Hello and welcome to the

emergency management protocol training.

This is our fifth one.

You're almost there.

You are over halfway done.

Let's move forward.

Okay, so we're going to go over our DBH

resources first, and then we're going to talk about

emergency screenings, what safety planning looks like in virtual,

and some special considerations, lessons from the crisis line

alerting the team to a crisis a little bit

on what to do when there are local emergencies

or an emergency specific to your area, like a

fire or a flood, something like that.

Emergency after care for teams and

then Covet related team support.

Welcome to Discovery Behavioral Health

Training on emergency management protocol.

This hour will be a comprehensive overview

of DBH's emergency management protocols and the

strategies recommended by leading telehealth organizations.

We will review screening, management

documentation, and after care.

Resources will also be provided for

additional information on emergency management.

Our learning objectives are going to be our in

house resources, how to screen while virtual, and if

there's an emergency safety planning while in virtual, team

communication during an emergency, documentation of an emergency, emergency

after care for teams, covert related team support, and

probably a little bit extra, too.

What are the emergency management protocols

and resources for Discovery behavioral help?

How do I effectively screen for emergencies in virtual?

What are important considerations for

safety planning while virtual?

How do I document emergencies and how do I

care for myself and my team when emergencies happen?

Hopefully you'll be able to answer all of these questions

and much more by the end of this training hour.

Okay, so let's look at some of

the DBH resources we have available.

Just like everything else, this is

going to be an overview.

We're not going to do anything super in depth.

You do have all of these policies built into, like your

Savannah trainings and into day horse, but I think it's helpful

for us to go over them here as well.

So the first thing that we're going

to look at is our DVH Joint

Commission Resource Manual from 2020, and page

27 specifically outlines our emergency management protocols.

Then we're going to jump over to Savanta.

They have the emergency management plan policy,

the medical emergency policy, and then the

action plan for a psychiatric emergency policy.

There are others in advance as well, and we'll kind of

take a look and I'll show you where to locate them,

but we won't spend as much time on those.

Okay, so starting with our Joint Commission resource Manual,

I am going to show you how to locate

this, but let's talk through highlights first.

So it reviews what to do in

case of an emergency or disaster.

Emergent situation is characterized by the extreme, and this

is going to be extreme hot or extreme cold.

Something going on with weather,

typically emergency medication management, the

chain of command, communication.

We're going to focus on that a little

bit more and then roles and responsibilities and

if necessary, what evacuation looks like.

So let's go ahead and jump over.

I'm going to stop screen sharing.

All right.

I'm going to show you one of

several ways that you can access this.

You guys have seen me do this before.

As I think you could probably tell,

it's my preferred way of locating information.

So I'm actually going to look up the

Joint Commission manual, and here it is just

super duper easy, something you can all do.

And we're going to go down to page 27.

So far, here we are.

So this is just one place you can locate this.

It is also in Savannah, and we'll take a peek at what

you guys sign in Savanta in terms of this, but I just

want to go over it a bit more in depth.

Not too in depth.

Again, I know you get it in

other trainings, but there are special telehealth

considerations it's important to acknowledge here.

So it's the company policy to ensure the

safety of patients, staff, visitors and visitors in

the event of an emergency, including and not

limited to emergencies involving safety, security, hazardous material,

natural disasters, and utility management.

To ensure safety discovery, Behavioral Health manages

the building, grounds and environment of the

facility with the goal of eliminating risk

to patients, staff, and visitors.

So what this manual specifically addresses

is medical emergencies or medical disasters.

Typically, we're using emergency as language.

There fires, earthquakes, floods, severe weather sufficient

enough to cause isolation of residents, explosions,

and then any internal or external event

that compromises or potentially could compromise the

safety of patients, visitors and staff.

Excuse me.

It also reviews what to do with emergent situations.

So things that are just popping up as far as

extreme heat, extreme cold, exposure to the elements, the loss

of shelter in some way, and then loss of utility.

So like loss of power.

Let's go ahead and re view this one.

So emergency medication management.

Bring patient reference binders with all

printed up to date orders.

All medications should be kept in a locked container.

Inventory control should be maintained at all times.

So if there is some sort of medication management

emergency or a psychiatric emergency where the patient needs

to be taken for an involuntary hold, it is

our duty to be able to provide whoever is

taking that patient for the hold or the hospital

that will be holding the patient with the appropriate

information and with their medication.

While we do have the medication and we are

in charge of some form of medication management, which

doesn't happen at all sites, it's important that those

binders or the digital tools that we use to

track those medications are up to date and easily

accessible and transferable to the appropriate sources.

Chain of command.

So we're going to start with the

clinical or program director, who's in charge

of making decisions in an emergency.

If the clinical or program director

is unavailable to service the facility.

The staff will notify the Nil,

you manager or other facility leadership.

When we are in virtual, the chain of command

is potentially going to be different for you.

Often times they'll be very much aligned with what

your division does anyway for in person or virtual.

But nonetheless, you want to be able to go to

the program or clinical director if they're not available.

You can go to the executive director

and you can also obviously go to

the million manager or million coordinator.

