documented.

4. If indicated, an Incident Report (form 1300) will be completed and forwarded to Quality Support Services within two hours of the incident (see CMHIP policy 32.02, Critical Incident Reporting).

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Teresa Bernal, RN, C, BS Interim Superintendent	Date

SECTION - PATIENTS RIGHTS
POLICY NO. 16.13

Effective Date: 6/13/12

TITLE: PROCESS WHEN A PATIENT REQUESTS A CHANGE OF TREATMENT STAFF AND/OR PROGRAM

This replaces policy 16.13 dated 9/28/05.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to provide quality care and treatment in a manner that meets the patient's needs and preferences.

The purpose of this policy is to describe the process to be followed should a patient request a change in treatment program or team, including but not limited to, physician, nurse, social worker or other key -treatment staff.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include team leaders, psychiatrists, lead nurses and other key treatment staff.

III. PROCEDURE

A. This procedure goes into effect when a patient requests a change in treatment program or team, or other key staff. The request may be presented to staff in writing or orally, in a grievance, indirectly through another staff member, or through the Patient Rights Specialist. The staff member or Patient Rights Specialist shall bring the request to the attention of the team leader or his/her designee.

B. When discussing any change(s), decisions shall be based on weighing several factors including, but not limited to, the following:

1. The patient's clinical needs
2. Quality of care
3. Maintaining the patient's dignity
4. The basis for the patient's request
5. Patient's rights
6. Other CMHIP policies and procedures related to patient assignment to clinical programs and/or transfers (e.g., policies 10.00, Admissions, and 10.45, Legal Status Categories and Computer Codes)
7. Avoidance of double standards of care for similar patients and illnesses
8. Consideration of security and safety risks, and
9. Unit-specific program requirements

C. Process

1. The treatment team shall designate one of the treatment staff to clarify with the patient his/her request for a change. If possible, the patient's concerns or problems should be resolved within the context of the same treatment team, program, and/or responsible staff. Resolution of the patient's concerns and his/her perceptions of conflict shall be resolved in the simplest responsible clinical manner. The request and the resolution shall be documented in the progress notes and/or the Plan of Care of the patient's clinical record.

2. If the patient still wishes to make changes, and his/her concerns have not been resolved to his/her satisfaction, the treatment team shall discuss and document in the patient's clinical record the patient's request, a summary of the team's discussion, and the team's recommendation/plan for resolving the conflict. If the patient's clinical status allows him/her to participate in the team discussion without negative clinical consequences, he/she shall be allowed to do so.

3. If the attending psychiatrist, and/or treatment team recommends against changes for any reason, the patient shall be informed that he/she may request a consultation from the division chief psychiatrist, team leader, or division director.

D. Nothing in this policy shall be construed or used to deny any patient's rights or to deny a patient's right to initiate a grievance. Also, no patient shall be disciplined or punished for making any request according to this policy.

____________________________________ __________________________

William J. May
Superintendent

Date

SECTION – PATIENT RIGHTS
POLICY NO. 16.14

Effective Date: 10/9/13

TITLE: PEER COACH PROGRAM

This replaces policy 16.14, Peer Coach Program dated 2/13/13.

I. DEFINITION/PURPOSE

PURPOSE

It is the policy of CMHIP to promote rehabilitation and recovery options for patients by encouraging patients to work as a Peer Coach with peers, staff and family members who benefit from enhanced hope, alliance and preparation for next-step according to the principles of Recovery.

It is the policy of CMHIP to require Peer Coaches to complete screening procedures and training.

It is the policy of CMHIP to pay Peer Coaches for services rendered.

The purpose of this policy is to define the selection, training and administrative requirements that must be met in order for current or former patients, or patients of another treatment program, to participate in the Peer Coach Program.

DEFINITIONS

Peer Coach Trainee is a current or former patient of CMHIP or another treatment program who has applied for a Peer Coach position and has been recommended for the Peer Coach program by his/her clinical treatment team. Upon completion of training and orientation, the Review Team and clinical treatment team will determine whether each trainee continues to meet the criteria of III.A and has full support of the clinical treatment team to function as a Peer Coach.

Peer Coaches are current or former patients of CMHIP or another treatment program who assist, support and advocate for other patients, providing a bridge between patients and their clinical treatment team and other support networks. They are not employees of the hospital.

Peer Coach Coordinator is a CMHIP staff member who coordinates recruitment, hiring, training, and placement of all Peer Coaches.

Peer Coach Supervisor is a CMHIP staff member who supervises Peer Coaches, facilitates placement and assignments, and manages all Peer Coach activities.

Peer Coach Training Coordinator is responsible for arranging and providing training for peer coach candidates.

Peer Coach Trainers are CMHIP employees responsible for training prospective Peer Coaches.

Peer Coach Staff is comprised of Peer Coach Coordinator, Supervisor and Training Coordinator.

Peer Coach Unit Liaison is a CMHIP designated unit staff member assigned by the Clinical Team Leader/Coordinator to act as a liaison between the Peer Coach, patients, and the unit's clinical treatment staff.

Peer Coach Review Team is a three-member panel comprised of the Peer Coach Coordinator, Supervisor, and a Training Coordinator. The Review Team is responsible for reviewing applications, team referrals, and patient health information.

Peer Coach Interview Team is comprised of the Peer Coach Coordinator, Supervisor, a Training Coordinator, and one or more Peer Coaches. The Interview Team is responsible for interviewing candidates. Peer Coaches will not review patient health information.

Peer Coach Program Manual contains reference materials for Peer Coaches such as policies, expectations, application materials, records, training requirements, program guidelines, and resources that Peer Coaches may use to perform their functions and is incorporated by reference into this policy.

Duty to Tell: Peer Coaches have a duty to tell staff if a patient is a danger to self or others, contemplating harm to self or others, or has or may violate any CMHIP rule or regulation, or any state or federal law, such as possession or introduction of contraband or escape.

Hawkins Building (Bldg 140): Formerly the High Security Forensic Institute (HSFI)

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include the Peer Coach Coordinator, Peer Coach Supervisor, Training Coordinator, current Peer Coaches and the Assistant Superintendent for Clinical Programs.

III. PROCEDURE

A. Criteria for Consideration

1. Patients must apply for open positions in the Peer Coach program by completing and submitting an Application for Peer Coach form and arranging for their clinical treatment team to complete and submit a Peer Coach Candidate Team Referral form to the Peer Coach Supervisor

2. Peer Coach candidates within the Peer Coach program must meet certain criteria for consideration for inclusion in the program.

   a. The patient must be a current or former patient of CMHIP (either inpatient, temporary physical removal or conditional release) or another treatment program.

   b. Staff within the Sexual Treatment and Evaluation Program must evaluate candidates with a history of sexual offenses for appropriateness for Peer

Coach duties. Following the evaluation, candidates with a history of sexual offense may be eligible for the Peer Coach program upon the recommendation of staff within the Sexual Treatment and Evaluation Program.

c. Patients with pending charges of any kind are not eligible for the Peer Coach Program. Pending charges are those charges unresolved by either a finding of guilty, not guilty or Not Guilty by Reason of Insanity (NGRI) (with the exclusion of misdemeanor traffic tickets).

d. Patients with a dual commitment (NGRI and a DOC commitment) for any crime are not eligible for the Peer Coach Program.

e. Patients must be able to speak, read, write, and understand English.

f. Patients must have at least On-Grounds Unsupervised (ONGU) privileges upon completion of Peer Coach Training.

g. Patients must demonstrate the ability to manage symptoms substantiated by the clinical treatment team.

h. Patients must project a positive view of psychiatric medication and the treatment of mental illness as substantiated by the clinical treatment team.

i. Patients applying for the program must complete a CDHS background investigation. The resulting information will be taken into consideration in regard to their eligibility to complete the training.

j. Patients must be at least 21 years of age.

3. Peer Coach Candidates, Trainees, and Peer Coaches are required to report any tickets, violations of the law and or new legal charges to the Peer Coach Supervisor or Peer Coach Coordinator immediately.

B. Review Process

1. The Review Team shall use the following process to screen prospective applicants.

   a. Ensure application materials are complete

   b. Review clinical treatment team referral to verify treatment team supports the applicant.

   c. Review medical record to ensure applicant meets all criteria set forth in this policy.

2. Any applicant not meeting all of the criteria of III.A will not be allowed to participate in the Peer Coach Program but may reapply in the future when he/she meets the criteria.

C. Interview and Selection Process

1. Applicants who pass the preliminary screening defined in III.A. will be interviewed by the Peer Coach Interview Team, which will refer their top applicants back to the Review Team that will select from among the applicants.

2. The Interview Team shall select from applicants who successfully meet all the criteria in III.A, have successfully gone through the interview process, and are willing to assume responsibilities of a Peer Coach. Selected applicants will enter into a Peer Coach training program.

D. Orientation and Training for Peer Coach Candidates

1. The Peer Coach Coordinator will notify the Clinical Team Leader/Coordinator of an applicant's selection for orientation and training for Peer Coach Trainee. The Clinical Team Leader/Coordinator will inform the clinical treatment team of the selection.

2. The Peer Coach Trainee shall attend and successfully complete Peer Coach orientation.

3. The Peer Coach Trainee will be paid for attending initial training and orientation sessions.

4. Upon completion of training and orientation, the Review Team and clinical treatment team will determine whether each trainee continues to meet the criteria of III.A and has full support of the clinical treatment team to function as a Peer Coach.

5. Acceptance into the Peer Coach program as a Trainee and completion of Peer Coach training and orientation does not guarantee a patient will be assigned or employed as a Peer Coach.

E. Assignment of Duties

1. Before any assignments are made, the Peer Coach Trainee must sign the Peer Coach Program Agreement, which details the rules and expectations of the Peer Coach program, including a list of prohibited activities and acknowledges that Peer Coach earnings might impact the patient's benefits.

