Office of the Inspector General
for the
Department of Mental Health,
Mental Retardation
And Substance Abuse Services

Semiannual Report
October 1, 2003 – March 31, 2004

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Southwestern Virginia Mental Health Institute

FORWARD

The Office of the Inspector General (OIG) for the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is pleased to submit this semiannual report of activities for the period ending on March 31,2004. This report is issued in accordance with the provisions of VA § 37.1-256.1, which specifies that the Office report on the significant issues related to the administration of the publicly funded services system.

On February 1, 2004, Governor Mark Warner appointed James W. Stewart, III to the position of Inspector General. The Virginia General Assembly confirmed his appointment during the 2004 Session.

Mr. Stewart has worked in the publicly funded mental health, mental retardation and substance abuse system for over 30 years. Prior to accepting this appointment, he served as the Mental Health Director (1977-1981) and the Executive Director (1981-2004) of the Henrico Area Mental Health and Mental Retardation Services Boards. Throughout these years he worked actively at state, federal and local levels to help shape policies, regulations and funding initiatives with the goal of enhancing services for individuals with mental illness, mental retardation and substance abuse problems.

As this six-month period represented one of transition, the Office of the Inspector General focused on completing review activities that represent the core services of inspecting, reviewing and monitoring. Specifically this included conducting unannounced inspections, tracking data submitted by the facilities and reviewing critical incidents as reported.

HIGHLIGHT OF ACTIVITIES

- **Ten unannounced inspections** were conducted, which included seven snapshot inspections and three secondary reviews. The seven snapshot inspections were conducted at the following facilities:

  Catawba Hospital
  Central State Hospital
  Commonwealth Center for Children and Adolescents
  Northern Virginia Mental Health Institute
  Northern Virginia Training Center
  Piedmont Geriatric Hospital
  Southwestern Virginia Mental Health Institute

  The Secondary Reviews were conducted at the following facilities:

  Central State Hospital
  Commonwealth Center for Children and Adolescents
  Southwestern Virginia Mental Health Institute

- **Twelve reports were completed.** All the reports completed have been released for posting to the office website, except Secondary Inspections.

Completed reports included:

Report #85-03 at Hiram W. Davis Medical Center
Report #86-03 at Central State Hospital
Report #87-03 at Commonwealth Center
Report #88-03 at Northern Virginia Mental Health Institute
Report #89-03 at Southwestern Virginia Mental Health Institute
Report #90-03 at Commonwealth Center
Report #91-04 at Southwestern Virginia Mental Health Institute
Report #92-04 at Central State Hospital
Report #93-04 at Central State Hospital
Report #94-04 at Catawba Hospital
Report #95-04 at Northern Virginia Training Center
Report #96-04 at Piedmont Geriatric Center

- This office **reviewed approximately 550 critical incidents** during this six-month period. An **additional follow-up on 78 of the critical incidents occurred.**

- Monthly quantitative data was received and reviewed from the fifteen state operated facilities. **6 follow-up inquiries were completed** regarding this data.

- A formal review has been completed of DMHMRSAS Departmental Instruction 313(QM) Clinical Quality Management Committee, The Comprehensive State Plan: 2004-2010 prepared by the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Final Report of the Task Force to Develop an Olmstead Plan for Virginia completed by the Olmstead Task Force.

- There were a number of opportunities for this office to participate in activities relevant to the mental health, mental retardation and substance abuse services community through the completion of **4 presentations within the state and nationally.**

- The Office of the Inspector General has received **an increasing number of concerns, complaints and inquiries** from citizens and state employees regarding a variety of issues. Of the 32 concerns received, 23 were received during the last half of this reporting period.

- **New legislation** was introduced during the 2004 General Assembly session, which provided clarification regarding the Inspector General's access to privileged information.

- **Inspector General James W. Stewart, III was appointed and confirmed by the General Assembly.** In addition, to executing the responsibilities of his position, Mr. Stewart has been actively engaged in traveling to the state facilities to tour and meet with senior staff, meet with key staff within DMHMRSAS and dialogue with representatives of consumer advocacy groups and community providers.

ACTIVITIES OF THE OFFICE

A. INSPECTIONS

The OIG conducted ten unannounced inspections during this reporting period. The reports include seven snapshot inspections and three secondary reviews. The OIG performs at least one unannounced inspection annually at each of the state facilities operated by DMHMRSAS. The inspections are based on the calendar year.

A sixteenth facility became operational during this reporting period. The newest facility, currently located in Petersburg, offers a behavioral rehabilitation program for individuals who were determined to meet the criteria for civil commitment as sexually violent predators. Inspector General Stewart toured the facility and became familiar with its program objectives.

SNAPSHOT INSPECTIONS

A Snapshot inspection encompasses at a minimum a review of the physical conditions of the facility, staffing patterns and treatment activities available to the residents or patients. Each report identifies findings and provides recommendations for improvement to observations made by the Inspector General's staff. A snapshot inspection was conducted at each of the following facilities during this reporting period:

Commonwealth Center for Children and Adolescents in Staunton
Central State Hospital in Petersburg
Northern Virginia Training Center in Fairfax
Northern Virginia Mental Health Institute in Falls Church
Southwestern Virginia Mental Health Institute in Marion
Catawba Hospital in Catawba
Piedmont Geriatric Hospital in Burkeville

General system-wide findings for the areas of review as outlined in VA § 37.1-256.1 are as follows:

General Environmental Conditions

The ability to receive appropriate services in a safe environment is a basic quality care issue and essential component of review. One of the goals of the unannounced visits is to be able to view the facility at any given point in time to assure that the services are provided in an environment that is first and foremost safe. The review of a safe environment encompasses a wide range of issues and concerns from the need for routine and consistent safety inspections of equipment and furniture; the elimination of cords which could pose a hazard; routine and unannounced fire drills across all shifts; egress routes that are free of clutter to the general upkeep of the buildings and grounds.

As noted during the tours of the facilities, a majority of residential units statewide are located in older buildings and are not ideally suited for managing the care and treatment of the populations currently being served. Shifts in the populations served have evolved, resulting in a number of buildings being used in a manner for which they were not originally designed.

Overall, it was noted that each facility toured during this reporting period provided environments of care that were clean, comfortable and well maintained. Each facility has made considerable efforts in assuring that the living units are maintained so as to enhance patient safety and programming.

Three of the facilities reviewed during this period were undergoing renovations. These included Southwestern Virginia Mental Health Institute, Northern Virginia Training Center and Central State Hospital.

Staff Patterns

All of the facilities reviewed during this reporting period continue to focus on recruiting and retaining quality staff, particularly nursing personnel. Nursing personnel are the staff most involved in the hands on implementation of care and treatment. Maintaining adequate staff to resident/patient ratios is a crucial element in the provision of on-going quality care.

The majority of staff interviewed, from administration to direct care providers in each of these facilities, indicated that the recruitment and retention of direct care staff remains one of the greatest challenges to the provision of quality care for the residents. In order to achieve adequate staffing levels, overtime is frequently required. Facilities have used a variety of techniques to lessen the need for mandatory overtime, including self-scheduling, modified hours, and utilizing contract employees. They also modified staff to patient/consumer ratios through diversion programs, effective discharge planning and unit closures.

This is not a new issue as a majority of facilities are facing challenges associated with maintaining an adequate workforce. A pilot program, College of Direct Support, which is designed to enhance the skills of direct care staff will be implemented within community based programs and two facilities. The web-based curriculum includes 56 lessons on issues such as safety, documentation, and abuse and neglect.