If for whatever reason, none of them are available,

you're going to reach out to your regional director.

And if the regional director

somehow everybody's totally unavailable.

You're going to reach out to operations leadership.

If you are unsure of who your operations leaders

are, please ask your director, executive director and they

can review that for you or make sure that

you have the appropriate chain of command phone tree

and we'll talk about how to create that document

or that system for you later in this training.

The roles and responsibilities during an emergency

is who does what incredibly important here.

So facility leadership pulls the responsibility for ensuring

that all physical elements of the emergency management

plan are implemented, maintained, and properly documented in

compliance with all relevant standards.

This includes 24 hours, seven days a week

on call coverage to provide assistance needed.

And the consideration here is that when we're virtual,

we might be in all different parts of the

state or all different parts of the country.

So one of us may be going through

an emergency that the other one is not.

And it all comes down to communication and letting whoever's

the appropriate person in that chain of command know and

be able to support you in making sure you are

safe, making sure your patients are safe, making sure the

team is aware all of that jazz.

Another element here is that if you are spread

out all over the state, say, Florida, for example,

and there's a Hurricane coming, that Hurricane may affect

certain people before it affects others.

So the team needs to know in advance.

Are we relying on our North Florida team, members of

the Hurricanes in South Florida to really hold down the

Fort because we know that South Florida is going to

be having a difficult time or vice versa?

Or is the entire team compromised and we need

additional support in some way or the other?

The hope is, since we are virtual, we will be

able to support patients through these emergencies in ways that

we can't when we are in physical program.

Nonetheless, it's something we need to keep in mind.

It just could look very different.

Be aware of what types of

disasters happen in your region.

If you're in California, are

you dealing with wildfires?

Whatever it is, just know that it's not going to be

as consistent as it would if we were in person programs.

I would really recommend going through

this for yourself, making sure you've

read through the emergency management plan.

It's not super long.

It is also located in Savannah.

Again, I do know that you guys are trained on it.

Some things here will not apply, like emergency food.

You guys are going to be at your home.

So emergency food for facilities isn't

as much of a concern.

But power outages or the inability to have

Internet access, that would be a big concern.

So what is your team prepared for?

What are you not prepared for?

Does everybody know who they need to contact?

Does everybody know in general, like, what is this going

to look like for my job and for my patients?

If a more common disaster that we would expect

in this area happened, we can't plan for everything.

We can't plan for an asteroid crashing down to Earth.

But if we know we live in Florida and it's going

to be Hurricane season, we can definitely prepare for that.

If we know we're in California.

And while the fire season, we

can definitely prepare for that.

Just making sure we're all communicating, staying

up to date with our emergency management

trainings and all that jazz.

All right, that's enough on that.

Let's go back to our presentation.

So next, let's talk about what is in Savannah.

So what I'm going to do here is I'm

going to go through all of our Savannah slides,

and then we'll jump over to Savannah kind of

all at once and just practice finding these documents.

So the first one is

our DBH, medical emergency management.

So this is going to be you're in a telehealth

session, and somebody says, my chest is really hurting.

Like, I don't feel okay.

There's some sort of medical compromisation.

911, get 911 to that person's

house as soon as possible.

If they cannot call 911, call 911 for

them and have them sent to the location

that is on file for that patient.

If this is the appropriate action and if for

whatever reason, you don't feel confident or it's not

appropriate for you to call 911, get on the

phone with that emergency contact as soon as you

can and get services for this client.

It is incredibly important that we know where patients are

every single time they are in a telehealth session.

So even if we know that they're not at home or if

we assume they are at home, but for some reason, we need

to know what is the address that you are located at?

Is it different than where you usually at?

And this needs to be written down?

Because if we don't know and like, maybe it's an adolescent

and they have parents with Flick custody, and we're used to

seeing them in these two rooms and one's at mom's house

and one's at dad's house or one's at mom's house and

the other one's at mom's house, too.

We need to be able to send resources to

where they are and maybe their spaces look very

similar, and we just have to keep checking.

Is it Mom's house?

Mom's up to date address is XYZ.

Unfortunately, I've seen it where, like, it's really

hard to get DCF to the proper location

because a child is at another parent's house

and that house is not on file.

So just make sure everything is on file.

If they're at Susie Hughes house down the street,

for whatever reason, the address of that specific house

and how to direct services there if something happens.

Let's go over the highlights here.

So the company focuses on six critical

areas communication, patient and clinical and support

activities, resources and assets, safety and security,

utilities, management and staff responsibilities.

We focus on emergency and disaster, including medical,

fire, earthquake, flood, severe weather sufficient to cause

isolation of residence, explosion, or any internal or

external event that could compromise or could potentially

compromise the safety of patients, visitors, staff, et

cetera, and then emergent situations characterized by extreme

here cold.

As we talked about earlier,

let's talk about medical emergencies.

Okay, so this is more specific to

medical emergencies than the previous slide.

And this could be ankle injury.

They were walking and they hurt their ankle,

and now they can't get up and we

need to have somebody go help them.

Or if you're working with eating disorders, the patient's

been on hunger strike and they're no longer safe.