2. Before a Peer Coach is assigned to a unit or patient for coaching, the Peer Coach Coordinator, in collaboration with the psychiatrist and clinical treatment team, will review assignments for compatibility of patients and treatment objectives.

3. Before assuming any duties, the Peer Coach and the Peer Coach Supervisor (or other program designee) will visit treatment units in order to determine the appropriate assignment and meet the Peer Coach Liaison.

4. Clinical treatment teams or patients may request the assistance of a Peer Coach. The clinical treatment team will be involved in the selection of a compatible Peer Coach for the assignment. The Peer Coach relationship is voluntary on the part of a patient.

5. The Clinical Team Leader/Coordinator on each unit shall assign a Peer Coach Unit Liaison to work with the Peer Coach and Peer Coach Supervisor to coordinate Peer Coach activities for the unit.

F. Security Measures

1. Peer Coaches will wear a CMHIP Peer Coach identification badge attached to the front of their clothing above the waist at all times when performing Peer Coach duties.

2. Peer Coaches will not wear their CMHIP Peer Coach identification badge while off duty.

3. Peer Coaches will be "touch-searched" by Department of Public Safety (DPS) staff when entering the Hawkins Building and at other times deemed necessary by DPS.

4. Peer Coaches will be accompanied at all times by a CMHIP staff member when working in the Hawkins Building.

5. Peer Coaches will arrange coaching interventions in collaboration with unit Liaison and Peer Coach Supervisor in order to establish the date, time, and location for patient contact. Peer Coach patient contact in the Hawkins Building can take place either in the Hawkins Building visiting area or on the unit, whichever is deemed most appropriate by the Clinical Team Leader/Coordinator or the attending psychiatrist.

6. Peer Coaches will inform Peer Coach Liaison (or designee in the absence of the Liaison) when they have arrived on a unit and debrief with the Liaison or designee following the coaching intervention.

7. On minimum-security units, Peer Coaches will receive prior approval from the clinical treatment team and Peer Coach Supervisor to meet with patients outside of patient areas and without staff supervision if the patient has On-Grounds Unsupervised privileges.

8. Peer Coaches will adhere to the patients' current privilege level when meeting with them. Based on the patient's privilege level, the meetings will occur in common areas where staff can monitor the meeting such as unit day rooms, courtyards, patios, Treatment and Learning Center, visiting areas, and cafeteria.

9. Any Peer Coach interaction that occurs in an area that cannot be directly supervised by the unit staff will need to be discussed with and approved by the Peer Coach Supervisor and unit Liaison prior to the meeting.

10. Any Peer Coach will not have other patients in his or her vehicle as part of their peer coaching duties.

11. Peer Coaches will not meet with patients in the patient's off-campus homes.

G. Supervision and Performance Evaluation

1. The Peer Coach Supervisor will establish a schedule for regular supervision meetings with the assigned Peer Coach.

2. In conjunction with the Peer Coach's psychiatrist and clinical treatment team, and the unit(s) to which the Peer Coach is assigned, the Peer Coach Supervisor will evaluate the Peer Coach's self-management and regulation of his/her mental illness.

3. Patients within the Peer Coach Program must adhere to all applicable CMHIP policies, conditions of hospitalization, and conditions of release.

4. In the event that the mental status or treatment issues of the Peer Coach is such that he/she is unable to work, the Peer Coach's participation in the program will be placed on hold until the Peer Coach Supervisor, Peer Coach clinical treatment team and Peer Coach Coordinator determine that the Peer Coach is able to return to work.

5. In the event that a Peer Coach violates the Peer Coach Program Agreement, the Peer Coach/Patient Agreement, or for any other reason is deemed inappropriate by the Peer Coach Coordinator or the Peer Coach's clinical treatment team, the Peer Coach may be suspended or terminated from the program pending the outcome of an investigation. In the event a Peer Coach fails a random drug test, he/she will be suspended until the results of the test have been confirmed. Peer Coaches do not have employment rights, as they are not employees of CMHIP.

6. The Peer Coach Supervisor shall maintain a file containing documentation of training, supervision and performance.

H. Record-Keeping

1. Peer Coaches are required to maintain and submit documents related to their work with patients such as the Peer Coach Visit and Supervision Record, Peer Coach Diary Note, and other such forms. Files will be maintained by Peer Coach Coordinator or Supervisor and will not be in the possession of the Peer Coaches as they contain confidential information on patients.

2. Peer Coaches are permitted to work only the hours on the monthly work schedule developed by the Peer Coach Supervisor. Working beyond the approved number of hours may result in non-payment for time worked.

3. When a Peer Coach is scheduled to visit in the Hawkins Building, the Peer Coach Coordinator shall inform the Chief of the Department of Public Safety in advance of the visit to determine appropriate security measures for each unit and grant permission to enter.

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William J. May
Superintendent

Date

SECTION - PATIENT RIGHTS
POLICY NO. 16.15

Effective Date: 09/15/11

TITLE: ADULT PATIENT ABUSE/NEGLECT

This replaces CMHIP policy 16.15 dated 10/1/02

I. DEFINITION/PURPOSE

It is the policy of CMHIP that all employees will treat all patients with dignity, courtesy and respect.

This policy defines patient neglect and abuse and prescribes the process to be followed in investigating witnessed abuse/neglect, suspicion or allegation of patient abuse/neglect and in ensuring patient safety during investigation.

DEFINITIONS

1. **Patient neglect** is the failure of the employee to provide proper care or treatment. This may be due to lack of knowledge, ability, experience or attention on the part of the employee.

2. **Patient abuse** is any act, or omission of an act, that is inconsistent with prescribed patient care or treatment that violates the well-being or dignity of the patient and/or affects the patient detrimentally. This may include coercion exercised on a patient.

    a. **Physical abuse** is the act of intentional or reckless mistreatment that causes or is reasonably likely to cause physical pain, death or serious physical or psychological harm. Examples include but may not be limited to:
        i. hitting, pushing, pulling, rough handling, shoving
        ii. slapping, kicking, beating
        iii. unreasonable use of physical restraints or confinement not in accordance with policy
        iv. deliberate exposure to extreme weather
        v. use of an object as a weapon
        vi. misuse or withholding medication
        vii. use of medication for any purpose other than ordered
        viii. neglect (see above)

    b. **Verbal abuse** is any verbal communication that violates the well-being or dignity of the patient that places or attempts to place another person in fear of imminent serious bodily injury. Examples include but may not be limited to:
        i. yelling, harassment, intimidation, threats
        ii. cursing, foul language
        iii. racial or ethnic slurs
        iv. nicknames not requested by the patient, ridiculing, name-calling
        v. any remark that is intended to upset or provoke a negative response

c. **Sexual abuse** is any contact, verbal or physical, of a sexual nature between a staff member and patient. Examples include but may not be limited to:
   i. Sexual Harassment
      1. unnecessary and unwelcome physical contact including patting or touching
      2. demands for sexual favors in return for reward or threat of reprisal
      3. unwelcome sexual remarks or jokes that denigrate gender or sexual orientation
      4. displaying derogatory materials such as pictures or cartoons
      5. exhibitionism including provocative clothing or suggestive behavior/body display
   ii. Sexual Activity
      1. coercing patient through force, trickery, threats or other means into unwanted sexual activity including sexual assault/rape
      2. physically intrusive acts such as physical body to body contact, fondling or genital contact
      3. use of the patient for sexual gratification
      4. use of the patient to produce pornographic material or allowing others sexual access to the individual
      5. touching intimate parts or clothing covering intimate parts

d. **Financial abuse** is mistreatment that violates the well-being and causes material loss to the patient. Examples include but may not be limited to:
   i. theft, extortion, conning
   ii. deliberate misuse or mismanagement of patients' assets by a person in a position of trust
   iii. use of patients' property/money for purposes other than those intended by the patient
   iv. convincing patients to give away money, property or possessions with threats or coercion
   v. cashing patients' checks/money withdrawal slips without authorization
   vi. influencing patients to change wills or titles or influencing incompetent patients to change their will or power of attorney for personal gain
   vii. a pattern of misplacing, exploiting, or wrongful use of patients' property

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all CMHIP employees, especially any employee who witnesses or receives a report of abuse, supervisory staff, the Department of Public Safety (DPS), the appointing authority and the Superintendent.

III. PROCEDURE

Reporting, Investigating, and Correcting

For patients aged 17 and younger, refer to policy CMHIP policy 16.20.

In all cases where employee abuse or neglect of an adult patient is alleged, the following procedures shall apply:

1. Any employee witnessing, suspecting or learning of patient abuse or neglect shall immediately report the incident to his/her immediate supervisor. Any employee who has knowledge of, or is witness to, suspected patient abuse or neglect and fails to report it is also responsible for patient abuse. The immediate supervisor must report the alleged abuse/neglect to the appointing authority and to DPS immediately. The administrator on call may be informed to notify the appointing authority for after-hours occurrences. If an employee considers himself/herself to be in a situation of conflict regarding a report to a supervisor, the report to DPS will suffice. DPS will notify the appointing authority and Quality Support Services (QSS).

2. An Incident Report (form 1300) will be immediately completed by the reporting staff member and submitted to the supervisor. The form must be faxed to QSS at extension 4996 within two (2) hours of completion. QSS will assess the incident the next working day to determine if the incident is reportable to the Colorado Department of Public Health and Environment (CDPHE). If reported to CDPHE, QSS will inform the Superintendent and Director of Mental Health Institute Division.

3. For the protection of the patients, employees, and to facilitate completion of a prompt investigation, the employee shall be immediately placed on administrative leave with pay by the appointing authority. The appointing authority must notify the Superintendent of all staff placed on administrative leave. The supervisor will direct the employee alleged to have committed patient abuse/neglect to report to Building 125 west lobby prior to leaving the campus for an interview with DPS.