Challenges in maintaining adequate staffing patterns were noted as having become a more significant issue during this reporting period at the Commonwealth Center for Children and Adolescents (CCCA) and Catawba Hospital (CAT).

At CCCA, efforts are underway to address the staff turnover rate and a program of enhanced staff training is currently in development. Supervisory structure for direct care workers has been reorganized in order to enhance staff management and deployment.

Interviews with administrative staff at Catawba Hospital revealed that the facility is currently experiencing a nursing shortage, which was reported as primarily the outcome of budget shortfalls. It was maintained that the combination of previous budget reductions; a change in reimbursement practices for outpatient consultation services, including CT scans and X-rays; a growing competitive regional market and increasing healthcare costs have resulted in a shortage of funds.

The Central Office has provided consultation to both of these facilities regarding strategies for successfully recruiting and retaining qualified staff.

Active Treatment

All the facilities inspected offer an array of active treatment options for their consumers. Variations in quality were noted but these were often associated with other concerns such as adequate space or staffing patterns. There was evidence in each of the facilities that programming took into consideration patient preferences, with input from the patient/resident or authorized representatives, and on identified barriers to effective community living. Most of the facilities have developed methods for conducting on-going assessments of consumer needs and for shifting program offerings to address individualized concerns. Programs have developed tools for consumer participation and satisfaction.

SECONDARY INSPECTIONS

Three secondary inspections were conducted. A secondary inspection is conducted in response to a specific concern or complaint received by the OIG. Secondary inspections often involve patient or personnel specific and confidential information. As a result, the corresponding reports are not released to the OIG website. Secondary inspections were completed at the following facilities in this six-month reporting period:

Central State Hospital in Petersburg
Commonwealth Center for Children and Adolescents in Staunton
Southwestern Virginia Mental Health Institute in Marion

B. REPORTS

The OIG has completed twelve reports during this reporting period. Reports are generated as a tool for performance improvement and provide DMHMRSAS with findings and recommendations regarding observations of a number of quality indicators. DMHMRSAS develops a plan of correction (POC) for each recommendation made by the OIG. Implementation of the plan of correction is monitored until successful resolution has occurred.

The reports are as follows:

Report #85-03 at Hiram W. Davis Medical Center
Report #86-03 at Central State Hospital
Report #87-03 at Commonwealth Center
Report #88-03 at Northern Virginia Mental Health Institute
Report #89-03 at Southwestern Virginia Mental Health Institute
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Report #94-04 at Catawba Hospital
Report #95-04 at Northern Virginia Training Center
Report #96-04 at Piedmont Geriatric Center

Following release from the Governor's Office, the reports are posted to the OIG website except for those which contain specific identifying consumer information or are designated as peer review documents. All of these reports have been reviewed and the snapshot inspections were released for posting on the office website.

C. LEGISLATION

During the 2004 General Assembly, Senator John Edwards served as the Chief Patron for Senate Bill 212 (SB212). The primary intent of the bill was to provide clarification regarding access of the Inspector General to peer review information. The bill outlines the Inspector General's access as follows:

"To access any and all information, including confidential consumer information, related to the delivery of services to consumers in state facilities or served by providers as defined in § 37.1-179, including licensed mental health treatment units in state correctional facilities. ***However, the Inspector General shall not be given access to any proceedings, minutes, records or reports of providers as defined in § 37.1-179 that are privileged under § 8.01-581.17,*** *except that the Inspector General shall be given access to any such privileged information in facilities operated by the Department and licensed mental health treatment units in state correctional facilities. All consumer information shall be maintained by the Inspector General as confidential in the same manner as is required by the agency or provider from which the information was obtained."*

The Inspector General has the authority to review a wide variety of programs and services across the Commonwealth. In addition to the publicly supported services system, which is comprised of the 16 state facilities and 40 community services boards, the Inspector General has access to all providers of services that are licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services. As outlined in the provisions of this legislation, the Inspector General maintains access to

privileged information in the state facilities and the licensed mental health treatment units in the state correctional facilities.

This legislation, also, effectively moved the powers and duties currently ascribed to the Office of the Inspector General to the section of the code, which outlines the powers and duties of the Inspector General. Both the House and the Senate unanimously approved the changes in the legislation. The legislative changes become effective July 1, 2004.

The legislation is located in Addendum A.

D. DATA MONITORING

Critical Incident Reports

Critical incidents as defined by Virginia Code § *2.1-817* are sent to the OIG for review and monitoring. These incidents are those occurring in one of the facilities that are serious enough to be associated with the resident or patient being evaluated by medical staff.

Approximately 550 critical incident (CI's) reports were reviewed within this semi-annual period. The OIG conducted an additional level of scrutiny and follow up for 78 of the reviewed CI's. The information gathered from the additional inquiries was used to identify potential clinical problems with treatment of individuals within state facilities and to track trends in the facilities in areas such as falls risk. The information is often integrated into the inspections and scheduling priorities of the OIG.

Quantitative Data

In order to refine the inspection process so that core risks could be routinely monitored outside of the unannounced inspection process, a monthly facility report was instituted in January 2002. This report provides raw data on trends within facilities. Areas that are monitored through this monthly report include but is not limited to: facility census, seclusion and restraint use, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect. The office has used this data to process 6 clarification requests during this six-month reporting period. The requests asked for amplification regarding significant data fluctuations on issues associated with staff injuries, position vacancies, staff overtime and the use of seclusion and restraint. All of the responses provided by the facilities were satisfactory to meet the needs of the office.

E. FOLLOW-UP REPORTING

All active or non-resolved findings from previous inspection reports are reviewed through a follow-up process until they have been successfully resolved. In general, evidence is required from at least two sources in order to recommend that the finding become inactive. The sources may include observations by the inspection team; interviews with staff and/or patients; or a review of policies and procedures, memoranda, medical records, meeting minutes, or other administrative and/or clinical documents.

Follow-up reviews of all active findings are completed at the time of the on-site snapshot inspection. This allows for more timely feedback to the facilities regarding progress towards satisfying agreed upon plans of correction. This also consolidates travel and resources. DMHMRSAS currently provides comments in response to previous active recommendations simultaneously with the plan of correction regarding the snapshot inspection.

Follow-up reviews were conducted at the seven facilities where snapshot inspections were completed. Also included is the follow-up review from Hiram W. Davis Medical Center as that report was completed during this reporting period. Follow-up reviews included findings from 15 reports and 32 findings, which had previously been active or unresolved during prior follow-up reviews. 19 findings were resolved or made inactive.

F. REVIEW OF DEPARTMENT INSTRUCTIONS AND REGULATIONS

During this semi-annual reporting period a formal review has been completed of DMHMRSAS Departmental Instructions 313(QM), The Comprehensive State Plan: 2004-2010 prepared by the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Final Report of the Task Force to Develop an Olmstead Plan for Virginia.

- DI 313(QM) – Clinical Quality Management Committee - This departmental instruction included the Inspector General's involvement in the quality services peer review committee developed by the Central Office to identify, track and review critical issues.

- The Comprehensive State Plan identifies the services and support needs of the consumers of the publicly supported services system. The six-year plan, which is updated every two years, addresses the current and projected needs of consumers of mental health, mental retardation and substance abuse services, the resources necessary for successfully accomplishing the strategies and goals for the effective delivery of the services.

- The final report of the seventy-member Olmstead task force was released in September 2003. The report outlines the work of the task force in reviewing the needs of individuals with disabilities in a number of areas such as education, housing, services, employment and transportation.