And we need to get them

connected to the appropriate resources.

And that's going to depend on your area and what's

really going on, what you're going to contact there.

But so many emergencies can happen

if they're taking medications, they took

a medication inappropriately, what have you.

So in the event of a medical emergency or injury

or illness that is acute and possesses an immediate risk

to a person's life or long term, health staff shall

call 911 and stay with the injured person.

Stay on the line with the

injured person until services arrive.

So this is when you're going to need to

let your team know something is going on.

This patient is not safe.

I need this group covered.

I need my session covered.

I need the Mm to jump in to see

what they can do here as a clinical director.

But I have to stay with this patient

and then keep your team updated as you're

with that patient until the services have arrived.

Find out where the injured person is going to

be transported, if it's hospital or acute care unit,

when possible, obtained sign release of information from the

patient for the hospital to which they're being transported.

So you can collaborate with that medical

team, notify operations program or operations leadership.

We'll talk about again, we've already addressed that chain

of command in some ways, but we're also going

to talk about incident reporting, notify their emergency contact,

and then complete an incident report.

Again, we're going to go over it.

Next is action plan for psychiatric emergencies.

So contact the psychiatrist or on call therapist.

So this is typically when we're talking about

suicidality, but could also be psychosis or a

number of other things going on.

So if we need to reach out because there is

some sort of psychiatric crisis happening, we're going to see

if the patient has a psychiatrist, if they're in a

PHP program or if they're in a residential program, they

more than likely have a psychiatrist who's affiliated with discovery

be able to help in some way.

If they are an IOP client, they may not.

So that's when you really might need to rely

on that therapist, sometimes the psychiatrist is also just

not available or the therapist and you might need

to switch to the other one.

So make sure you have both phone numbers.

So you're going to contact the

psychiatric emergency response team or 911.

So let's talk about that.

So some areas of the country have

specific teams, whether through the fire Department

or the police Department, that are devoted

to responding to psychiatric emergencies.

And in some areas they do not.

And it's just go to 911 and police officers.

It's always good to know if you have a

crisis intervention team or the emergency response team in

the area for the client because that's who you're

going to want to call first.

They're just training how to deal with this stuff

more in depth than like a typical police officer.

But other times you're just calling 911.

So just know the resources for that specific client.

The psychiatric emergency response team should be

given copies of insurance cards, emergency contact

information, medication records and diagnoses.

Support the patient by encouraging them to put together

a bag of clean clothes or hygiene products.

And if the patient isn't in the state to

do that, try and work with their emergency contact

or somebody in the home that's a support person

to do that for them, provide a copy of

the patient's emergency information to the response team that

will be taking them somewhere or supporting them.

And then if directed by the program director, notify

the patient's family, and if possible, obtain an oral

release to communicate with the hospital or the facility

that the patient will be taken to complete an

incident report and seek support for yourself.

We're going to talk about some specific ways

to do that in this training as well. Okay.

And then there's a few more on Zivanta

as far as our emergency management protocol.

So let's go ahead and hop over there and take a look.

I'm going to stop screen sharing

and take us over to Savannah.

And now you guys have already seen Savannah a

couple of times in this training, but I think

it's just helpful to reiterate things multiple times.

Sometimes we have to learn things over and

over and over again before they really stick.

And I want it to truly feel like a

natural reaction, like your go to when you need

to check on an emergency management plan.

You know exactly where it is, you know exactly

how to access it, and it's not a problem.

All right, I'm going to start screen

sharing again, and we're back on Vidanta.

So what I would do to locate this, this

is not the only way to do it.

This is just my preferred way.

You can also just comb through things.

You can go directly to emergency management,

and everything will be there for you.

And as you can see, there's much more than I have

reviewed with you in this training that you have access to

and that you will be prompted to review by Savannah and

to sign off that you are aware of.

Let's say you didn't do that.

You were just like on leadership

in government for whatever reason.

But you want to find specific emergency policy.

If you type in emergency, they're all going

to come up just the same so you

can see what happens if there's a robbery.

What am I supposed to do?

What am I supposed to do as far as so the water supply.

A lot of these don't apply in telehealth,

as you might imagine, but nonetheless, they're located

right here for you if you need them. Okay.

And back to where we were.

Let's talk about screening, and we're

going to start with suicide screening.

So first of all, in an ideal world, we're

not going to be dealing with patients who have

high acuity in terms of suicidality in this program.

However, it's going to happen at points because we

work in the mental health industry, and suicidality is

a part of almost every mental illness.

Not every mental illness, but it is a part of them.

So we're going to see this, and we

need to feel confident and competent in our

ability to deal with suicidality, even while virtual.

Again, verify location before every session or

at the beginning of every session.

We always need to know where these patients are.

Even when we work with patients in

person, we are not within 24 hours. So it's important.

We're always confident in emergency screening.

However, there is this sense of like, oh, my gosh,

I'm not going to be in person with this client.

How am I going to help them

if they do start feeling suicidal?

Like, I'm not going to know what to do. But you are.