4. DPS shall immediately initiate an investigation into the facts surrounding the incident to determine probable cause/criminal intent and adherence to the agency policy and procedures. QSS will complete reports for the CDPHE as noted above.

    a. The employee shall inform the DPS dispatcher upon his/her arrival to Building 125 lobby and request that the DPS dispatcher place a call for a hospital police officer. The employee shall wait in the lobby area until the hospital police officer arrives to interview the employee as part of the investigation.

    b. QSS and DPS departments shall consult as needed with the appointing authority.

    c. The appointing authority will evaluate the allegations and risk to the patients and will review new information from the investigation daily to determine if the employee may return to work on his/her work unit or to another assignment.

    d. The final report to CDPHE and the DPS final report shall be forwarded to the Superintendent and the appointing authority when completed. After consultation, the appointing authority will initiate referrals to the appropriate peer review committee or department head for clinical review(s) of the occurrence.

    e. In the event of an occurrence where a patient is injured requiring off campus medical intervention, CMHIP will seek an independent investigation from outside

of the Institute and an outside independent clinical review of the occurrence. If DPS staff are involved in the occurrence, CMHIP will additionally seek an outside independent law enforcement investigation. These reports will be reviewed and acted upon by the Superintendent.

5. If the patient alleges sexual assault, procedures for Rape Crisis Intervention in CMHIP policy 8.57 will be followed.

6. Upon completion of the investigation, if indicated, an employee may be subject to corrective action and/or disciplinary action up to and including dismissal, by the assigned appointing authority.

7. Patient abuse or neglect may also violate State law and/or discipline practice standards. Allegations that are substantiated are reported to appropriate discipline regulatory boards or agencies. Employees may also be subject to criminal prosecution as well as administrative action.

8. When there is general or recurring abuse, a full inquiry will be directed by the Superintendent into the methods and type of supervision exercised in the care and treatment of the patients and the extent of management responsibility.

9. Every new employee will be required to acknowledge the receipt of this policy and will certify he/she have read and understand the policy on abuse of patients. This certification will be maintained in the employee's official personnel folder.

10. Steps will be taken to ensure that all CMHIP employees are kept fully aware and informed of this policy in order to take measure to avoid abuse and mistreatment of patients and to report instances of abuse/neglect in a timely manner to ensure that abusive employees are disciplined per CMHIP/MHI/CDHS policy.

________________________________ ________________________

Teresa Bernal, RN, C, BS Date
Interim Superintendent

SECTION – ASSESSMENT
POLICY NO. 16.17

Effective Date: 10/12/11

TITLE: ASSESSMENT FOR ABUSE AND NEGLECT OR DOMESTIC VIOLENCE

This policy replaces policy 16.17, dated 12/1/04.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to assess patients for evidence of abuse, neglect or domestic violence, to report such findings as legally required, and to address such findings in the patient's plan of care. These assessments will be based on criteria appropriate to each discipline responsible. "Evidence" must be observable beyond simple allegation. *Allegations, however, are sufficient grounds for reporting* (see below).

Assessment for abuse/neglect or domestic violence is conducted for the purpose of risk assessment and appropriate interventions that are meant to promote the patient's safety and assist the patient in coping with the physical and psychosocial effects of the identified abuse/neglect or domestic violence.

The assessment for abuse/neglect or domestic violence is not intended to be an uncovering process exploring developmental history or past events not a factor in the patient's environment outside the hospital. Patient reference to such past events will be noted for referral to the attending psychiatrist for further consideration. Once it is determined that the information does not bear on risks in the patient's current environment, the subject need not be further explored at time of the admission assessment.

MANDATORY REPORTING: Simple allegations are sufficient for activation of hospital and legal procedures for reporting. Refer to CMHIP policies below:
Policy 8.57 - Sexual Assault Allegations and Examinations
Policy 16.15 - Adult Patient Abuse/Neglect
Policy 16.20 - Abuse/Neglect of Minors: Definitions and Reporting

CMHIP may disclose Protected Health Information (PHI) about a patient, whom it reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including social services or protective service agencies, authorized by law to receive such reports.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include clinical staff involved in the assessment of patients, particularly physicians, nurses, and social workers.

III. PROCEDURE

A. Assessment in the admitting department

The admitting nurse and physician will perform initial screens for abuse, neglect or domestic violence to serve as indicators for unit assessment and follow-up. Findings are documented on form 190 (pg 2, 3), Admission Summary.

B. Assessment on the treatment unit

1. The interdisciplinary assessment process includes nursing and social work inquiries related to abuse and neglect. The assessing nurse and team social worker will note findings about any patient fears for safety, security of the disposition environment, collateral reports, and contradictory information on the Interdisciplinary Assessment, Form 140. (See mandatory reporting policy for children - CMHIP policy 16.20, Abuse/Neglect of Minors: Definitions and Reporting.)
2. Physicians complete page 9 of the Interdisciplinary Assessment, Form 140, within 24 hours of admission and a full dictated psychiatric assessment on Form 152 within 60 hours of admission. Potential abuse/neglect concerns that arise in the course of completing this assessment shall also be taken into account in the plan of care formulation process.
3. The treatment team shall determine if an adult patient meets statutory criteria as an "at-risk adult" (see item #6 below), and that there is reasonable cause to believe that mistreatment or self-neglect has occurred or that the patient would be at imminent risk of mistreatment or self-neglect after discharge. If these conditions are met, a report to Adult Protective Services of the patient's county will be made by the unit social worker; follow-up with that agency is to occur and be documented in the patient's medical record. The disclosure of PHI to Adult Protective Services must be documented on Form 600, Record of Protected Health Information Disclosures, are retained in the medical record pursuant to the CMHIP retention policy.

   If consideration of power of attorney, guardianship or conservatorship is warranted in the opinions of the attending physician, the unit social worker shall assist the patient and family or interested persons in liaison with courts, legal services and county protective services.
4. Whether or not a patient with indications of abuse or neglect meets "at risk adult" criteria, the unit social worker will provide resource information and discuss referrals with the patient (and others as appropriate) to resources and agencies in the patient's discharge placement community.
5. "**At risk adult**" is defined by statute C.R.S. 26-3.1-101 as a person susceptible to mistreatment or self-neglect "because the individual is unable to perform or obtain services necessary for the individual's health, safety, or welfare or lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the individual's person or affairs."
6. In any case where credible suspicion of abuse or neglect exists, appropriate interventions, both in-patient and for discharge planning, will be incorporated into the patient's plan of care.

C. Abuse and neglect assessment criteria are incorporated in the respective assessment tools for physicians, RNs and social workers. These criteria address physical assault, rape, sexual molestation, domestic violence, and abuse/neglect of elders or children.

D. Criteria for use by other disciplines providing clinical services to patients allow for observations of possible abuse or neglect to be forwarded to the treatment teams for specific follow-up assessment and intervention. These allied clinical providers are trained in the application of these criteria during New Employee Orientation. All employees receive education on observation of potential abuse and neglect, reporting procedures, and CMHIP's assessment process during the New Employee Orientation.

   1. Behaviors including: fearfulness, refusal, panic, physical resistance, moaning, weeping, screaming, pleading, trembling, perspiring, hyperventilating, pain behavior not previously addressed. (Observations shall be referred to the attending psychiatrist or RN.)
   2. Injuries including: unmentioned fractures, unmentioned tissue damage, unmentioned cuts, bruises, swelling. (Observations shall be referred to the attending psychiatrist or RN.)
   3. Conditions including: dirty, neglected hygiene, lice, improper/inadequate clothing. (Observations shall be referred to the attending psychiatrist or RN.)

E. Preservation of Evidence: When a staff member suspects possible abuse or neglect of a patient, the Department of Public Safety (DPS) is promptly notified. Pending the officer's arrival, only immediately required medical attention is provided. Otherwise, no interrogation, handling of the patient, or handling of the patient's property is to occur.

   The CMHIP police officer shall conduct an interview, and direct the proper collection, recording and preservation of any potential evidence.

F. Follow-up assessment: In cases where the suspected abuse/neglect is alleged to have occurred prior to admission or while on leave, once the Department of Public Safety has completed its interview with the patient, assessment by nursing and social work shall occur and be documented in a progress note and form 1300, Incident Report, shall be completed.

G. Alleged patient abuse/neglect by staff that occurs in the hospital is covered in policy 16.15. This policy deals with assessment of patients upon admission and during those first few days of hospitalization or when the patient goes on a pass.

____________________________ ____________________

Teresa Bernal, RN, C, BS
Interim Superintendent

Date

SECTION - PATIENTS' RIGHTS
POLICY NO. 16.20

Effective Date: 11/09/11

TITLE: ABUSE/NEGLECT OF MINORS: DEFINITIONS AND REPORTING

This replaces policy 16.20, dated 10/26/05.

I. PURPOSE/DEFINITION

It is the policy of CMHIP that the position of trust held by any employee who has contact with patients of minor age requires continual professionalism and particular regard for their safety and welfare.

This policy is intended to educate employees regarding breaches of professional conduct, statutory definitions, and statutory/hospital requirements for reporting allegations, observations and evidence of child abuse or neglect.

CMHIP may disclose Protected Health Information (PHI) about a patient whom it reasonably believes to be a victim of abuse or neglect.

1. If the patient agrees to the disclosure (communication between CMHIP and the patient, including agreement, may be oral);

   a. To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law; or

   b. To the extent the disclosure is expressly authorized by statute or regulation and:

      i. CMHIP, in the exercise of professional judgment, believes the disclosure to be necessary to prevent serious harm to the patient or other potential victims; or

      ii. If the patient is incapacitated and unable to agree to disclosing his/her PHI, a law enforcement or public official authorized to receive the report represents that the PHI, for which disclosure is sought, is not intended to be used against the patient, and that immediate enforcement activity is dependent upon the disclosure and would be adversely affected by waiting until the patient is able to agree to the disclosure of PHI.

2. If CMHIP discloses PHI about a patient, in accordance with #1 above, CMHIP will promptly inform the patient, that such a disclosure has been or will be made except with CMHIP:

   a. In the exercise of professional judgment, believes informing the patient would place him/her at risk of serious harm; or

   b. Would be informing a personal representative, and CMHIP reasonably believes the personal representative is responsible for the abuse, neglect, or other injury

and that informing such person would not be in the best interest of the patient as determined by CMHIP in the exercise of professional judgment.