G. PRESENTATIONS AND CONFERENCES

During this reporting period presentations were provided for the following state and national groups during meetings associated with the mental health, mental retardation and substance abuse community:

VA State Board for DMHMRSAS
Charlottesville-Albemarle County Mental Health Association
High Performance Organization Change Conference in South Carolina
Human Rights Conference in Charlottesville

H. MEETINGS

The OIG regularly participates in a variety of forums that address issues relevant to DMHMRSAS facilities and mental health issues.

DMHMRSAS Facility Directors' Meeting;
State Board for DMHMRSAS
VA Office of Protection and Advocacy Board
VOPA DD Advisory Council Meeting
State's Human Rights Committee Meeting
VOPA PAIMI Advisory Council Meeting

VIRGINIA ACTS OF ASSEMBLY -- 2004 SESSION

CHAPTER 169

An Act to amend and reenact §§ 37.1-255, 37.1-256 and 37.1-256.1 of the Code of Virginia, and to repeal § 37.1-257 of the Code of Virginia, relating to the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services.

[S 212]

Approved March 19, 2004

Be it enacted by the General Assembly of Virginia:

1. That §§ 37.1-255, 37.1-256 and 37.1-256.1 of the Code of Virginia are amended and reenacted as follows:

§ 37.1-255. Office created; appointment of Inspector General for Mental Health, Mental Retardation and Substance Abuse Services.

There is hereby created the Office of Inspector General for Mental Health, Mental Retardation and Substance Abuse Services to inspect, monitor and review the quality of services provided in the facilities operated by the Department ~~of Mental Health, Mental Retardation and Substance Abuse Services~~ *and providers as defined in § 37.1-179, including licensed mental health treatment units in state correctional facilities.* The Inspector General ~~for Mental Health, Mental Retardation and Substance Abuse Services~~ shall be appointed by the Governor, subject to confirmation by the General Assembly, and report to the Governor. The Inspector General ~~for Mental Health, Mental Retardation and Substance Abuse Services~~ shall be appointed initially for a term that expires one full year following the end of the Governor's term of office, and, thereafter, the term shall be for four years. Vacancies shall be filled by appointment by the Governor for the unexpired term and shall be effective until ~~thirty~~ *30* days after the next meeting of the ensuing General Assembly and, if confirmed, thereafter for the remainder of such term.

§ 37.1-256. Powers and duties of Inspector General.

The Inspector General ~~for Mental Health, Mental Retardation and Substance Abuse Services~~ shall have the following powers and duties:

1. To operate and manage the Office of the Inspector General ~~for Mental Health, Mental Retardation and Substance Abuse Services~~ and to employ such personnel as may be required to carry out the provisions of this chapter.

2. To make and enter *into* contracts and agreements as may be necessary and incidental to carry out the provisions of this chapter, and to apply for and accept grants from the United States government ~~and~~, agencies and instrumentalities thereof, and any other source, in furtherance of the provisions of this chapter.

3. To provide inspections of and make policy and operational recommendations for facilities operated by the Department ~~of Mental Health, Mental Retardation and Substance Abuse Services~~ and providers *as defined in § 37.1-179,* including licensed mental health treatment units in state correctional facilities, ~~as defined in § 37.1-179~~ in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of their programs and services. *The Inspector General shall provide oversight and conduct announced and unannounced inspections of the facilities operated by the Department and providers as defined in § 37.1-179, including licensed mental health treatment units in state correctional facilities, on an ongoing basis, in response to specific complaints of abuse, neglect or inadequate care, and as a result of monitoring serious-incident reports and reports of abuse, neglect or inadequate care or other information received. The Inspector General shall conduct unannounced inspections at each state facility at least once annually.*

4. *To access any and all information, including confidential consumer information, related to the delivery of services to consumers in state facilities or served by providers as defined in § 37.1-179, including licensed mental health treatment units in state correctional facilities. However, the Inspector General shall not be given access to any proceedings, minutes, records or reports of providers as defined in § 37.1-179 that are privileged under § 8.01-581.17, except that the Inspector General shall be given access to any such privileged information in facilities operated by the Department and licensed mental health treatment units in state correctional facilities. All consumer information shall be maintained by the Inspector General as confidential in the same manner as is required by the agency or provider from which the information was obtained.*

5. To keep the Governor, General Assembly and the Joint Commission on ~~Behavioral~~ Health Care, ~~or its successor in interest,~~ fully and currently informed, by means of reports required by § 37.1-256.1, concerning significant problems, abuses, and deficiencies relating to the administration of the programs and services of the facilities operated by the Department ~~of Mental Health, Mental Retardation and Substance Abuse Services~~ and providers *as defined in § 37.1-179,* including licensed mental health treatment units in state correctional facilities, ~~as defined in § 37.1-179,~~ to recommend corrective actions

concerning such problems, abuses, and deficiencies, and to report on the progress made in implementing such corrective actions.

~~5~~ *6.* To notify in a timely manner the attorneys for the Commonwealth for the jurisdiction in which a state facility is located and law enforcement, as appropriate, whenever the Inspector General has reasonable grounds to believe there has been a violation of state criminal law.

However, where the Inspector General has reason to believe that a criminal offense has been committed in a state correctional facility, notification of such suspicion shall be given to the Inspector General for the Department of Corrections.

7. To review, comment, and make recommendations, as appropriate, about any reports prepared by the Department and the critical-incident data collected by the Department in accordance with regulations adopted under § 37.1-84.1 to identify issues related to quality of care, seclusion and restraint, medication usage, abuse and neglect, staff recruitment and training, and other systemic issues.

8. To monitor and participate in the adoption of regulations by the Board.

9. To receive reports, information, and complaints from the Virginia Office for Protection and Advocacy concerning issues related to quality of care in state facilities and providers as defined in § 37.1-179, including licensed mental health treatment units in state correctional facilities, and to conduct independent reviews and investigations.

§ 37.1-256.1. Reports.

A. The Inspector General shall prepare, not later than May 31 and November 30 of each year, semiannual reports summarizing the activities of the Office during the immediately preceding six-month periods ending March 31 and September 30. Such reports shall include, but need not be limited to:

1. A description of significant problems, abuses and deficiencies related to the administration of the programs and services of the facilities operated by the Department ~~of Mental Health, Mental Retardation and Substance Abuse Services~~ and providers *as defined in § 37.1-179*, including licensed mental health treatment units in state correctional facilities, ~~as defined in § 37.1-179~~ during the reporting period;

2. A description of the recommendations for corrective actions made by the Office during the reporting period with respect to significant problems, abuses or deficiencies identified;

3. An identification of each significant recommendation described in previous reports under this section on which corrective action has not been completed;

4. A summary of matters referred to the attorneys for the Commonwealth ~~and~~, law enforcement, *and the Inspector General for the Department of Corrections* and actions taken on them during the reporting period; and

5. Information concerning the numbers of complaints received and types of investigations completed by the Office during the reporting period.

B. Within 30 days of the transmission of each semiannual report, the Inspector General shall make copies of such report available to the public upon request and at a reasonable cost.

C. The Inspector General shall report immediately to the Governor and the Commissioner ~~of the Department of Mental Health, Mental Retardation and Substance Abuse Services~~ or the Director of the Department of Corrections as may be appropriate whenever the Office becomes aware of particularly serious problems, abuses or deficiencies relating to the administration of the programs and services of the facilities operated by the Department ~~of Mental Health, Mental Retardation and Substance Abuse Services~~ and providers *as defined in § 37.1-179*, including licensed mental health treatment units in state correctional facilities~~, as defined in § 37.1-179~~.