You're going to do what you would have done

if they weren't with you, which they're only with

you, like a couple of hours of the day.

Anyway, there's lots and lots of

time for a crisis to happen.

And then we're going to jump into our suicide

screening protocols that we use at Discovery Behavioral Health,

and you complete other trainings on these.

There's other systems you can use, too, like

the Slap method, which is the suicidal intent.

It's just very simple.

So it's Slap.

I recommend looking it up.

I'm afraid I'm going to Butcher.

I've been doing these trainings all day.

So I don't want to speak to it inappropriately.

But essentially you want to identify,

like, what is the lethality here?

What is the danger they're going to cost to themselves?

Is what they're trying to do attainable?

Do they have access to materials that can

hurt themselves, and do they have a plan

that they intend to follow through with?

Have they already decided they're going to do

this in order to end them their lives?

And if that is the case and the severity

is really there, they need to have additional support.

And that support could be provided by parents,

depending on the level that they're at.

It could be provided by a wife or a

loved one, depending on the level they're at.

Or they might need an involuntary

hold where they are supervised.

And you're going to know this by your professional skill

and by using the tools that center for Discovery provides

for you and keep you whatever your EHR is.

We do know that depending on what area of

the country they're in, the response time may differ.

So if you're not 100% sure if this patient

needs to have a hold, but you also know

that they are very far away from the closest

possible authorities that would be able to help them.

That might be a decision you need to make to be

better safe than sorry and send them to a hold, whereas

with somebody else, if you know, somebody could respond within two

to three minutes, you might not make that choice.

So it really just depends.

And you need to know the full revedy of the situation.

Collaborate with the patient support team, and we've

kind of already talked to that a bit.

Ensure local emergency services are

included in the safety plan.

And what I mean by this is you

need to know what that services are.

If they're in Crownsville, Maryland, and you've never

been to Crownsville, Maryland, because you live in

four or five cities over, you don't know

what the emergency services are there.

So when you're making these safety plans with

them, work with them to identify those.

What is your local hospital

with a second local hospital?

For whatever reason, we can't get into that one.

Do you have non emergency resources in your area? Great.

Let's write down the contact information for those, but

get really specific and local about these plans.

Much more so than you might if they

were coming to a treatment center, verify the

involuntary commitment laws in the state and check

whether a telehealth clinician can initiate a hold.

So this is something we've talked about as well.

But let's spend a little bit more time here.

So in some States, as long as

you are licensed, you can initiate that

hold whether you're in telehealth or not.

In other States, this is not the case, and

you need them to be assessed in person in

order for an involuntary hold to take place.

If that is the law of that state, you

need to have that provider lined up ahead of

time identified, and they need to know that this

is something they could be called on to do.

I think it's usually best to work with

an outpatient provider if this is the case.

So if you have the partial hospitalization or intensive

outpatient and you're in a state where you cannot

initiate that hold, identify who their outpatient provider is

going to be when they discharge or who they've

had previously and are still comfortable working with and

ask if they're willing to do the in person

assessment for them.

As a backup, you can have the police do the assessment.

Hopefully they have a CIT team or

a specialized team that could do it.

Or you could have them go directly to

the hospital, stay on the phone with you

as they're getting there, as somebody is taking

them there and have the assessment down there.

Just make sure you know what your plan

is and what the requirements are for you.

If not, identify a local clinician who is willing

to support that patient as we've already addressed, and

then refer to the appropriate level of care.

If the suicidality is severe, as this

could be a potential contraindication for telehealth.

So somehow they got past this screening and it

turns out they really are struggling with intense suicidality.

That is not appropriate for telehealth.

Work with them to get them where they need to go.

And when they go to an involuntary hold,

that place might have a stipulation where they

cannot leave program until they have an in

person treatment team set up of some sort.

And if that's what needs to happen, work with

that team to get that plan in place.

If not, do everything you can to increase

support and protective factors for that patient.

So what do they have to live for?

What does their support team need to be aware of

that maybe the patient won't tell them on their own,

but through family sessions or couple sessions, we can support

them in being a little bit more honest and really

have robust plans in place until we can get them

to the appropriate level of care or facility.

Moving right along, we are going to talk

about self harm and virtual considerations next.

Again, we're screening for Fit.

This is not where we would prefer to have

our patients who have intense ongoing self harm with

or just they are not able to manage.

And we know we work in behavioral health and at

some point this is something that very well could happen.

It can be difficult to assess the severity of

self harm wounds, especially at cutting wounds over the

camera, because lighting is different, all sorts of things.

So if a patient reveals to you, I think, engaging

in self harm and they show you where this health

harm is on their body, you might be able to

tell some things from it, but you really want to

get an in person opinion on it.

So if it's appropriate, motivate or work with them

to increase motivation to share what they're going through,

hopefully with a support person or emergency contact that

can review the self harm in person and kind

of relay back to you what is happening.

Assess the self harm via the

company protocols to check for frequency.

How often are you self harming severity?

How severe is the self harm?

What is the potential for harm?

Are you self harming in an area

where you could cut an artery?

Are you using tools to self harm that could

cause long term serious damage or lead to death?