3. Documentation of disclosure (or non-disclosure, with the reason) to the patient shall be recorded on form 600 and placed in the patient's medical record.

A. BREACHES OF PROFESSIONAL CONDUCT

Examples of anti-therapeutic or unprofessional behavior toward patients include but are not limited to:

* Striking a patient, * Foul or offensive language, * Personal derogatory language,
* Persistent confrontation that exceeds therapeutic requirements, * Use of unnecessary force, * Sexual misconduct (see CMHIP policy 16.60), * Verbal or non-verbal threats,
* Intimidation or retaliation, * Withholding clinically indicated care, * Granting or restricting privileges for reasons other than therapeutic reasons (e.g., favoritism, retaliation), * Racial or ethnic slurs toward or about a patient.

Such breaches may or may not meet statutory definitions of child abuse/neglect and reporting requirements, but always constitute grounds for reporting to a supervisor (see CMHIP policy 16.15, Adult Patient Abuse/Neglect, section III, 1).

B. STATUTORY DEFINITIONS:

In order to properly make and route reporting of Child Abuse/Neglect, it is necessary to know the distinctions made by statute among various types of abuse and neglect. The terms in this policy are defined in C.R.S. 19-1-103, and consist of the following:

1. **"Abuse" or "Child abuse or neglect"** means an act or omission in one of the following categories that threatens the health or welfare of a child:

   a. Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death; and either such condition or death is not justifiably explained, the history given concerning such condition is at variance with the degree or type of such condition or death; or the circumstances indicate that such condition may not be the product of an accidental occurrence.

   b. Any case in which a child is subjected to unlawful sexual behavior as defined in section 16-22-102 (9), C.R.S.

   c. Any case in which a child is a child in need of services because the child's parents, legal guardian, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take.

   d. Any case in which a child is subject to emotional abuse. "**Emotional abuse**" means an identifiable and substantial impairment of the child's intellectual or psychological functioning or development, or a substantial risk of impairment of the child's intellectual or psychological functioning or development.

e. If a parent, guardian or legal custodian has abandoned the child or has subjected him/her to mistreatment or abuse, or a parent, guardian or legal custodian has suffered or allowed another to mistreat or abuse the child without taking lawful means to stop such mistreatment or abuse and prevent it from occurring.

f. The child lacks proper parental care through the actions or omissions of the parent, guardian or legal custodian.

g. The child's environment is injurious to his/her welfare.

2. **"Institutional abuse"** means any case of abuse that occurs in any public or private facility in the state that provides child care out of the home, supervision, or maintenance. "Facility" includes, but is not limited to, any facility subject to the Colorado "Child Care Licensing Act" and which is defined in section 26-6-102, C.R.S. "Institutional abuse" shall not include abuse that occurs in any public, private, or parochial school system, including any preschool operated in connection with said system; except that, to the extent the school system provides extended day services, abuse that occurs while such services are provided shall be institutional abuse.

3. **"Intra-familial abuse"** means any case of abuse, as defined above, that occurs within a family context by a child's parent, stepparent, guardian, legal custodian, or relative, by a spousal equivalent, as defined in section 19-1-103 (67), or by any other person who resides in the child's home or who is regularly in the child's home for the purpose of exercising authority over or care for the child; except that "intra-familial abuse" shall not include abuse by a person who is regularly in the child's home for the purpose of rendering care for the child if such person is paid for rendering care and is not related to the child.

4. **"Third party abuse"** means a case in which a child is subjected to abuse, as defined above, by any person who is not a parent, stepparent, guardian, legal custodian, spousal equivalent, as defined in section 19-1-103 (108), or any other person not included in the above definition of intra-familial abuse.

5. **"Law enforcement agency"** means a police department in incorporated municipalities, or the county sheriff's department, local to where the abuse/neglect is alleged to have occurred.

6. "**Child**" means a person less than 18 years of age.

The law states that persons defined as having reporting responsibility shall immediately report or cause a report to be made. The nature of "immediate" is to provide for protection to the child or others from possible risk.

II. ACCOUNTABILITY

The individuals responsible for implementing this policy include any staff member to whom an allegation of abuse is made or who observes the same. The local law enforcement agencies have the responsibility to investigate all reports of "**third-party**

abuse or neglect." The County Department of Social Services is the responsible agency for investigating **"intra-familial abuse"** and **"institutional abuse."**

III. PROCEDURE

A. Immediate Reporting and Evaluation Requirements

1. CMHIP staff shall immediately report:
   - all alleged, suspected or observed evidence of child abuse or neglect;
   - any injury that is self-inflicted or an inappropriate incident resulting from contact with other patients or staff, or is the result of a seclusion and restraint action.

   The Institute's statutory obligations will be met so long as staff report immediately and follow up promptly.

2. An evaluation of the patient condition must be made. The evaluation of the medical and psychological condition of the patient and all actions taken to ensure patient safety must be documented in the patient record.

B. Procedures for reporting suspected "institutional abuse/neglect" occurring at CMHIP

In all cases where employee abuse or neglect of a child patient is alleged, the following procedures shall apply:

1. Any employee witnessing, suspecting or learning of patient abuse or neglect shall immediately report the incident to his/her immediate supervisor. Any employee who has knowledge of or is witness to suspected patient abuse or neglect and fails to report it is also responsible for patient abuse. The immediate supervisor must report the alleged abuse/neglect to the team leader or administrator on call and to the Department of Public Safety immediately.

2. All allegations or observations of institutional abuse/neglect suspected of occurring under the care of CMHIP shall be reported immediately. The staff member to whom the allegation is made or who observes same must relay the report to the Pueblo County Department of Social Services: Reports are noted in the patient's medical record.

3. An Incident Reporting Form (form 1300) will be immediately completed by the reporting staff member and submitted to the supervisor. The form must be faxed to Quality Support Services (QSS) at extension 4996 within two (2) hours of completion. QSS will assess the incident the next working day to determine if the incident is reportable to the Colorado Department of Public Health and Environment (CDPHE). If reported, QSS will inform the Superintendent and the Director, Mental Health Institute Division.

4. The team leader or administrator on call will notify the appointing authority. Appointing authorities are responsible to notify the Superintendent of all staff placed on administrative leave.

5. If an employee considers himself/herself to be in a situation of conflict regarding a report to a supervisor, the report to the Department of Public Safety (DPS) will

suffice. DPS will notify the team leader or administrator on call and QSS. QSS will complete the assessment and the administrator will notify the appointing authority.

6. DPS shall immediately initiate an investigation into the facts surrounding the incident regarding probable cause/criminal intent. QSS will assess the incident for CDPHE as noted above. The supervisor will direct the employee alleged to have committed patient abuse/neglect to report to Building 125 west lobby prior to leaving the campus for an interview.
   a. The employee shall inform the DPS dispatcher upon his/her arrival to Building 125 lobby and request that the DPS dispatcher call for a hospital police officer. The employee shall wait in the lobby area until the hospital police officer arrives to interview the employee as part of the investigation.
   b. Both DPS and QSS shall consult as needed with the appointing authority.
7. For the protection of the patients, employees, and to facilitate completion of a prompt investigation, the employee shall be immediately placed on Administrative Leave with Pay. The appointing authority will evaluate the allegations and risk to the patients and will review new information from the investigation daily to determine if the employee may return to work on his/her unit or to another assignment.
8. If the patient alleges sexual assault, procedures for rape crisis intervention in CMHIP policy 8.57 will be followed.
9. Upon completion of the investigation, if indicated, an employee may be subject to corrective action and/or disciplinary action up to and including dismissal, by the assigned appointing authority.
10. Patient abuse or neglect may also violate state law and/or discipline practice standards. Allegations that are substantiated are reported to appropriate discipline regulatory boards or agencies. Employees may also be subject to criminal prosecution as well as administrative action.
11. When there is general or recurring abuse, a full inquiry will be directed by the Superintendent into the methods and type of supervision exercised in the care and treatment of the patients and the extent of management responsibility.
12. Every new employee will be required to acknowledge the receipt of this policy and will certify he/she has read and understands the policy on abuse/neglect of patients. This certification will be maintained in the employee’s official personnel folder.

C. Procedure for reporting suspected “institutional abuse/neglect” originating at another facility prior to admission to CMHIP

   1. A report shall be made promptly to the County Department of Social Services for the location of the facility in question. The report is noted in the patient’s medical record.

2. The Alleged Child Abuse/Neglect form is completed then reviewed and signed by the team leader and forwarded to the Division Director.

D. Procedure for reporting "intra-familial abuse/neglect"

1. The report is made promptly to the Department of Social Services for the county of the familial residence. Any known other minor at risk is included in the information.
2. The Alleged Child Abuse/Neglect form is completed then reviewed and signed by the team leader and forwarded to the Division Director.

E. Procedure for reporting "third party abuse/neglect"

1. All third party reports shall be filed promptly with the Police or Sheriff Department for where the alleged abuse/neglect occurred. If there is reason to believe that any other minor child is at risk, that information is included in the report. The report is noted in the patient's medical record.
2. The Alleged Child Abuse/Neglect form is completed then reviewed and signed by the team leader and forwarded to the Division Director.

F. All disclosures of PHI to an authorized outside agency must be recorded using form 600, Record of Protected Health Information Disclosures, and retained in the patient's medical record pursuant to CMHIP policy 12.55, Retention of Medical Records.

G. Employees disclosing PHI will follow appropriate policies and procedures for verifying the identity and authority of individuals requesting PHI. Refer to CMHIP policy 14.54, Verification in the Release of PHI.

H. Once it is determined that the use or disclosure of PHI is appropriate, the responsible staff with the appropriate access clearance will access the PHI and deliver to the requesting individuals in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to the PHI.