D. The Inspector General may conduct such additional investigations and make such reports relating to the administration of the programs and services of the facilities operated by the Department ~~of Mental Health, Mental Retardation and Substance Abuse Services~~ and providers *as defined in § 37.1-179*, including licensed mental health treatment units in state correctional facilities, ~~as defined in § 37.1-179~~ as are, in the judgment of the Inspector General, necessary or desirable.

E. Notwithstanding any other provision of law, the reports, information or documents required by or under this section shall be transmitted directly to the Governor, the General Assembly and the Joint Commission on ~~Behavioral~~ Health Care~~, or its successor in interest,~~ by the Inspector General without preliminary clearances or approvals. The Inspector General shall, insofar as feasible, provide copies of the semiannual reports to the Governor in advance of the date for their submission to the General Assembly and the Joint Commission on ~~Behavioral~~ Health Care~~, or its successor in interest~~, to provide a reasonable opportunity for comments of the Governor to be appended to the reports when submitted to the General Assembly and the Joint Commission on ~~Behavioral~~ Health Care~~, or its successor in interest~~.

F. Records that are confidential under federal or state law shall be maintained as confidential by the Inspector General, and shall not be further disclosed, except as permitted by law.

G. The Inspector General's written reports accompanying the ~~individual~~ *state* facility inspections ~~performed by the Office pursuant to § 37.1-257~~ shall be transmitted to the Governor for review and comment as deemed necessary by the Governor. The Inspector General shall report on the general conditions, staffing patterns and access to active and contemporary treatment ~~of~~ *in* each *state* facility, at a minimum, on an annual basis. The Department ~~of Mental Health, Mental Retardation and Substance Abuse Services~~ shall comment in writing on any recommendations made by the Inspector General.

2. That § 37.1-257 of the Code of Virginia is repealed.

HIRAM W. DAVIS MEDICAL CENTER
DAVID ROSENQUIST / FACILITY DIRECTOR
OIG REPORT # 85-03
SNAPSHOT INSPECTION

Date: August 27, 2003

Reviewers: Anita Everett, MD
Cathy Hill, LPC

A Snapshot Inspection was conducted at Hiram W. Davis Medical Center in Petersburg, Virginia on August 27, 2003. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and activity of patients.

This unannounced inspection began with a tour of the facility. Interviews were conducted with both administrative and direct care staff. Sections of four clinical records (all active) were reviewed with a focus on treatment planning, the integration of psychiatric and medical care and documentation of rehabilitation services.

Hiram W. Davis Medical Center (HWDMC) is the only state-operated freestanding medical center. Although most of the referrals for care come from the two facilities in Petersburg that share the same campus, Central State Hospital and Southside Virginia Training Center, the facility serves patients from across the Commonwealth. This eighty-bed facility provides skilled, intermediate and acute care services. Sixty beds are certified for skilled nursing care; therefore the majority of persons served are in need of very intensive nursing services. On the date of the inspection, the census of the facility was seventy.

Overall, the facility was clean comfortable and well maintained. Renovations to the building had been completed. Efforts at providing increased environmental stimulation for the residents were noted.

HWDMC maintains a minimal staff to client ratio enabling the provision of training, care and supervision of the residents served. Interviews with staff revealed that the facility's hiring of additional staff on the second shift has decreased the use of mandatory overtime.

Residents at HWDMC are provided with opportunities to participate in active treatment programming in a variety of settings depending upon their level of functioning

PART I: STAFFING ISSUES

Number of staff scheduled for this shift for this unit. RN = registered nurses LPN= licensed practical nurses CNA= certified nursing assistant	**August 27, 2003 (Day shift)** On the 3rd floor (both sides) 2 RNs 4 LPNs 7 CNAs On the 2nd floor (both sides) 3 RNs 4 LPNs 8 CNAs
Number of staff present on the unit	The number of staff present on the units varied only for the 2nd floor in which there was one less LPN because a person had been pulled from the unit to provide coverage on the 3rd floor. Therefore the numbers present were as follows: 3rd floor 2 RNs 4 LPNs 7 CNAs 2nd floor 3 RNs 3 LPNs 8 CNAs
Number of staff doing overtime during this shift or scheduled to be held over	Interviews indicated that there was not any staff doing overtime during this shift on either of the floors.
Number of staff not present due absence because of workman's compensation injury	Interviews revealed that one staff member that normally would be present during this shift was absent due to a worker's compensation injury.

Number of staff members responsible for one-to-one coverage during this shift	1:1 coverage was provided three patients during the time of the inspection. Coverage was for behavioral reasons for one person and to allow time for acclimating to the setting for another. One patient was a forensic patient from CSH. Many of the patients at this facility require intensive nursing services, but may not be identified as needing constant 1:1 coverage.

Are there other staff members present on the unit? If so, please list by positions?
Housekeeping staff were on the unit as well as members of the therapeutic services. Rounds are conducted each morning on the units during which both medical and rehabilitative staff members review the current status of the patients and discuss treatment options.

Additional comments regarding staff:
Interviews were completed with both administrative and direct care staff members. HWDMC has been diligent in its efforts to maintain an adequate staffing pattern consistent with facility policy. The Director of Nursing conducts ongoing administrative reviews regarding the maintenance of an appropriate number of staff for the safety and supervision of the residents.

Interviews with direct care staff indicated that the use of mandatory overtime has been very limited during the past six months. Staff indicated that even opportunities for voluntary overtime have been limited, which was disconcerting for several persons interviewed. Staff, on a whole, attributed the decrease in the use of mandatory overtime to the facility's success in hiring LPN and CNA staff for the evening shift. Having a full complement of staff allows for greater flexibility in arranging coverage and maintaining routine scheduling.

Interviews with staff indicated that one of the strengths of this facility centers on the commitment of the staff to the residents as well as their efforts in functioning as team members with each other. All of the staff interviewed maintained that they felt supported in their work and valued for their efforts made on behalf of the residents. Those interviewed indicated that both administrative and direct care staff shared in patient care and treatment. It was commented that the Director reads to several patients on a regular basis.

Interviews with administrative staff indicated that the facility has a contract psychiatrist from the Virginia Commonwealth University, Medical College of Virginia (MCV) to provide coverage for patients within the facility who could benefit from psychiatric interventions. Interviews indicated that the psychiatrist has become a valuable team member.

Finding 1.1: Observations and interviews revealed that the facility has increased the number of direct care staff, particularly on the second shift. This enables them to meet the minimal staffing patterns consistent with facility policy without the excessive and unsafe use of overtime.

OIG Recommendation: None. HWDMC has been committed to the hiring of staff, particularly on the second shift in order to enhance its ability to provide for the care and supervision of its residents while minimizing the use of mandatory overtime.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

Census at the time of the review:
This eighty-bed facility provides skilled, intermediate and acute care services. On the date of the inspection, the census of the facility was seventy.

Sixty patients / skilled care
One patient / acute care
Nine / intermediate care

The majority of patients at the facility require intensive skilled nursing interventions for basic physical maintenance. The medical and rehabilitation staffs are frequently assessing appropriate levels of care for this complex population.

Nursing staff conduct daily assessments of the patients and provide ongoing monitoring. The level of care provided includes constant individualized physical management to maintain skin integrity, overall care and support of activities designed to preserve the patients' current level of functioning. The team was informed of a recent commendation offered the facility regarding the remarkable recovery experienced by a patient, which was achieved through staff attentiveness to patient care.

Number of patients/residents on 1 to 1
Three persons were identified as on a 1:1 status.