What is the intention behind the self harm?

Is it to self soothe or is it a part of suicidality?

Self harm is not always an indication of suicidality,

and it is an important term for that.

And then what is your ability to manage self harm

if there is no ability to manage self harm?

Virtual is probably not for them, and we want

to be able to support them in finding an

in person program or program where they will have

the support they need to be safe.

If it's a one time thing that we believe we

can work to manage, that does not rule out telehealth.

So it is all case by case, and then if

necessary, we will refer to the appropriate level of care

or facility, other things that we might need to emergency

screen for if a patient goes on hunger strike.

So typically a hunger strike would need to be

about three days, no eating, and then we need

to really consider hospitalization at this point.

We want to avoid that at all costs.

And again, it's not something I hope or expect

we will see much of in the virtual setting.

But could it happen with our eating disorder patients?

Absolutely.

And then what is your plan for managing hunger strikes?

Does your team know what a hunger strike is?

How to manage the hunger strike?

What is the point of the hunger strike

when we reach out to other policies?

Do you have emergency contacts in place who are also

aware of what a hunger strike is in the length

of time that hunger strikes are not permitted to go

on, but can go on before there is medical intervention?

That is like unavoidable?

What is the working time with that?

If your patient is having delusions or

hallucinations or is exhibiting signs of schizophrenia,

not that delusions or hallucinations are exclusive

to schizophrenia, because of course they're not.

But those would be roll outs and screening

for those would I definitely would say, involve

collateral resources, their emergency contacts, their support team,

and connecting them with the appropriate providers.

We treat patients who have

substance use disorder in virtual.

Undoubtedly it's appropriate for them.

It's when the substance use is very active and

if they are showing up intoxicated two sessions.

That is absolutely inappropriate.

We don't want them using it all.

We want them to be in recovery.

But we understand the nature of substance

use, and we need to be very

intentional about screening for these things.

Show me your space.

Let's take a tour of our space.

Let's see what the kitchen looks like right now, or

if you know some other behaviors that they might see

or they might exhibit in their home and you kind

of check for that or assess homicidal ideation.

Same thing as suicidal ideation.

Make sure that you are following,

like the Terrace off act.

And if you're aware that somebody has

intentions to hurt others, you are reporting

it to the state immediately.

You are taking the appropriate action.

Domestic and intimate partner violence.

These can be really tricky situations.

And telehealth in situations like this can

be incredibly emotionally taxing for the provider.

And they can also increase danger

for the victim in the household.

If their partner, for example, is listening to their sessions

that they're trying to be screened for the ITV or

for the DV, you really want to make sure they're

in a safe space where they are not near shot

of that abuser contacting collateral if you're going to make

safety plans with them on specifically getting out of the

situation, but make sure you know what you're doing when

you're doing that.

That can truly endanger the patient.

If it's not done correctly, just make

sure those are hidden very strategically.

There's no way they can find them on the computer.

Whatever it needs to be, knowing that there's

a higher potential of that user to go

through their technology than maybe a traditional client

screen for all of that stuff.

Ideally, it's best to have patients who are

experiencing DV or IPV in an inperson setting.

Sometimes this is absolutely their only chance

to get care because for whatever reason,

they need to stay home.

Maybe that's part of the isolation tactics.

And if that's the case, I

would recommend collaborating with a local.

If they have it a domestic violence

shelter or program or education program.

So there's something local on the ground there that they

can go to that they feel connected to and that

they feel supported by for that safety and then abuse

in general, make sure we're screening for abuse.

Same thing.

You might not be able to see bruises

or other wounds inflicted by abuse as easily

on the computer as you would in person.

If it is appropriate, try and

get other eyes on that person.

Do your due diligence.

Follow your DCF training.

The Department of Children and Families.

Contact DCF even if you're not sure it's

not fun, but you are not an investigator.

We're going to talk about this a little bit more later

in the training, so I'm going to leave it here.

But these are tough situations that can be

screened for while virtually it is challenging.

You can do it.

Just take your time, slow down whenever you

can get collateral collaboration with their support system,

that's going to be the most helpful thing.

And then connecting with local resources.

All right, let's talk just briefly

about lessons from crisis lines.

So crisis lines have been around since the 50s.

They are very old.

The first one, I believe is 1953 from

the UK, and then it's 1958 from La.

And they manage suicidality over the phone and have done

so for over half a century at this point.

And they managed to do it effectively.

Some of the things that they use that

are the most helpful are verbal deescalation skills.

If you don't have training in

verbal deescalation, I highly recommend it.

I think it's a great skill in general to

have, whether you're evaluating suicide ally or not, but

that's really the main tactic they rely on.

There's a bunch of cheap, affordable and

even free resources on verbal de escalation,

if you're interested in it.

And then I also included here

a suicide prevention lifeline assessment standard.

It's very similar to the one we use.

I just like the graphic that they use to lay it out.

So I included that here for you guys.

It's giving me like a little

bit of an issue moving forward. We can do it.

Okay, perfect.

Let's talk about our unique

virtual safety planning reminders.

And I've been dropping into this entire training.