__________________________________ __________________________

Teresa Bernal, RN, C, BS — Date
Interim Superintendent

SECTION - PATIENTS' RIGHTS
POLICY NO. 16.35

Effective Date: 4/25/12

TITLE: PATIENT GRIEVANCE RESOLUTION PROCESS

This replaces CMHIP policy 16.35, dated 1/25/11.

I. PURPOSE

It is the policy of CMHIP to provide patients with accessible information about the CMHIP Patient Grievance Process, and to operate a grievance process that promotes the prompt and courteous resolution of patient complaints.

The purpose of this policy is to describe how patients and others may access the CMHIP Patient Grievance Process and how grievances will be investigated and resolved.

DEFINITIONS

A "**Complaint**" is a verbal request for assistance or an objection raised by a patient, family member or other representative of the patient, which is resolved at the time of the complaint by the staff present or others quickly available. If resolved in this manner, the complaint is not a "Grievance."

A "**Patient Grievance**" is a formal or informal written complaint, including an emailed complaint, that is made to CMHIP by a patient or a patient's family member or other representative of the patient, regarding the patient's care; abuse or neglect; issues related to CMHIP's compliance with the CMS Conditions of Participation; or a Medicare patient billing complaint related to rights and limitations provided by 42 CFR 489. A "Patient Grievance" also includes any verbal complaint concerning the above matters that is not resolved at the time of the complaint by the staff present or others quickly available.

A "**Patient**" includes any person currently enrolled as a patient of CMHIP and any discharged patient. For purposes of complaining about the care of a patient, "patient" includes a patient's legal representative or family member.

A "**Unit Patient Representative**" is any direct-care staff member, regardless of discipline (for example, social worker, nursing staff, occupational therapist, psychologist) who receives a complaint or grievance form from a patient, or alternatively who is designated by the Clinical Team Leader or, in his/her absence, the charge nurse to resolve a patient complaint or grievance. This person serves as the primary contact with a patient when a verbal complaint or written grievance is received, and should make responsible efforts to address the patient's complaint or grievance at the unit level. This should be done on the same day the complaint or grievance is presented whenever possible, but in any event within the time frames set out in this policy. (This staff person fills the role of "Patient Care Advocate" as defined in CDPHE regulations.)

A "**CMHIP Patient Representative**" is a staff member of the Office of Patient and Consumer Relations who is designated by the Superintendent to review the resolution efforts of the patient and the Unit Patient Representative, and who is responsible for

further investigation and resolution efforts at the Institute level. (This staff person fills the role of "Administrative Officer's designee" as defined in CDPHE regulations.)

A "**Closed Grievance**" is an unresolved grievance which has been appropriately and reasonably addressed at the unit level and does not require further investigation or action by the CMHIP Patient Representative, despite the fact that the person filing the grievance remains dissatisfied with CMHIP's action.

A "**Resolved Grievance**" is one in which the patient or the patient's representative is satisfied with the outcome.

A "**Grievance Response**" includes the steps taken to resolve the grievance; the results of the grievance process (i.e., the decision or outcome); the date of completion; and the identity of the hospital employee who resolved the grievance. This information can be provided on the Grievance Form.

II. ACCOUNTABILITY

All CMHIP staff will responsibly address any patient's complaint, concern, or grievance and those presented by family members or a patient's representative, as soon as reasonably possible and with the fewest steps possible.

III. PROCEDURE

A. Advisements and Postings

1. Advisements at Admission

   At the time of admission to CMHIP, the patient is given the "For Your Information" (FYI) packet, form 672 regarding institutional disclosures, and a list of patient's rights (the M-2 form). This M-2 form includes the name and contact number for the CMHIP Patient Representative, and is available in English and Spanish, with translation into other languages available.

2. Postings and Forms on Treatment Units

   Treatment units will post, in an area visible to patients, a sample Grievance Form and information on how to obtain a form; a description of the grievance resolution process; and the CMHIP Patient Representative's picture, name and phone number. Grievance forms must be readily available to patients.

3. No Discrimination

   Patients will be encouraged to voice complaints or recommend changes in CMHIP practices, and will not be subject to interruption of care, coercion, discrimination, or reprisal for doing so.

4. Access to Any Step of the Process

   A Grievance may be filed at any step of the process below, including directly with External Agencies, as set out in Section III (D) below.

B. Resolving Complaints

1. Complaints that are Quickly Addressed

Any patient, and any family member or representative of a patient, may verbally report a complaint to any staff member. All staff will respond to patient's complaints and attempt to resolve the matter at the earliest time and with the fewest steps possible. If resolved at the time of the complaint, this is not considered or recorded as a Patient Grievance.

2. Complaints to Officials

Complaints addressed directly to CDHS officials, CMHIP administrators or staff, or referred to CDHS by legislators or other officials, will be provided to the Office of Patient and Consumer Relations for investigation. A copy of any response prepared by CDHS will be forwarded to the Office of Patient and Consumer Relations for record-keeping purposes.

C. Unit Responsibilities in Grievance Process

The Clinical Team Leader, or person designated to carry out his/her functions in the Clinical Team Leader's absence, is responsible for oversight of the following actions and time frames:

1. Patient Completes Grievance Form

If a verbally reported complaint is not resolved at the time of the complaint, the staff member will provide the patient a Grievance Form, and will help the patient complete the form if the patient requests assistance.

2. Unit Patient Representative

The patient may give the completed Grievance Form to any staff member. The staff member will meet with the patient as soon as possible to attempt to resolve the issue. If resolution is not achieved, the staff member will forward the grievance immediately to the Clinical Team Leader, or in his/her absence, the charge nurse, who will assign a staff member to serve as Unit Patient Representative for this grievance.

3. Three-Day Time Frame

Whether resolved or not, the Unit staff member will scan or fax the completed Grievance Form to the CMHIP Patient Representative's office within three (3) days after the patient first presented the written grievance to the staff member. When necessary, the Clinical Team Leader or charge nurse may extend this time frame to seven (7) days. Further extensions of time at the unit level must be for good cause and must be arranged with the CMHIP Patient Representative.

4. Unit Resolution Process

The Unit Patient Representative will:

(a) meet with the patient or person filing the Grievance, investigate if necessary, and attempt to resolve the Grievance;

(b) complete the Grievance Form, outlining the steps taken to resolve the grievance, the resolutions proposed, and the outcome of the resolution process;

(c) provide the patient with a copy of the completed Grievance Form;

(d) scan or fax the Grievance Form to the CMHIP Patient Representative; and forward the original of the Grievance Form to the CMHIP Patient Representative. For unresolved grievances, the staff member should include any supporting or helpful documents that could speed the resolution of the grievance. Examples are progress notes, doctors' orders, or property or clothing records.

5. Special Reporting Requirements for Abuse or Neglect

CMHIP staff will immediately report any complaint of abuse or neglect to the CMHIP Department of Public Safety, complete and fax an incident report (form 1300) to Quality Support Services, and follow the procedures outlined in CMHIP Policy 16.15, Adult Patient Abuse-Neglect or, when applicable, CMHIP Policy 16.20, Abuse-Neglect of Minors-Definitions and Reporting.

D. CMHIP Patient Representative Responsibilities

1. Telephone/Verbal Complaints

The CMHIP Patient Representative will keep a record of complaints that are reported directly to the CMHIP Patient Representative, such as by telephone call. If the CMHIP Patient Representative is able to resolve this issue immediately, or if it is simply a request for information, it will not be treated as or recorded as a Grievance. If the CMHIP Patient Representative is not able to resolve the matter at the time of the complaint, it becomes a Grievance. The CMHIP Patient Representative may refer the Grievance to treatment unit staff for completion of a Grievance Form and action as set forth in Section C (4) above. Alternatively, the CMHIP Patient Representative may request that the patient prepare a Grievance Form, and may proceed directly with resolution efforts, as discussed below.

2. Review and Assessment of Grievance Form

On receipt of the Grievance Form, the CMHIP Patient Representative will review the form and the treatment unit's documentation of investigation and resolution efforts.

a. Resolved Grievance

If the patient and the treatment unit have resolved the Grievance, the CMHIP Patient Representative will classify and enter a summary of the matter into the Patient Grievance database. No further action is required.

b. Closing a Grievance

If the CMHIP Patient Representative determines that the unit staff have taken appropriate and reasonable action in an effort to resolve the grievance, the CMHIP Patient Representative may close the grievance without further investigation. In this case, the CMHIP Patient Representative will send the patient written notice that the Grievance has been closed, and will provide an

advisement that further review is available from CDPHE and the Division of Behavioral Health.

c. Investigation

If the CMHIP Patient Representative determines that further investigation or efforts at resolution are warranted, the CMHIP Patient Representative will conduct an investigation and make efforts at resolution. This may include meeting with the patient and others with relevant information, and reviewing documentation.

d. Resolution or Further Review

If the patient and the CMHIP Patient Representative are able to resolve the grievance, they will sign and date their agreement on the Grievance Form. The CMHIP Patient Representative will provide the patient a copy of the completed Grievance Form, and file the original of the Grievance Form in the CMHIP Patient Representative's Office. If they are unable to resolve the grievance, the CMHIP Patient Representative will provide the patient with a copy of the Grievance Form showing their resolution efforts, and an advisement that the patient may request further review by CDPHE and the Division of Behavioral Health.

e. Time Frames

Generally, grievances will be resolved or closed within 15 days of the date of receipt by the CMHIP Patient Representative. In special circumstances when a grievance cannot be resolved in 15 days, additional time must be approved by the Superintendent or designee. If the CMHIP Patient Representative cannot resolve or close the grievance within 15 days of receipt, the CMHIP Patient Representative will notify the patient that the investigation or resolution efforts are ongoing, and will provide the patient an estimate of the date on which the matter will be concluded and advise the patient that the patient will be notified of the outcome of the matter.

f. Priority Investigations

Immediate attention will be given to any allegations that, if true, could result in physical harm to patients. If the CMHIP Patient Representative learns of such a situation, or receives a Grievance Form containing such allegations, the CMHIP Patient Representative will immediately notify appropriate staff (for example, Department of Public Safety, Infection Control, Safety and Risk Manager, Quality Support Services for reporting to CDPHE) and follow the matter to an effective resolution.

g. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance Issues

If the patient's grievance involves a matter covered by the HIPAA Privacy Rule or other HIPAA provision, the CMHIP Patient Representative will provide the patient with the appropriate forms; provide an explanation of the HIPAA compliance process; and forward the information provided by the

patient to the HIPAA Privacy Liaison for investigation and resolution. The HIPAA Privacy Liaison will provide the results of the investigation to the patient within the time frames set forth in CMHIP Policy 14.41, "Privacy Rights of Patients."