Identify the activities of the patients/residents?
Interviews and a review of scheduled activities revealed that HWDMC offers a variety of activities for all of the patients, which are based on individual need. Activities are available during day and evening shifts as well as on holidays and weekends. Programs and activities are designed to offer the most appropriate level of stimulation for each individual, with an effort to increase out of bed activity. Bedside interventions are made available for persons who are confined.

There has been a focus on increasing environmental stimulation for the residents since the last inspection. This includes the placement of brightly colored ceiling tiles above the patient beds and in other areas within the facility to enhance visual stimulation. In addition, cable access has allowed for better television reception in the residential areas. Sets were placed near the ceilings in all units. This enhances the patients' ability to see programming and/or hear musical offerings. Patients have access to a computer, which reportedly was a very popular activity.

The facility has been active in developing and implementing several restorative programs including a Bowel and Bladder and Splinting and Positioning program. Competency based training for direct care staff have been completed. The primary goal of these programs is to facilitate the restoration of functioning to the degree possible. The facility is also preparing for the implementing of additional programs.

What scheduled activities are available for patients/residents during this shift?
On the date of the inspection, a musical / remembrance group was scheduled as well as an art activity. There was also a planned outing. These activities were in addition to the individualized interventions.

Do patients/residents have opportunities for off-ground activities?
The purchase of a specialized wheel chair lift equipped van for use by therapeutic recreational staff increases patient access to community activities. Recent outings have included trips to a local fair, an IMAX theater, a ballgame and rides.

As appropriate, do patients/residents have opportunities for snacks?
Snacks are available, as appropriate and dictated by dietary needs as determined by their physician. Afternoon snacks were available during designated break times during the activities.

OIG Finding 2.1: HWDMC offers a variety of treatment options for its residents based upon their individual needs and abilities.

OIG Recommendation: None. This facility continues in its efforts to maximize the degree of functioning of its patients through activities, intensive nursing interventions and the introduction of restorative programs.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
The common areas are clean and well maintained.	Tours of the living areas during the day indicated that the common areas are clean and well maintained.
Furniture is adequate to meet the needs and number of patients/residents.	Tours indicated that the furniture in common areas meets the needs of the patients. In preparation for a dining/meal restorative program, tables designed to accommodate wheelchairs have been purchased.
Furniture is maintained and free from tears.	All furniture observed during tours was free of tears and was well maintained.
Curtains are provided when privacy is an issue.	Tours and observations indicated that curtains are provided for privacy.
Clocks are available and time is accurate.	Observations indicated that all clocks were accurate.
Notification on contacting the human rights advocate are posted.	Observations during tours indicated that each residential area visited by OIG staff had a human rights poster placed in a common area.
There is evidence that the facility is working towards creating a more home-like setting.	Tours of the units indicated that this facility works to create a more home like setting. Environmental enhancements noted included the addition of painted ceiling tiles above most of the beds providing primarily increased stimulation for the residents but also a decorative touch. Interviews indicated that staff and patients alike have enjoyed the creation of these tiles. Cable access has allowed for better television reception in the residential areas. Sets were placed near the ceilings in all units. This enhances the patients' ability to see programming and/or hear musical offerings.
Temperatures are seasonally appropriate.	Tours of units indicated that on a very hot summer day the living areas were cool and comfortable.

Patients/residents have access to telephones, writing materials and literature.	Interviews with staff indicated that residents have access to writing materials and telephones, as appropriate to their level of functioning.
Hallways and doors are not blocked or cluttered.	Tours and observations indicated that hallways and doors in the residential areas were not blocked or cluttered.
Egress routes are clearly marked.	Tours and observations indicated that egress routes were clearly marked.
Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews were not conducted with the patients regarding this issue. Staff were well informed regarding the procedures to follow in the event of a fire. This is particularly important when the majority of the patients are unable to ambulate on their own.
Fire drills are conducted routinely and across shifts.	Staff interviewed indicated that fire drills are conducted routinely and across shifts.
Bedrooms	**Comments and Observations**
Bedrooms are clean, comfortable and well maintained.	Observations revealed that bedrooms were clean, comfortable and well maintained.
Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Tours indicated that all bedrooms are furnished with a mattress, sheets, blankets and a pillow. Many accommodations were noted to assist in patient care in the least restrictive manner possible.
Curtains or other coverings are provided for privacy.	Tours revealed that curtains or other coverings are provided for privacy.
Bedrooms are free of hazards such as dangling blind cords, etc.	Tours reveled that bedrooms are free of dangling cords as hazards.
Patients/residents are able to obtain extra covers.	Interviews revealed that residents could obtain extra covers if needed.

Patients/residents are afforded opportunities to personalize their rooms.	Interviews and observations revealed that residents and the families/authorized representatives have a choice on how to decorate and personalize their rooms.
Bathrooms	**Comments and Observations**
Bathrooms were clean and well maintained	Observations revealed that overall bathrooms were clean and well maintained.
Bathrooms were noted to be odor free.	Observations indicated all bathrooms were odor free.
Bathrooms were free of hazardous conditions.	Observations revealed that all bathrooms were free of hazards.
Buildings and Grounds	**Comments and Observations**
Pathways are well lit and free of hazardous conditions.	Observations indicated that pathways are free of hazardous conditions.
Buildings are identified and visitor procedures for entry posted.	Members of the team were asked to sign in and were provided with visitor's badges.
Grounds are maintained.	Tours and observations indicated that grounds are well maintained.
Patients/residents have opportunities to be outside.	Interviews with staff demonstrated that residents have the opportunity to be outside, weather permitting.

Other comments regarding the environment: Construction on the pavilion located behind the main building has been completed. Easy access to this area increases opportunities for patients to be outside in a protected shelter. Interviews indicated that the pavilion has been the site of a variety of activities such a therapeutic groups, informal gatherings and picnics.

The staff office space in the 3rd floor Therapeutic Recreation Room was consolidated to increase space for patient use. Interviews indicated that nursing utilizes the room when it is not in use by therapeutic recreation services providing for an additional area for patients to gather and engage in activities. The goal of increasing socialization and allowing the patients increased time out of their rooms, as outlined in the POC response,

has been accomplished. During the tour, it was noted that a patient was watching a news program on the television in the room. Part of the room is being used for patient dining in order to increase opportunities for interaction and to help normalize mealtimes.

OIG Finding 3.1: Overall, the facility was noted to be clean, comfortable and well maintained. Recent environmental enhancements were noted.

OIG Recommendation: None

CENTRAL STATE HOSPITAL
CHARLES DAVIS / FACILITY DIRECTOR
OIG REPORT#86-03
SECONDARY INSPECTION

This Inspection relied, in part, upon information provided by committees at Central State Hospital that reviewed, evaluated and made recommendations on the adequacy and quality of services provided. The Inspection included a review of precipitating factors and a clinical review of the acute management of the incident. In accordance with Virginia code, §8.01-581.16 – 17, this report is not available for public release in order to protect the privacy of the patients and/or personnel referenced in the report concerning this incident and the privilege for peer review documents.

COMMONWEALTH CENTER FOR
CHILDREN AND ADOLESCENTS
WILLIAM J. TUELL / FACILITY DIRECTOR
OIG REPORT #87-03
SECONDARY INSPECTION

This Inspection relied, in part, upon information provided by committees at Commonwealth Center that reviewed, evaluated and made recommendations on the adequacy and quality of services provided. The Inspection included a review of precipitating factors and a clinical review of the acute management of the incident. In accordance with Virginia code, §8.01-581.16 – 17, this report is not available for public release in order to protect the privacy of the patients and/or personnel referenced in the report concerning this incident and the privilege for peer review documents.