So first of all, we want to screen for fit.

So I have included screening protocols at

the basic and advanced level for our

admissions team and our outreach teams, everybody.

So hopefully the clients that do come

to program are appropriate for a program.

And people change.

Illnesses change.

We are working with mental illness.

Things are going to happen.

Document location every single session.

I don't know how many more times I can say it.

Verify emergency contact numbers work

and update them regularly.

So this is something we need to be

very intentional about while we are virtual.

When you are provided with an

emergency contact number, call that number.

Make sure that it wasn't Typed in correctly.

Make sure they didn't just write down Sue's

cue number from 8th grade and that person

is actually ready to be an emergency contact.

Also update these numbers regularly or at least

check that they are still valid semi regularly.

And this can be as quick as a phone call just to

make sure you're getting the right voicemail and just say Hi.

So and so just verifying this number is up to date.

The worst possible situation is

an emergency does happen.

You go to call that number and it

goes and you have nobody to talk to.

So now you really don't have an emergency contact.

They didn't know they were the emergency

contact or their number has changed.

So just make sure all of that is good to go.

Document local resources and any

specialized resources by specialized resources.

I'm really preference, like the CIT teams.

But this can also be like your local TV

shelter, your local detox program, like whatever it is,

make sure each patient has this documented individually, especially

if they're in an area you're not familiar with.

If you're in Tampa and they are in Tampa and

you know where to send them, okay, got you a

regularly on what is appropriate for discovery behavioral health.

If you've never been to Pensacola, Florida, you're

going to need to do some research.

You're going to need to collaborate with that

patient and identify some resources for them.

And then highlight protective factors regularly.

So protective factors are the

things that keep us going.

They're the things that make us want to live.

So they're almost like the opposite of triggers or

traumas, where they make us just want to disconnect

and they make us not want to be here.

Highlight those protective factors.

Highlight those glimmers.

To me, that's the opposite of triggers.

Like, what are the little things that brought you joy?

Try and end on those not in a toxically positive

way, but also in a way we're trying to re

attribute some of our energy to the positive.

And then I skipped over boundaries here.

Review boundaries and plans for

in between sessions consistently.

So if there's an emergency between session, call 911.

I'm not available after hours.

This is who is available after hours.

These are other places you can call

and you can give them hotlines.

There's a lot of appropriate resources to give them.

But reiterate more than one time, like if there's

an emergency and I am not available, you call

nine on one as much as you can.

Now, this is something that you're going to

hear on every medical, behavioral health providers.

Phone, voicemail, pretty much for good reasons.

And you need to do the same thing for

your patient in just about every session here's.

National resources.

You can provide them for those in between sessions.

I pulled a whole bunch for you all.

Some of these places have websites.

Some of them are a little old

school, and it's just the number.

Some of them you can chat online.

There are lots of options here.

And then let's talk about

alerting teams to emergencies.

So first of all, you're going

to follow that chain of command.

You're going to go to the clinical director, and

then you're going to go to the mail, your

manager, mail, you coordinator, and then you're going to

go to the executive director, and then they're mutual,

and then the operations leader again.

This is all unique to which

division and Department you're working in.

But make sure you know that chain of command.

Make sure that you have an emergency phone tree.

So typically these are completed

for you guys and provided.

And if they are not, they might live somewhere else.

But just make sure you have

all of this information for yourself.

How do you contact your program director.

Don't rely on the contact in your phone.

Have it written somewhere else as well.

Same thing with your mail manager.

How does your client contact these

people if they need something?

What if you guys don't need

building management and stuff like that?

But if you're having a Ki Poo problem, do

you know how to access Shane or whoever it

is that's going to help you with Kikuo?

All of that jazz?

Just do what you can to be prepared.

And then my last note here is team.

So we will be using Microsoft teams to communicate.

And although we want to be professional with how

we communicate in teams, we also want to let

our teams know when something is going on.

So in the team's message, it's okay to say

like, hey, I'm with client with initials A. B.

They are in crisis mode.

I will not be able to cover the next group.

I will keep you guys updated

on the crisis if it's appropriate.

You can share more information, but nonetheless

let them know what's going on.

You can definitely set that flag and keyboard so

that alerts everybody via their electronic health record that

something is going on or that they are on

high alert needs to be assessed daily for suicidality,

for example, but let the team know so they

have the opportunity to support you.

And this is our emergency contact list.

So I recommend completing these plans for each patient.

Maybe not this exact version, but something

so something with specific resources in their

area once again, especially if they're in

regions you are not familiar with.

So what is their local Department

of Children and Family Services number?

Florida has the Florida Abuse Hotline.

It's a very simple number, but you need

to write these down for whatever areas in

their state or whatever resources in their state.

Excuse me, is there a local psychiatric unit?

What's that number?

Is there more than one local psychiatric unit?

What's that number?

In case they're full all this stuff,

let's talk about regional disasters and emergencies.

So again, we're going to follow the chain

of command and collaborate with our regional directors

and operations leaders and strategies to keep your

team safe and support your patients.

But it's just something to be aware of

that this is going to look a lot

different in virtual because depending on where you

are, you're going to be experiencing different things.