E. Further Review

1. Superintendent's Office Review

The Superintendent, or an Assistant Superintendent or designee, will review all unresolved or closed grievances, generally within 10 days of the action taken by the CMHIP Patient Representative. The Superintendent or Assistant Superintendent may direct that further investigation or attempts at resolution be made by the CMHIP Patient Representative or, alternatively, may note his/her review of the matter on the Grievance Form, which will be returned to the patient. The Form will advise the patient that he/she may request that the CMHIP Patient Representative forward the grievance to CDPHE and the Division of Behavioral Health for further review.

2. Executive Committee Review

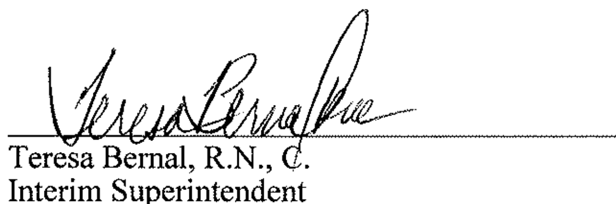
The CMHIP Governing Body has delegated to the Executive Committee the review of unresolved grievances, which the Committee conducts monthly.

3. Division of Behavioral Health

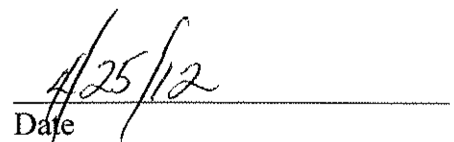
If the patient requests this review, the CMHIP Patient Representative will send unresolved grievances to the State of Colorado Division of Behavioral Health, for further review and investigation. The Division of Behavioral Health will review the grievance, gather additional information as needed, and will provide a response to the patient and the CMHIP Patient Representative with 30 days of receipt.

4. Contact with External Advocates

If requested by the patient, the CMHIP Patient Representative will provide information on contacting any appropriate regulatory or accrediting agency, including but not limited to the following: The Legal Center for Persons with Disabilities and Older People, the State Board of Medical Examiners and other professional licensing boards, the Colorado Department of Public Health and Environment, the CDHS Division of Behavioral Health, The Joint Commission, or the Office for Civil Rights (OCR)/U.S. Department of Health and Human Services. Patients have the right to file a complaint with any agency, including the OCR, and are not required to waive that right as a condition of the provision of treatment, payment, enrollment in a health care plan, or eligibility for benefits.



Teresa Bernal, R.N., C.
Interim Superintendent



Date

SECTION - PATIENTS' RIGHTS
POLICY NO. 16.50

Effective Date: 5/8/13

TITLE: PATIENTS' RIGHTS

This replaces policy 16.50, dated 2/1/11.

I. PURPOSE/DEFINITION

It is the policy of CMHIP to provide care and treatment that is skillfully and humanely delivered, with respect for the patients' dignity and privacy and in compliance with constitutional, civil and statutory rights, and that all staff are advised of patients' rights and are provided the guidance to assist staff in upholding these rights.

The purpose of this policy is to describe the rights of patients at CMHIP.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy are staff in the Office of Patient and Consumer Relations, and all CMHIP staff. All staff is responsible for protecting and advocating for the rights of patients.

III. PROCEDURE

A. Patients' Rights

1. **TREATMENT**: CMHIP believes that when a patient participates in treatment planning decisions and understands the treatment options he/she has, a patient will achieve better results. The physician will explain procedures and medications that will be offered, including benefits, risks, potential side effects, and alternatives to this treatment. A patient has the right to participate in planning where he/she will live, and where he/she may get treatment after discharge from CMHIP, when possible. A patient has the right to be given the names and the professional status of the staff members responsible for his/her care. Patients have the right to be informed that CMHIP is a teaching hospital and provides intern opportunities for a number of disciplines.

2. **NO DISCRIMINATION**: A patient has the right to treatment that is not based on or influenced by age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. CMHIP does not discriminate on the basis of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. The ban on discriminatory practices extends to a patient's visitors. The patient has the right to choose who may or may not visit him/her. If there is a restriction on visitation for clinical or other reasonable reasons, those reasons must be clearly explained to the patient (or personal representative). CMHIP will ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

3. **ATTORNEY:** A patient has the right to retain an attorney and to consult with an attorney at any time. If a patient is here involuntarily for emergency evaluation

and treatment, the court has appointed an attorney. If a patient is here involuntarily under a short-term or long-term certification for treatment, the court will appoint an attorney to advise and represent him/her in mental health proceedings, unless the court finds that the patient is able to engage an attorney at his/her own expense.

4. **REFUSAL OF TREATMENT**: A patient has the right to refuse medication unless, due to mental illness, he/she poses an imminent danger to self or others, is gravely disabled or the court has ordered medications. A patient has the right to refuse any test, medical procedure or treatment unless his/her ability to make decisions is impaired or a life-threatening condition exists. A patient has the right to express his/her medical wishes through an Advance Directive. Within reasonable guidelines, CMHIP will honor a patient's Advance Directive. (See CMHIP policies 6.25, Involuntary Psychiatric Medications and 8.50, Advance Directives.)

5. **INVOLUNTARY MEDICATION COURT PROCEEDINGS** (See CMHIP policy 6.25, Involuntary Psychiatric Medications): Medication is a fundamental aspect of good psychiatric care. A patient shall expect to be educated about why medication is being prescribed for him/her, what symptoms are expected to change with medication, and potential side effects.

   A physician may order involuntary medication on an emergency basis, without a hearing. If the emergency medications will continue beyond 72 hours, the physician will initiate an affidavit to request a court hearing for court ordered medication.

   At the court hearing, the patient has the right to appear before a judge to present his/her case and voice objections to involuntary medication, with representation by an attorney at the hearing, if so desired.

6. **COURT PROCEEDINGS REGARDING DISCHARGE FROM HOSPITAL**: Discharge proceedings for patients under commitments vary depending on the type of commitment. (a) If a patient is hospitalized at CMHIP under a short-term or long-term certification under Title 27, Article 65, C.R.S., the patient has the right to review of his/her certification or treatment by a judge or jury. A patient may ask the court to appoint an independent psychiatrist or psychologist to examine him/her and to testify at his/her hearing. (b) If a patient has been found not guilty by reason of insanity or impaired mental condition, the patient has the right to petition the court for release six months following the patient's commitment, and annually thereafter. A patient may ask the court to appoint an independent psychiatrist or psychologist to examine him/her and to testify at his/her hearing. (c) If a patient has been found incompetent to proceed in a criminal case, he/she has the right to have his/her case reviewed every three months. (d) If a patient has been committed to the hospital for a sanity or competency evaluation, he/she will usually be returned to jail, or bond status, after the evaluation is complete. More information about patient's rights regarding discharge is available from the patient's attorney or from the Patients' Legal Access Attorney, at extension 4378. **There is no charge to a patient for assistance from CMHIP's Patient Representative(s) or the Patients' Legal Access Attorney.**

7. **CONFIDENTIALITY**: A patient has the right to confidentiality of his/her treatment records, except as required by law. When a patient is admitted to CMHIP, he/she receives a written advisement regarding confidentiality rights under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. For additional information, patients may call the HIPAA Privacy Liaison at extension 4343. It is a violation of state criminal law for staff or patients to release any information about another patient's condition or treatment to anyone, unless the patient has authorized, in writing, the disclosure. See Section 18-4-412, C.R.S.

8. **VOTING**: Those patients who are eligible to vote in elections have the right to vote by absentee ballot. Staff will assist patients with understanding and using the absentee voting process.

9. **ACCESS TO MEDICAL RECORDS**: A patient has the right to review his/her medical records at reasonable times unless the physician determines that in doing so would present a risk of harm to himself/herself or others. A patient has the right to appeal the physician's decision for this denial. (See CMHIP HIPAA Policy 14.46, Authorizations for Disclosure or CMHIP Policy14.41, Privacy Rights of Patients.)

10. **DAY-TO-DAY LIVING**: If a patient is receiving care and treatment under any provision of the Colorado Care and Treatment of Persons with Mental Illness Act (Title 27, Article 65, C.R.S.), he/she has the statutory rights listed below. Even if a patient is not receiving care and treatment under the Care and Treatment Act, these provisions are applied to patients by CMHIP, regardless whether they have statutory rights. All patients will be treated according to the following rights or standards, and are entitled to receive help from the Patient Representatives to make sure they receive these benefits.

    a. TELEPHONES: A patient has the right to readily access telephones, both to make and receive calls in privacy.

    b. LETTERS: A patient has the right to receive and send sealed letters. No incoming or outgoing letters shall be opened, delayed, held or censored by the personnel of the facility. For the safety of the patient and staff, all incoming mail and packages are opened in the presence of a staff person, to prevent the introduction of dangerous or restricted items ("contraband").

    c. WRITING MATERIALS: A patient has the right to access letter writing materials, including postage. A reasonable amount of postage and stationary will be provided to him/her. Staff are available to help patients write, prepare, or mail correspondence.

    d. VISITORS: Visitors are welcome. A patient has a right to frequent and convenient opportunities to meet with visitors. A patient may meet with his/her clergy, attorney, or physician at any time, but to expedite these visits, the visitor should notify staff prior to the visit. All units have certain regular days and times for visits. Staff will work with patients to schedule visits at times more convenient for their visitors. If staff cancels a scheduled family visit, they will document in the progress notes the reason for the cancellation.

    e. CLOTHING AND POSSESSIONS: A patient has the right to wear his/her own clothes, to keep and use his/her own possessions, and to keep and spend a

reasonable sum of his/her own money. Personal items may be limited due to space, or for clinical or security reasons.

f. RESTRICTIONS: The statutory rights listed above concerning **clothing, telephone use, visitation, personal items, and mail** may be restricted for good cause by a psychiatrist providing treatment, but the patient must be given an explanation as to why the right is restricted. Restricted rights shall be evaluated for therapeutic effectiveness and re-ordered every seven days except in the Hawkins Building when restriction of rights may be based on the safety and security needs of the unit. The order for restriction shall be renewed every 30 days in such cases.