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
LYNN DELACY/ FACILITY DIRECTOR
OIG REPORT #88-03
SNAPSHOT INSPECTION

Date: November 4, 2003

Type of Inspection: Snapshot Inspection / Unannounced

Reviewers: Cathy Hill, LPC

INSPECTION SUMMARY

A Snapshot Inspection was conducted at the Northern Virginia Mental Health Institute in Falls Church, Virginia on November 4, 2003. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and activity of patients.

NVMHI has undergone a number of changes in personnel particularly in administration since the completion of the 2002 OIG inspection. Most notably was the naming of Lynn Delacy as the Facility Director in August 2003. With twenty years of service at the facility, Ms. Delacy is well known and respected. She served the facility as both the Director of Nursing and Acting Facility Director prior to her current position. Interviews with staff indicated that they felt positive about the changes within the facility as a result of her leadership style, which is based on ongoing and effective communication. Staff morale appeared high.

A decrease in the staff turn over rate coupled with increased applications and fewer position vacancies has resulted in an increasingly stable workforce at this facility. Staffing patterns were noted to be adequate to provide for the supervision, safety and treatment needs of the patients.

The facility continues to offer a variety of active treatment programming options for the patients including the introduction of groups based on principles of dialectical behavior therapy and a group which focuses on assisting patients in identifying personal values, goals and strategies for taking a more active role in their own life processes.

Overall, the facility was well maintained, clean and comfortable. Efforts to make this institutional setting appear more homelike were noted. Patients interviewed during the inspection process commented that they felt safe and comfortable within the setting.

PART I: STAFFING ISSUES

Number of staff scheduled for this shift for this unit. DSA= Direct Services Associate	**June 4 – Evening Shift** Unit F – 25 patients 4 DSA's, 3 RNs Unit I1 – 29 residents 3 DSA's , 4 RNs Unit I2 – 31 residents 6 DSA's , 3RNS Unit K – 44 Residents 7 DSA's, 6 RNs
Number of staff present on the unit	OIG staff noted that the actual staffing patterns varied somewhat from those identified above. On I-1, one of the RNs was off the unit with a patient and one of the DSAs was out sick. On I-2, one of the DSAs was scheduled to come into the facility later in the evening. On K unit, one of the RNs had called in sick and two of the DSAs were late reporting for the shift.
Number of staff doing overtime during this shift or scheduled to be held over	During the inspection, it was learned that there were not any persons doing OT on the evening shift. Although the use of mandatory overtime has been very limited at the facility, interviews indicated that there had been an increase in the amount of voluntary overtime utilized due to the number of patients on constant observation status, which has increased over the past three months.
Number of staff not present due absence because of workman's compensation injury	Interviews with administrative staff indicated that there were two staff members out on workman's compensation. Neither of these was patient related.

Number of staff members responsible for one-to-one coverage during this shift	Interviews with facility staff indicated that during the inspection 4 staff members were responsible for a 1:1 coverage, one on F Unit, one on I-1, and 2 on I-2. This was either "within-sight" or "at arms length" due to self-injurious, aggressive behavior precautions or other behavioral or medical concerns.

Are there other staff members present on the unit? If so, please list by positions? Observations and interviews revealed a number of other disciplines on the units including activity therapists, social workers, psychologists and psychiatrists. In addition, the Human Rights Advocate was noted engaging in an interview with a patient.

Additional comments regarding staff: Since the last inspection at this facility, there have been a number of changes in personnel, particularly in administration. Staff commented that the facility has a very strong leadership team under the direction of the new facility director, Lynn Delacy. Ms. Delacy was named the Facility Director in August 2003. She had served the facility as the Director of Nursing and Acting Facility Director prior to her new position. Many commented on the increase in facility-wide communication under her leadership. Staff related that it was during the development of the facility's strategic plans that this process of facility-wide involvement can be best exemplified. Those interviewed indicated that the leadership team felt it was very important to have involvement by all disciplines and levels of staff regarding the mission, core values, and goals of the facility.

In addition, there is a new Medical Director. Dr. Robespierre Maximillian del Rio has been in the position since May 2003. He has reviewed many of the established clinical practices and implemented several initiatives designed to enhance the peer review process and increase awareness among the clinical staff regarding the importance of obtaining an extensive admission history so as to capture the events associated with the entire episode for which hospitalization was deemed necessary.

Interviews also indicated that the staff turn over rate has decreased since the last inspection. This coupled with increased applications and fewer position vacancies has resulted in an increasingly stable workforce at this facility. The facility has implemented a "Spend a Day with a Psychiatric Nurse" program. This program provides interested candidates with an opportunity to spend up to a day with one of the nurses learning about the practice of nursing within the setting. The chance to experience the environment without pressure for a commitment enables perspective candidates the ability to determine on a more personal level whether the setting would be a match for them. Provisions have been made to interview individuals for employment while they are on site both for their convenience and to expedite the process once they express a desire to seek employment.

Finding 1.1: Direct observation, interviews and a review of staffing documentation revealed that the facility provided for adequate staffing patterns. This is consistent with facility policy and provides for treatment, supervision and the safety concerns of the patients.

OIG Recommendation: None

DMHMRAS Response: *DMHMRSAS appreciates recognition of NVMHI maintenance of appropriate staffing levels.*

Finding 1.2: Interviews indicated that a decreased turnover rate coupled with fewer position vacancies and increased applications has resulted in an increasingly stable workforce.

OIG Recommendation: None. Many elements were identified as having a positive impact on the retention of staff at this facility including increased communication and increased opportunities for staff of all levels to participate and provide feedback regarding a variety of issues impacting the facility. NVMHI has initiated a creative program for recruiting prospective nursing personnel. Staff morale appeared high.

DMHMRAS Response: *DMHMRSAS appreciates recognition of NVMHI's leadership in on-going efforts to enhance facility communication, staff participation and staff recruitment and retention.*

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

Bed capacity for the unit: **Census at the time of the review:**

The census on the day of the inspection was 129 patients. This included: 25 patients on F Unit, 29 patients on I-1, 31 patients on I-2 and 44 patients on K Unit. This facility has reportedly been running at capacity or near capacity for the past six months. Interviews with administrative staff indicated that the facility has had to purchase additional bed space within the community due to the high census.

The facility has identified the establishment of a leadership role on the Northern Virginia Regional Partnership Planning Project as an important goal. It was generally believed that this additional time commitment by staff has benefited the facility in a number of ways including assisting in the identification of opportunities for addressing needed resources, the ability to forge relationships with other providers on a different level, and the ability to demonstrate a wide range of expertise within the sitting. NVMHI participants developed a descriptive model regarding four levels of psychiatric inpatient care as a tool for determining the types of patients currently served by the various facilities. In this model, levels are determined based on the acuity and complexity of the

patients as well as the expected lengths of stay. The descriptive model includes patient profiles, interventions and the expected outcomes for each level. The levels are Level 1: Acute Stabilization (high acuity, low complexity), Level 2: Intensive Care (high acuity, high complexity), Level 3: Intermediate Care (high complexity, variable acuity) and Level 4: Rehabilitation Services (high complexity, low acuity). It was reported that this model was adopted for use/testing in other state facilities as well as in some facilities in the private sector.

Number of patients/residents on special hospitalization status.
Interviews with administrative staff indicated that there were not any patients on special hospitalization status during the time of the inspection.

