Application and Review of Patient Safety Risk Flags

PREAMBLE: Individuals of certain backgrounds may be more likely than others to be perceived as aggressive, threatening or violent. Please recognize the role of implicit biases and assumptions and conduct applications of Safety Risk Flags using an antiracist and equitable approach.

KEYWORDS: violent, violence, assault, threat, threaten, unsafe, harm, RL, Midas, dangerous, flagging

PURPOSE: To define the process of responding to and communicating unsafe and/or physically threatening patient behaviors by equitably applying and reviewing Safety Risk Flags in patients' Electronic Health Records (EHR).

DEFINITIONS:

Safety Risk Flag: A flag within a patient's electronic health record, shared between MGB entities and placed to indicate an individual deemed at risk of physical harm to others.

Safety Care Plan: A plan of care accompanying the Safety Risk Flag to describe how those seeing the flag can mitigate the safety risk.

Safety Flag Committee (Committee): A group of individuals at each MGB entity tasked with the placement, removal and review of all safety risk flags initiated at that entity.

POLICY STATEMENT: Patients identified as a safety risk will have a Safety Risk Flag placed within the EHR. Periodic reviews will be conducted to determine whether an existing flag placed should be continued or removed. This policy does not authorize the removal of flags placed by other institutions. When a patient has exhibited behavior that is seriously threatening, or dangerous to others, and poses a risk of harm to others the Safety Flag Committee will be convened to determine whether a Safety Risk Flag should be placed in order to alert other members of the health care team of the patient's history and communicate the safety care plan.

PROCEDURE:

Creating the Safety Risk Flag Committee:

1. A Safety Flag Committee shall be convened at each site. In alignment with this MGB Policy and any site policies and protocols, a charter shall be made defining the committee purpose, authority, responsibilities, membership, and meeting schedule.
2. Role groups suggested to serve on the Committee may include but are not limited to: Nursing, Physicians/Advanced Practice Providers, Social Workers, Police and Security, Quality/Safety representatives, Behavioral Health, and Risk Management.
3. Depending on the circumstances of cases being reviewed, the Committee may include *ad hoc* representation from those with department- or content-specific expertise such as Emergency Medicine, Psychiatry, Patient Advocacy/Patient Relations, or Substance Use Disorder (SUD). Alternatively, such representatives may be considered as standing members of the committee. MGB can provide SUD subject matter experts for ad hoc discussions.
4. Each Committee member (and any designated proxy) must be onboarded prior to attending a Committee meeting in a decision-making role. Ad hoc attendees do not need onboarding. Onboarding at a minimum shall consist of training on safety risk flag background, this MGB policy as well as any site-specific policies or protocols, and the site's Committee charter
5. Members of the Committee (and any designated proxy) should receive health equity and anti-racism training; consultation with Health Equity Subject Matter Experts can be considered in the process of case review.
6. At least one member of the Committee should have the ability to place a safety risk flag in the event a case review deems placement necessary.

Convening the Committee:

1. Hospital staff will alert a representative of the Committee via site-specific protocols and request that a patient be considered for placement of a Safety Risk Flag and accompanying Safety Care Plan.
2. The Committee (to include a quorum of 70% of required role groups) will meet within 2 business days of the incident to review the facts and determine whether criteria are met for Safety Risk Flag placement. Effort should be taken to include all Committee roles during the initial review, but the timeframe may need to be prioritized over including all desired participants.
    a. In order to ensure that a quorum is met within 2 business days, standing Committee members may designate proxies representing the same role group in the event that they are needed for future incident reviews in the absence of a standing Committee member. Proxies must be onboarded prior to joining the committee.
    b. In cases in which the initial evaluation deems the risk of physical harm to others to be extremely high, a "Temporary Safety Risk Flag" may be placed immediately, prior to formal Committee review.
3. If the Committee decides a Safety Risk Flag is not appropriate, a designated member will inform the patient's care team of the decision.
4. If the Committee decides a Safety Risk Flag is appropriate, a representative from the Committee will notify the patient's care team of the decision.
    a. The care team will be tasked with developing a required safety care plan within 2 business days, which will follow a standardized template, and will be shared with the Committee.
    b. The Committee will complete documentation of the meeting and inform the entity's designee for Safety Risk Flag placement to apply the flag.
5. Flag Placement Criteria:
    a. The Committee can place a Safety Risk Flag in the following situations:
        i. Physical assault with or without intent or injury
        ii. Credible threat that physical harm to others may be imminent
    b. The Committee should **not** use Safety Risk Flags for:
        i. Concern or evidence of self-harm
        ii. The perceived possibility of violence, absent a credible threat
        iii. Code of conduct violations or "disruptive" behavior
        iv. Substance use (e.g. history of drug use, use of drugs in hospital)
    c. The Safety Risk Flag must have an associated safety report in the site's safety event reporting system
6. A visual cue or signage may be placed proximate to the patient (e.g. on an inpatient room door) to indicate the increased safety risk per local policy and availability.

Maintaining Safety Risk Flags:

1. The Committee will meet at least every 6 months, and preferably every 3 months, to review Safety Risk Flags and the accompanying Safety Plans with all efforts to include all Committee members.
2. The Committee will discuss and reach consensus whether each flag should continue to stay active or whether the flag should be removed.
3. Flag Removal Criteria:
    a. Situational factor changes that may sufficiently mitigate the context for the original flag placement. The Committee will consider context and medical diagnosis resolution or mitigation.
        i. Examples include: initial placement in the setting of altered mental status secondary to medical conditions no longer applicable (e.g. resolved delirium or psychosis).
    b. Pattern of additional contact with the patient that demonstrates consistently changed behavior relative to that demonstrated at the time of initial flag placement.
        i. Time and treatment have mitigated the context such as: several documented visits within Mass General Brigham without negative incident over a period of time.

4. Flag Removal Request:
    a. Entity staff or staff from another MGB site may request flag removals by contacting the Safety Flagging Staff identified in the flag. The Committee will consider the context cited by staff in support of flag removal using an equity informed approach to determine if flag removal is indicated.
5. Safety Care Plan Review:
    a. At the time of the Safety Risk Flag review, the Committee will also review accompanying Safety Care Plans.
    b. If the Safety Risk Flag is removed, the Committee should consider whether removal of the Safety Care Plan is also appropriate, or the Safety Care Plan should at least be modified to reflect updates related to the flag removal.
    c. If the Safety Risk Flag is not removed, the Committee should consider whether adjustments or modifications to the Safety Care Plan can improve how staff will interact with the patient.