   Additionally, rights may be restricted by court order or as otherwise provided by law.

g. LEAST RESTRICTIVE ENVIRONMENT: A patient has the right to receive medical and psychiatric care and treatment suited to meet the patient's individual needs and provided in the least restrictive environment. A patient has the right to be free from physical restraint and not be placed in seclusion against his/her will except in emergency situations or other limited situations allowed by law.

h. TRANSFER TO OTHER HOSPITALS OR FACILITIES: If a patient is certified under Title 27, Article 65, C.R.S., he/she has the right to 24-hour notice before being transferred to another "27-65" designated facility, unless an emergency exists. A patient also has the right to protest to the court any such transfer, the right to notify whom he/she wishes about the transfer, and the right to have the facility notify up to two persons designated by him/her about the transfer.

i. FINGERPRINTS: A patient committed under Title 27, Article 65, C.R.S., will not be fingerprinted, unless it is required by other provisions of law.

j. PHOTOGRAPHS: A patient has the right to refuse to be photographed except for hospital identification purposes and the administrative purposes of the facility. Photographs shall be confidential and shall not be released except by court order, to law enforcement to address commission of a criminal act, or in the case of escape of persons committed as Not Guilty by Reason of Insanity (NGRI)/Impaired Mental Condition (IMC) or persons who have criminal charges pending, which includes Incompetent to Proceed (ITP) patients. In some common areas and seclusion rooms, video-surveillance may be used. Signs are posted to advise patients and staff of this surveillance.

k. SIGNING IN VOLUNTARILY: A patient has the right to sign in voluntarily, unless reasonable grounds exist to believe he/she will not remain a voluntary patient. Persons under criminal court commitments may not sign in voluntarily.

l. DUAL LEGAL STATUS: In cases where a patient is committed to CMHIP and is also committed to the custody of another institution, such as a county jail or the Department of Corrections (DOC), CMHIP may impose security procedures that are consistent with the security level of the facility from which the patient was admitted. These security procedures may limit the above rights. Security limitations are available in written form through the unit policies.

11. **GRIEVANCES**: Patients are encouraged to discuss their care and treatment, and any difficulties they are having, with their treatment team. A patient also has the right to file a complaint about his/her care or treatment. Grievances or complaints can be submitted to any CMHIP staff person, including treatment unit staff, and to the CMHIP Patient Representative, CDHS Division of Behavioral Health, or the CDHS Client Rights Program Director for allegations of discrimination. Other agencies that accept and act on complaints by patients include the Colorado Department of Public Health and Environment, the Department of Regulatory Agencies, Office of Civil Rights/U.S. Department of Health and Human Services, and The Legal Center for People with Disabilities and Older People. On request from the patient, the treatment team or CMHIP Patient Representative will provide him/her telephone numbers and addresses for contacting these or other agencies. (See CMHIP policy 16.35, Patient Grievance Resolution Process.)

12. **PATIENT RESPONSIBILITIES**: Patients are responsible for providing information, asking questions, following instructions, accepting consequences, following rules and regulations, showing respect and consideration, and meeting financial commitments. Patients are informed about their responsibilities verbally, in writing, or both, and through the "For Your Information" (FYI) handbook, which addresses the SpeakUp program.

B. Patient Notification and Education About Rights

1. Upon admission, a patient is provided a written list of rights in English or Spanish and the "For Your Information" (FYI) handbook. All patients will be provided an explanation of these rights in a language and by a means that the patient can understand.

2. Rights will be posted in patient areas on each unit.

3. The CMHIP Patient Representative's picture shall be posted on all units with information describing how he/she may be contacted.

4. The right to complain or object to treatment and the procedure for doing so will be clearly posted on each unit.

    a. Grievance forms will be readily available to patients.

    b. If requested to do so by a patient, unit staff will assist in filing a grievance.

    c. The originals of grievance forms, including the resolution efforts made by the unit and CMHIP patient representatives and any review of these resolution efforts by the Superintendent's Office or Division of Behavioral Health, shall be maintained by the Office of Patient and Consumer Relations for a period of ten years from the date that the patient submitted the grievance.

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William J. May
Superintendent

Date

SECTION - PATIENT RIGHTS
POLICY NO. 16.51

Effective Date: 6/11/14

TITLE: PATIENT'S RIGHT TO REPRESENTATION BY AN ATTORNEY

This policy replaces CMHIP policy 16.51, dated 9/15/11.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to provide patients their right to legal counsel.

The purpose of this policy is to describe the procedure for obtaining legal counsel for civil involuntary commitment.

II. ACCOUNTABILITY

Persons accountable for implementing this policy include admissions staff, and clinical staff who obtain required documentation.

III. PROCEDURE

All patients admitted involuntarily under a short-term or long-term certification shall be advised of their right to counsel, including a right to a court-appointed attorney without cost, if unable to pay. The court will determine indigency in connection with an Application for Representation by Legal Counsel (form M-19) to be filled out by the patient or, if incapable, by a hospital staff member. This procedure will be implemented in the following manner:

1. All patients shall be advised of their rights at admission (form M-2, Rights of Patients).
2. Whenever the psychiatrist decides to certify a patient for short-term or long-term treatment, a clinical staff member shall obtain a waiver of counsel (form M-23, Petition for Imposition of Legal Disability – Deprivation of Legal Right) or an application for Representation by Legal Counsel (form M-19) and this document shall be sent to the court with the Notice of Certification and Certification for Short-Term Treatment (form M-8).
3. If the patient requests an attorney and states he/she cannot afford one, but refuses or is unable to supply information for form M-19, then the interviewing staff member shall sign form M-19, supplying whatever information is known. The staff shall write an additional statement identifying the patient's refusal or inability to supply the information. The same procedure applies if the patient declares counsel is not desired, but refuses to sign form M-23.
4. The Legal Services Section of the CMHIP Medical Records Department may be contacted for questions regarding the above.

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Birgit M. Fisher, PhD Date
Interim Superintendent

TITLE: VOCATIONAL REHABILITATION/INDUSTRIAL THERAPY

This replaces CMHIP policy 16.54 dated 12/14/11.

I. PURPOSE/DEFINITION

It is the policy of CMHIP to offer patients employment opportunities at the hospital and in the community when the job is consistent with the patient's clinical status, ability and privilege level and when funding is available. CMHIP acknowledges the patients' right to refuse such work and does not engage in coercion in any form aimed at forcing a patient to complete tasks they do not wish to perform.

It is the policy of CMHIP to pay wages to the patients through the Vocational Rehabilitation Department of the hospital in accordance with applicable labor laws and regulations of the State of Colorado.

The purpose of this policy is to assure the safety of patients, staff and the community while promoting the patients' independence and self-reliance and allowing them to earn monetary compensation for their efforts.

DEFINITIONS

Industrial Therapy (IT): IT jobs are generally for patients who have limited privileges that require at least minimal staff supervision. The assignments are hospital-wide and include, but are not limited to, tasks such as light housekeeping on a treatment unit (e.g., dusting), newspaper delivery on campus, teacher's aide, library aide and minor grounds keeping. Work therapy and vocational counseling is provided for all patients working in an IT position.

Vocational Therapy (Voc Rehab): Voc Rehab jobs are generally more complex and require a higher level of privilege as some of them are performed in the community with minimal supervision. Components such as job skill development, positive work behaviors and vocational counseling are included in many of these positions. These positions are assigned based on an assessment by a Vocational Evaluator or Vocational Rehabilitation Counselor who take into account the patient's level of functioning, physical status, intended therapy benefits and in some cases, legal status.

Independent Employment: Patients working independently require minimal vocational staff contact. Patients are encouraged to seek employment with some help from Vocational Rehabilitation staff. After they secure a community-based job, patients can expect that Vocational Rehabilitation staff may check in with them and/or employers at least one time per month to make sure the job is going well for both parties. Vocational counseling is available on an as-needed basis.

IT Assignments or Voc Rehab jobs are not the same as tasks expected of patients and outlined in patients' responsibilities such as keeping their personal room area and clothing clean.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include the Vocational Rehabilitation staff, psychiatrists and clinical staff.

III. PROCEDURE

A. Upon consensus decision by the treatment team, that must include the unit Lead Nurse, that an on unit IT assignment would be of therapeutic value to the patient, a referral is made.

1. Once the decision has been made to refer a patient for an IT assignment, the unit physician shall write an order for the referral. The order drives completion of a Consultation Form (form 405), which is sent to the Voc Rehab Department. When a patient has been assessed, accepted and given an IT assignment, the Voc Rehab Counselor must add this to the patient's plan of care.
2. The unit Lead Nurse must be involved in all levels of discussion and creation of the IT assignments involving nursing staff since the Lead Nurse will assign the IT supervisor. The Lead Nurse must consider the unit needs and nursing staff availability in this decision.
3. The Lead Nurse will select a unit IT supervisor from nursing staff on his/her treatment unit. The unit supervisor cannot be an RN.
4. Only one staff member can supervise a patient as the unit IT supervisor. There shall be no more that one IT assignment per two treatment units where a member of nursing staff is the IT supervisor.
5. No IT assignments requiring a nursing staff supervisor will be made in the Hawkins Building or on admission units outside of the Hawkins Building (Unit 67 and Locked Adolescent Unit).