Number of patients/residents on special precautions?
Interviews with staff, on the units toured, indicated that residents were noted to be on special precautions addressing issues such as falls, aggressive behavior, self-injurious behavior, and/or other behavioral or medical issues.

Number of patients/residents on 1 to 1?
Interviews with facility staff indicated that during the inspection shift on the units listed above 4 patients were on 1:1 coverage status, either “within-sight” or “at arms length” distance.

Identify the activities of the patients/residents?
Patients, with recommendations from their treatment team, are provided with opportunities to participate in psychosocial rehabilitation programming within the facility. Programming occurs both within the treatment mall and on the units. Treatment mall (off-unit) activities are offered Monday through Friday from 10:00 am to 3:00 pm on a twelve-week cycle. Structured activities are available during the evening and on weekends.

During this inspection, a group regarding symptom management was observed. This group’s curriculum describes it as designed to aid individuals in learning more about symptom management including recognizing symptoms associated with their illness such as the warning signs of relapse, methods for coping with persistent symptoms, how the use of alcohol and other drugs may impact their illness and how to effectively engage treatment providers and others in assisting them with their illness and symptom management. The topic for the group observed focused on the symptoms, treatment and ongoing management of arthritis. Even though the curriculum identifies that the primary focus of the activity centers on the patient’s mental illness, the group members were attentive and seemed interested in the film and discussion.

Tours of the units occurred during the time when patients were returning from the treatment mall. This was identified as typically leisure time. The majority of patients were observed quietly resting in their rooms or watching television in the dayroom.

Several were participating in a card game, some were noted walking the halls and many were observed engaging in conversation with staff.

Are smoke breaks posted?
Smoke breaks are allowed at this facility. Smoking occurs in designated areas and under staff supervision. Unit tours and interviews with patients revealed that smoke breaks were posted.

Do patients/residents have opportunities for off-ground activities?
Interviews with facility staff and patients indicated that there are opportunities for patients to participate in off-grounds activities once they have achieved the necessary level.

As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff indicated that snacks do occur as appropriate for individualized diet plans.

Other comments regarding patient activities:
NVMHI has established a Treatment Mall Council to review and provide recommendations regarding the treatment programming. This multi-disciplinary group is made up of individuals from the various units. One advantage of this group over performance improvement teams, which are convened to address a specific charge, is that it is not time limited and can be flexible in addressing a variety of issues that impact programming such as the classes offered and the content.

A number of recommendations have been forwarded to the Council for review. Among these were the process of scheduling patients for a new treatment mall programming cycle, consideration whether language-specific groups are needed and how to best absorb patients into mall activities when they are being transferred from the admissions unit to the intermediate or rehabilitation units.

In addition, the facility has conducted two performance improvement reviews associated with the treatment mall. One of the reviews focused on the issue of decreased attendance, which was noted in a previous OIG inspection report.

NVMHI has introduced several groups based on Dialectical Behavior Therapy (DBT). This therapy is an empirically researched treatment modality developed by Dr. Marsha Linehan. This form of treatment uses the application of a number of cognitive and behavioral strategies to address symptoms associated primarily with borderline personality disorder such as intentional self-harm, chronic suicidality, and other behaviors that interferes with the therapeutic process and/or the person's quality of life. The theory maintains that some individuals react abnormally to emotional stimulation, which is believed to be result of being brought up in an emotional invalidating environment and possibly due to as yet unknown biological factors. Dr. Linehan's studies as well as several other replication studies demonstrate that the approach

consistently reduces the amount of self-injury and crisis reactions among the clients for which the approach was designed.

DBT programming is offered in a weekly 90 minutes skills group and in an art therapy group. Both groups are designed to assist participants in understanding and utilizing a variety of techniques in their daily lives in terms of emotional regulation, becoming more "mindful" of the present, increasing interpersonal effectiveness and increasing adaptive responses to stress. Interviews indicated that several patients who have participated in the DBT programming while hospitalized were referred to similar programs following discharge.

OIG Finding 2.1: Interviews, reviews of programming schedules, direct observation and record reviews revealed that persons receiving care and treatment at NVMHI have access to a variety of programming opportunities designed to enhance their skills for successful community living.

OIG Recommendation: NVMHI has established a mechanism for reviewing and assuring that the programming available addresses the active treatment needs of its patients. A focus on meeting the goals as identified by the course curriculum is recommended with expected outcomes measured to determine the effectiveness of the programs offered. With limited resources and increased efforts at effective bed utilization, this focus approach can increase patient's awareness and adaptive responses during the limited time in which they are hospitalized.

DMHMRSAS Response: *Initially the NVMHI Treatment Mall Council plans to review program content for: 1) support of the facility's mission, vision and values, 2) support of the facility's strategic goals, and 3) integration of recovery principles. Once course objectives are reviewed for these areas, a mechanism will be established to measure outcomes and use these results for on going program refinements. Currently, each program offered has identified objectives. However, members of the Treatment Mall Council will prioritize evaluating the outcomes of the programming provided on the Treatment Mall to ensure that the established objectives are being met. Additionally, the Clinical Leadership team has identified, and the Treatment Mall Council has implemented, core treatment responsibilities for each clinical discipline consistent with each discipline's identified scope of services. Disciplines' program offerings will thus make use of each discipline's areas of expertise in providing active treatment to enable individuals to return to their community as quickly as possible.*

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations

The common areas are clean and well maintained.	Tours indicated that the residential areas visited were clean and well maintained.
Furniture is adequate to meet the needs and number of patients/residents.	Tours of units indicated that furniture was adequate to meet the needs of the patients.
Furniture is maintained and free from tears.	Tours of the common areas indicated that furniture was free from tears and was well maintained.
Curtains are provided when privacy is an issue.	Tours of the units demonstrated that window coverings are provided for privacy from the outside.
Clocks are available and time is accurate.	Clocks were available in public areas and a majority had the correct time.
Notification on contacting the human rights advocate are posted.	A tour of each unit and interviews with patients indicated that information on how to contact the Human Rights Advocate was effectively communicated.
There is evidence that the facility is working towards creating a more home-like setting.	Efforts at making this institutional setting more homelike were noted. Patients indicated that they are allowed to have personal items in their rooms and encouraged to display photos or pictures that might assist in their adjustment to the environment.
Temperatures are seasonally appropriate.	Tours of units indicated that temperatures were comfortable, even though it was unseasonably warm.
Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Interviews with patients revealed that the facility makes every effort to afford privacy when there are visitors to the unit. Each indicated that even though there are recommended visiting hours, visits are not limited at other times.
Patients/residents have access to telephones, writing materials and literature.	Interviews with patients indicated that they have access to communication materials and literature.
Hallways and doors are not blocked or cluttered.	Hallways, doors and egress routes were not blocked and were free of clutter.

Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.
Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews with patients indicated that staff assist them during fire drills but that they were informed in community meetings as a part of orientation where to go for safe egress.
Fire drills are conducted routinely and across shifts.	Fire drills are conducted once per shift per month.
Bedrooms	**Comments and Observations**
Bedrooms are clean, comfortable and well maintained.	All residential units toured were clean and well maintained.
Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Interviews with the patients and observation indicated that each patient has a mattress, sheet, blankets and pillow and if more is needed can obtain them upon request.
Curtains or other coverings are provided for privacy.	Tours of the units confirmed that curtains and/or other coverings are provided for clients' privacy.
Bedrooms are free of hazards such as dangling blind cords, etc.	In the rooms observed there was not any evidence of hazards resulting from dangling cords, etc.
Patients/residents are able to obtain extra covers.	Interviews with patients indicated that they are able to obtain extra linens and covers. Housekeeping assists them in changing linens weekly or more often if necessary.
Patients/residents are afforded opportunities to personalize their rooms.	Interviews with patients indicated that clients are given the opportunity to personalize their rooms.
Bathrooms	**Comments and Observations**
Bathrooms were clean and well maintained	Bathrooms were noted to be clean and well maintained. Housekeeping maintains these areas.