Like maybe you're having just a really bad storm

and the power is out in your area.

Your team needs to be malleable

and able to respond to that.

And you guys need to feel confident knowing that things

are going to be okay when these moments happen.

And we unfortunately know they're

happening more and more often.

So just being ready to kind of jump up and

support one another here, as far as documenting the emergency,

we're going to follow whatever protocols are in place.

For example, with the suicide assessment

and you can find the suicide

assessment documentation procedures in Savannah.

Csqm also has resources on them, and then

you might have division specific resources as well.

Always update the suicideality homicidality

and self palm screenings.

You can set flags so essentially, like, their

little profile will bleep red every time a

provider logs in, just so they're aware that

there's been a change in that patient state.

You can turn that off, by the way,

if you just click it, you've read it.

If that's something that bothers you.

But it's a good way to let

the team know what's going on.

We need to be more aware of what the

station is going through and how they're behaving.

Make sure you're including into your session notes every

single time patient did not or did endorse suicidality,

as evidenced by whatever it was in that session.

They said they did have intentions,

that it was passive overactive, and

you assessed for severity, lethality access.

We can do it. Come on.

We did it.

Okay, so let's talk about what

to do after an emergency.

So emergencies are obviously incredibly draining.

They affect the entire team, not just

the provider handling the emergency, not just

the patient experiencing the emergency.

And we really need to take some time

to settle, to evaluate, to validate what we

just went through when these things happen.

So my first tip here is going to

be follow your personal self care plan.

I remember when I went to school to become a therapist.

The first thing we did was develop self care plans,

and it's something that has definitely changed over time.

Like my opinion or my ideal version

of self care has changed over time.

But make sure you have this for yourself.

Make sure as a supervisor you encourage your team members

to have this and share your self care plan, if

appropriate, with your team so they can help you in

getting it and having that plan and those needs met.

Ensure you are getting every type of rest.

Oftentimes we think of rest as just like sleep.

Sure, most of us probably aren't

getting enough of that either.

But rest can also be broken down, similar

to how your wellness wheel is broken down,

meaning there's more than one dimension of rest.

Just like we have social wellness, environmental

wellness, intellectual wellness, spiritual wellness, financial wellness,

and physical and emotional wellness.

We need all of those types of rest.

We need social rest.

Do you feel burned out socially and

you just find yourself avoiding social situations?

You've probably extended a little bit too

much of your social battery, and you

need to socially recharge and socially rest.

Take some more time to yourself.

Do you feel like it's just incredibly

draining and exhausting and frustrating every time

you have to learn something new because

you're constantly intake so much overwhelming information?

You probably need a little bit more intellectual rest.

Give your brain a break.

Do some self soothing things watch some lighter

TV, just take all these things into account

and do what you can to bring yourself

to holistic wellness and have yourself be holistically

well charged, and then complete the stress cycle.

I love this book.

Burnout the secret to Unlocking the Stress cycle.

The sisters that wrote it, Emily and

Amelia, are just incredible human beings.

They have another book as well that's coming as you

are, I believe, much more about like, human sexuality.

And that actually might just be Emily.

But the burnout book does a great job of addressing the

stress cycle and the fact that if we're going all the

time and we never take a moment to celebrate or a

moment to rest or a moment to just acknowledge we have

survived that fight, we have survived that thing.

We never give our nervous systems a minute to breathe.

And that compounds into burnout.

The other reason I like this

book is it's pretty inclusive.

I think they're very aware of just a lot of

the toxic burnout culture of like, well, you're not taking

enough bubble baths, so of course you're stressed.

Like, that's not what self care is.

Self care is different for everybody.

Self care is about routine, and it's so

much more than bubble baths and like, going

to Lush or doing nice things for yourself.

Obviously that stuff is important.

But connecting with yourself, taking time to stop taking time

to understand how you complete the stress cycle is much

more helpful, and I think much more validating.

So if you haven't read this, get it

on Audible, complete the PDF, worksheets for yourself.

Give it to your clients, give it to your mom.

It's great.

Let's talk a little bit about

supporting the team after an emergency.

I would love to see every single team have

some sort of strategy in place for this, and

I want it to be unique to each team.

I don't want it to feel like

it's cookie cutter or like it's compulsory.

This is something that we want to

be individualized to the team's needs.

So after an emergency, it's important that we

feel connected and supported by our teams.

We want to plan for how we will connect.

So does your team really love coffee?

Let's plan like, a fun coffee morning date.

That's my idea of connecting with my team.

You guys probably have better ideas.

Maybe you need to have almost like a support group

of your own where you take 30 minutes at the

beginning of Thursday and you all get on and just

talk about what it's been like for you so you

can all professionally and appropriately support one another.

It's not a true therapy session or anything like that,

but we all need to know where we're at so

we know how to jump in or we know how

to stay back, like, whatever that is.

If you develop a really wonderful after

an emergency team strategy and you think

you'd be helpful for other teams. Please share with me.

I would love that. All right.

We're almost through it here, guys.

So next we're going to talk about incident reporting.