B. On-Unit IT Supervision by Nursing Staff:

1. The Director of Voc Rehab is responsible for providing annual training for the Lead Nurse, unit IT supervisor, and the patient, covering all aspects of the assignment including paperwork necessary, hazards (if any) and step-by-step instructions for job completion. Assignments are made based on assessment by the Voc Rehab Director who takes into account the patient's level of functioning, physical status and intended therapeutic benefits and in some cases, legal status. The patient, Lead Nurse, and the unit IT supervisor will sign a roster provided by the Voc Rehab Director attesting that they have had this training.
2. The Voc Rehab Director is responsible for completing yearly competencies for unit IT supervisors. Upon completion, competencies will be forwarded to the unit Lead Nurse for inclusion in the staff member's educational profile. Voc Rehab

staff will monitor unit IT supervisors/patients once per month to ensure staff are monitoring correctly and patients are performing the task correctly.

3. The unit IT supervisor must maintain line of sight observation of the patient at all times when the patient is performing his/her IT assignment.
4. The unit IT supervisor is responsible for completion of the patient's time sheets.
5. Upon receipt of the referral, a Voc Rehab Counselor or Evaluator will assess the patient and make recommendations for a particular job. The assessments and subsequent job recommendations may also include input from the unit or area IT supervisors, unit Lead Nurse, program vocational counselors or the job coaches.

C. Less than satisfactory job performance or concerns about privilege abuse are grounds for dismissal from IT or Voc Rehab assignments. Such circumstances shall be discussed with the treatment team, but the Voc Reh Department retains the right to make the final decision about whether a patient needs to be re-assigned or dropped from the program. Patients may be re-referred to the program at a later date as their behavior allows.

D If the patient is in agreement and accepts the assignment, short-term objectives that are individualized, behavioral and measurable as well as treatment interventions that outline expectations for the work process shall be developed with the patient and entered onto the Plan of Care for both IT and Voc Rehab assignments.

E. IT supervisors and job coaches shall provide monthly documentation about the patient's work efforts and progress toward meeting identified short-term objectives. This may be completed in the "Comments" section of the Work Therapy Evaluation (form 360) that also serves as the patient's time sheet. Additionally a monthly time sheet (form 206M) is placed in the progress note section of the chart. The chart reader is directed to see form 360 (Work Therapy Evaluation) and form 206M (Patient Monthly Progress Note) in the progress note on form 206 filed on the chart.

F. Voc Rehab IT supervisors and job coaches are responsible for educating the patients about all expectations of the job they are undertaking including, but not limited to, how to "call off" if they are ill, or whom to inform if they are going to be late for work.

G. Off campus, the Voc Rehab Department is associated with businesses such as Pueblo Diversified Industries where positions may be grounds keeping, landscaping, cartridge recycling, etc. Assigned Voc Rehab Department job coaches are responsible for oversight of these community-based positions and complete unannounced spot checks of patients with these IT jobs while they are working as well as maintain communication with supervisors of the businesses involved. Additionally, the job coaches assume responsibility for the patients' time sheets and paycheck dispersal.

William J. May
Superintendent

Date

SECTION - PATIENT RIGHTS
POLICY NO. 16.55

Effective Date: 5/9/12

TITLE: PATIENT-VOTER ASSISTANCE

This replaces CMHIP policy 16.55 dated 2/23/05

I. DEFINITION/PURPOSE

It is the policy of CMHIP to provide timely information and assistance to patients desiring to vote in primary or general elections.

The purpose of this policy is to outline the procedures to be followed at times of primary and general elections.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include the Director of Social Work, CMHIP PatientRepresentative, Patient Librarians, and Program Directors.

III. PROCEDURE

A. Posted Information

1. At least six weeks prior to a primary or general election, the Director of Social Work and the CMHIP Patient -Representative will distribute to all adult units and the Forensic Community-Based Services office instructions on voting, with sufficient copies for handouts. At least one copy is sent to the patient libraries for posting.

2. The Program Directors will assure that at least one of these bulletins is posted on the unit or area.

B. Assistance to Patients

1. A supply of voter registration forms and absentee ballot applications will be kept in the patient libraries. They can be obtained there or mailed by patient request to the unit.

2. The patient may request the assistance of any staff member in filling out a registration form or ballot application.

3. Any patient registered to vote but whose disability prevents private completion of a ballot, can request the assistance of a representative of the County election office. HOSPITAL STAFF MAY NOT PERFORM THE TASK OF ASSISTING IN BALLOT MARKING. It is the responsibility of the Program Director to ascertain whether any patient who has received an absentee ballot requires

assistance in voting, and to notify either the Director of Social Work or the CMHIP Patient Representative of this need. Either of those persons will make arrangements with the County elections office for a representative to come and assist the patient voter.

C. Voting Procedures

Mailing registration forms, ballot applications and absentee ballots is the responsibility of the patient voter, who can ask for staff assistance in the mailing process.

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Teresa Bernal, RN, C, BS
Interim Superintendent

Date

SECTION - PATIENT CARE DOCUMENTATION
POLICY NO. 16.60

Effective Date: 12/11/13

TITLE: DUAL RELATIONSHIPS WITH CURRENT AND FORMER PATIENTS

This replaces policy 16.60dated 6/13/12.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to protect current and former patients from dual relationships with CMHIP staff and to recognize the ethical considerations concerning involvement with patients and their families. Maintaining the public's trust while serving patients and their families is critical to the mission of CMHIP. Therefore, the welfare of the patient and the therapeutic relationship shall always be considered primary and protected.

A dual relationship is defined as a non-treatment (e.g. social, personal, financial, or sexual) interaction between a CMHIP staff member and a **current or former CMHIP patient.**

II. ACCOUNTABILITY

Individuals responsible for compliance with this policy include all CMHIP staff.

III. PROCEDURE

CMHIP staff shall maintain the priority of the treatment relationship between themselves and patients and between the hospital and its patients or patients' families.

CMHIP staff shall not initiate or engage in sexual, social, personal or financial relationships with patients ***either during or any time after hospitalization,*** even if the patient requests or initiates such a relationship.

A. Behaviors Indicating a Dual Relationship

(Behaviors include, but are not limited to the examples below.)

1. **Socializing with a patient** when it is not part of a clinically prescribed CMHIP program is prohibited. Examples:

   - Inviting a patient to the staff person's home
   - Accompanying a patient to a social function when it is not clinically prescribed or a part of a CMHIP-related or sponsored activity
   - Going out to eat, shop, attend an athletic event, movie or the like with a patient when the event is not a part of a CMHIP-related activity or part of the patient's plan of care
   - Providing a patient the staff member's home phone number, address or any other personal information

- Personal communications or correspondence to and from a patient regarding the patient's or staff member's personal information, personal life or another staff member's personal life with intent to develop a social or intimate relationship, or for any other reason other than one therapeutically prescribed and directed by the treatment team.

2. **Providing clinical services at CMHIP to fellow employees or patients who are colleagues, relatives or close friends** is prohibited because it is likely to impair professional judgment or do harm to the patient/therapeutic relationship or increase the risk of patient exploitation. Examples:

    - Being a member of the treatment team for a fellow employee, colleague, relative or close friend unless approved by CMHIP following disclosure
    - Providing treatment/therapy to a fellow employee in the same line of supervision or work unit

3. **Personal or financial gain of a staff member or a third party** by exercising undue influence on the patient, including the promotion and sale of services, goods, property, or promotion of religion or politics is prohibited. Also prohibited are bartering with, selling to, buying from, lending to, or borrowing from a patient. Examples:

    - Giving cigarettes to patients
    - Buying something, including a gift, for a patient that is not sanctioned by the clinical team.
    - Employing a patient to do chores or other services for the staff member or third party that is not part of a clinical program
    - Accepting goods or services from a patient
    - Personal gifts from patients or their families should not have significant monetary value in the judgment of the staff member and supervisor. In any case, all personal gifts must be disclosed to the staff member's supervisor. Gifts of significant monetary value must either be declined or returned after consultation with the supervisor, with the explanation that hospital policy prevents acceptance of such a gift.

4. **Sexual interactions with current or former patients** are an extreme form of professional boundary violation. Sexual interactions include engaging in sexual contact, sexual intrusion, sexual penetration, any behavior that is sexually seductive, sexually demeaning, sexually harassing or reasonably interpreted as sexual by the patient.

    - Fondling, touching or hugging a patient in a way that could be interpreted as sexual
    - Making comments to a patient that could be interpreted as sexual
    - Any kind of sexual contact with a patient
    - Flirtatious behavior
    - Inappropriate sexually laden or sexually abusive language

5. **Pre-existing relationships between staff and patients** (e.g., relative, neighbor) before hospitalization shall be disclosed by staff to their supervisors. After the patient is discharged from CMHIP, CMHIP staff are bound by CMHIP's ethical and professional standards in their conduct toward former patients. This includes, but is not limited to, confidentiality.

B. Reporting and Investigation

Violation of this policy is subject to disciplinary action up to and including termination of employment. If there is a suspected or actual social, sexual, financial or personal relationship between a staff member and a current or former patient, then staff with such information shall report the allegation to the hospital Department of Public Safety (DPS), the employee's (who has been alleged to have done something) appointing authority (to direct/supervise the employee), the Program Director (to address the clinical needs of the patient) and the Administrator on Call (if after hours/weekend/holiday). The investigation process is outlined in policy 16.15, III. The Team/Program Leader or Administrator on Call will also make a referral to the Patient Rights' Specialist for follow up with any issues the patient might have.

Documentation of any corrective or disciplinary action as a result of the investigative findings shall be placed in the staff member's personnel file.

Any violations of Colorado Department of Regulatory Agencies (DORA) statutes and regulations will be reported as required by state law.

C. Education and Training

All CMHIP staff members will receive education about dual relationships and applicable CMHIP policies during new employee orientation.

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William J. May Date
Superintendent