So incident reporting is done through Origami.

I am just going to go ahead and show you.

I think it's way easier.

All right.

So I'm pulling that up.

And then you guys do receive training

on Origami and the person who oversees

Origami offered to train us Additionally.

So I'll probably also provide that to you

all been done in the last year.

It's the important thing.

So when something happened, you need

to do an incident report.

You need to let us know this thing happened.

This is where you're going to go.

So you're going to go to the Internet, you're

going to scroll down, you're going to click organic

incident report and here's where you can report that.

And this is important for

letting us know what happened.

But this is also incredibly important for us

to help continue to reshape and improve these

strategies, to decrease risk over time and to

learn from what has happened.

So we put even better and more

robust team or plans in place.

Okay, we're almost done reporting abuse.

So I told you we are going to

talk a little bit more about it.

You are not an investigator.

If you suspect that abuse is happening to somebody that is

under 18, somebody who is at risk adult or an adult

who cannot stand for themselves, maybe they have special needs or

something that they don't have their own saying like what is

done for them medically, whatever it might be, or they're over

the age of 65, you need to report that abuse suspicion

of that abuse to the state.

You are not an investigator.

It is not your job to confirm suspicions of abuse.

It is not your job

to investigate or gather information.

It is your job to call report what you

know and they will decide if it is appropriate

to conduct an investigation and then do so.

Each state has a hotline or some

sort of number where you can report

abuse and potentially an online reporting system.

There is different requirements per state.

So in some States, Corporal punishment is illegal.

You're not allowed to hit your kids.

In other States, you're allowed to hit your kids if it

doesn't leave a Mark or if it doesn't leave a Mark

to a certain degree and it just depends on the state.

Make sure you have either done some sort of

DCF training or are aware of what your state's

specific requirements are for what constitutes of use.

And then be sure to document, when you do, call,

the ID number of who you make the report to.

So typically they'll give you like their first

name and then their two or three digit

number and just write that down.

Not write it down on a piece

of paper, but document that in.

Keepu along with the collaboration of care.

Note about calling the fact that if they accepted

the report and they're going to make an investigation

or if they're not able to accept it and

what the reasoning was, do you request that they

give you a call back with updates?

All of that jazz.

When they do assign an investigator that investigators name,

document their information, all of that jazz, and then

follow up with them as is appropriate.

Also, of course, make sure all of

your abuse trainings are up to date.

And if you want additional training on, you

know, screening for abuse, what constitutes abuse?

I would always recommend training with DCF

in that state covert related emergencies.

So we follow the CDC guidelines and we

also look at what the WH O says.

Make sure you stay up to date with the DVH policies.

Also, make sure you understand the

long term effects of Cobid.

If you yourself, a team member

or a patient has had Cobid.

Just because you've recovered from COVID does not

mean necessarily that things go back to normal.

There's unfortunately, a lot more research saying that it

just sticks with us for such a long time,

and it's important to know that, hey, that's happening.

You're not crazy.

They're not crazy.

They're not lazy.

Covet has very long term effects, and we

just need to be mindful of it.

There's also covet support groups.

If you really find yourself, your patient or a

team member struggling that you can direct them to.

One more resource for you is we actually just

had a coveted fatigue webinar, and I can share

with you guys later where that will be posted.

They haven't completed the video, but I did go ahead

and share what my tips are for managing Cobbt fatigue,

so I want to walk through those with you.

First of all, I want you to check in with yourself

on a scale from one to ten or tennis the worst.

How bad is the pandemic anxiety right now?

How bad is your clove anxiety or your clovet fatigue?

Whatever is happening for you, is it

specifically Blue screen or Zoom burnout?

Is it something else, like what's going on?

A tool to help you do this

is the Zoom Exhaustion and Fatigue scale.

I believe it's by Stanford.

It's pretty quick and easy and it's easy to locate.

I would recommend filling that out for yourself or

directing whoever would benefit from it to complete it.

Write it out Journal, like put it on paper, put

all these IDs you walk around with constantly on paper,

take a break, and then come back with a highlighter

and go through it for yourself and really acknowledge, oh,

wow, I didn't even realize that was in there.

That's tough, man.

I would think that was tough for anybody else.

Whatever it is in the makeup plan, what

are things that you can do to start

making yourself feel like yourself again?

Do you love gardening?

Well, maybe you don't have the energy to go to a

full garden but you can get like a couple new succulents.

You know, what is that little thing going to be for you?

What are your glimmers if you don't

feel comfortable going to restaurants again?

We used to love doing what you look forward to.

What are small ways you can bring that in?

Like can you order food from good belly? Good belly?

Is this really cool site where it'll send you food from

restaurants like all over the country, maybe the world, but I

know at least it's the country and just get a little

bit creative about how to make yourself feel a little bit

more like you and find joy again.

Okay, we did it.

I'm not going to summarize at this time.

I think you all got it.

If you have any additional

questions, as always, reach out. Let me know.

Let me know how I can support you and

if you have any further recommendations for this training

or for others trainings, definitely let me know too.

Good luck on your quiz and see you in training six.