Bathrooms were noted to be odor free.	Tours of unit bathrooms indicated that all were odor free.
Bathrooms were free of hazardous conditions.	Tours of unit bathrooms indicated that all were free of hazardous conditions.
Buildings and Grounds	**Comments and Observations**
Pathways are well lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were well lit and free of hazardous conditions.
Buildings are identified and visitor procedures for entry posted.	Upon entering the center all visitors are greeted by staff and asked to identify themselves with a badge or other form of identification. A sign-in procedure is required and visitors are given a badge for identification purposes.
Grounds are maintained.	Grounds are well maintained. There is a great deal of construction occurring at the hospital adjacent to the facility but it was noted that this did not create a hazardous situation for the patients.
There are designated smoking areas with times posted.	Interviews with patients and observation revealed that the times when smoking breaks occurs were adequately communicated.
Patients/residents have opportunities to be outside.	Interviews with patients and observations revealed that persons with the appropriate privileges regularly go outside on and off grounds.

OIG Finding 3.1: Observations and interviews with patients demonstrated that the facility is well maintained, clean and comfortable.

OIG Recommendation: None.

DMHMRAS Response: *DMHMRSAS appreciates recognition of NVMHI's continuing efforts to maintain a clean, comfortable environment.*

PART IV: OTHER ISSUES

Reports regarding critical incidents, as required by the code of Virginia, are sent for review to the Virginia Office of Protection and Advocacy (VOPA), DMHMRSAS Central Office as well as this Office. These incidents as defined include events that resulted in injuries that required treatment by a physician or physician extender, loss of

consciousness, allegations of sexual assault /rape and deaths, which occur within the facility or within 21 days of discharge. Reports are to be forwarded within 48 hours of occurrence or within 48 hours of discovery, if the time of occurrence is not known. Follow-up reports are also completed on each event that outline the incident, provide the known facts and give an update regarding the status of the patient/resident.

Reports demonstrate that there is a wide continuum of events being reported particularly in the area of serious injuries because of the availability of physicians for assessment and review of patient care.

NVMHI thoroughly reviews these events and addresses any identified trends and patterns in a number of ways. For example, when it was noted that there had been several incidents associated with patient possession of contraband the facility established a FMEA (Failure Mode and Effects Analysis) Team to review this issue. This review involved an analysis of potential contributing causes as well as an examination of applicable policies and procedures. This review also included a study of policies and procedures regarding the possession of contraband as practiced at seven other state-operated facilities. Among the recommendations implemented as a result of this review are the following: the revision of policies and procedures to provide additional clarity regarding items allowed within the facility, including the education of visitors so that items are not brought into the facility inadvertently; lockers have been made available for visitors to store personal belongings while visiting to diminish the risk of unauthorized items from entering the facility as well as to provide for safe storage of visitor belongings; provide clear instruction to staff outlining the procedures for searching and scanning patients and visitors for unauthorized items; clarify procedures for conducting room searches and the establishment of procedures for communication between security and clinical staff when contraband is found.

Risk Management thresholds have been established by the facility through policy and procedures for behaviors such as incidents of falls, assaults/aggressive behavior, self-harm, possession of contraband and use of seclusion and restraint. When a patient has been identified as meeting this threshold for high-risk behavior, the treatment team convenes to review treatment strategies and to revise interventions as appropriate.

In addition to a Safety Committee, which provides oversight to issues of safety related to the physical environment, NVMHI has recently established a Patient Safety and Risk Management Committee. This committee reviews all aspects of risk management within the facility including the critical incidents reports. As a result, a number of performance improvement opportunities have been identified.

Finding 4.1: NVMHI has a mechanism for reviewing critical incidents and other potential areas of risk. This includes the establishment of performance improvement teams and other review processes for assuring patient and environmental safety.

OIG Recommendation: None. The Office looks forward to reviewing the work of the recently established Patient Safety and Risk Management Committee during future inspections.

DMHMRAS Response: *DMHMRSAS appreciates recognition of NVMHI's systematic monitoring and corrective actions of critical incidents and other potential risk areas.*

SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
CYNTHIA MCCLURE / FACILITY DIRECTOR
OIG REPORT #89-03
SNAPSHOT INSPECTION

Date: November 17, 2003
Type of Inspection: Snapshot Inspection / Unannounced
Reviewers: Cathy Hill, LPC

INSPECTION SUMMARY

A Snapshot Inspection was conducted at Southwestern Virginia Mental Health Institute in Marion, Virginia on November 17, 2003. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and activity of patients.

Overall, the facility was well maintained, clean and comfortable. The facility continues in its efforts to renovate the Harmon Building in order to increase programming space. It is projected that this project will be completed in the spring.

SWVMHI has a Centralized Rehabilitation Services program, which provides an array of active treatment group activities designed to assist each patient increase their ability to successfully function within the community. The groups are offered on a twelve-week cycle with a week off in between so that program offerings can be reassessed and adjusted depending on patient needs. There has been an increased effort to integrate services for the adult populations, as appropriate, instead of offering groups for specific populations at varying times, as was the case in the past.

SWVMHI continues its efforts to enhance treatment through a number of mechanisms. One such mechanism is in the hiring of staff whose credentials offer increased clinical options within the setting. Since the last inspection, the facility has hired two additional board certified psychiatrists lessening its dependence on locum tenens for psychiatric coverage. There are currently two medical staff positions within the facility, which are not permanently filled. The facility has also hired a new pharmacy director whose credentials will provide increased opportunities for medication consultation, monitoring and safety.

PART I: STAFFING ISSUES

Number of staff scheduled for this shift for this unit. DSA= Direct Services Associate	**November 17, 2003 – Evening Shift** A/B Unit: 33 patients and one in admissions 4 RNs, 1 LPN and 6 DSAs C/D Unit: 27 patients (one on pass) 2 RNs, 1 LPN and 6 DSAs E/F Unit: 35 patients 2 RNs, 1 LPN and 6 DSAs G Unit: 13 patients 1 RN, 1 DSA H Unit: 12 patients and 2 admissions 2 RNs and 7 DSAs I Unit: 17 patients 1 RN, 1 LPN and 4 DSAs J Unit: 20 patients 1 RN, 1 LPN, 5 DSAs Infirmary: 3 patients 1 RN
Number of staff present on the unit	OIG staff noted that the actual staffing patterns varied somewhat from those identified above. On C/D Unit, one of the DSAs was off the unit transporting a discharged patient. On E/F Unit, 1 LPN was "pulled" to help on the adolescent unit. On J Unit, there was an RN on the unit who was completing orientation and not included in the count. G Unit usually operates with an additional DSA, but that individual was on annual leave.

Number of staff doing overtime during this shift or scheduled to be held over	During the inspection, it was learned that there were not any persons doing OT on the evening shift. The use of mandatory overtime has been very limited at the facility. Interviews indicated that there has been a steady increase in the use of voluntary overtime utilized due to the number of patients on constant observation status, which has increased since the last inspection. Requests by staff to use vacation time have also added to the use of voluntary overtime.
Number of staff not present due absence because of workman's compensation injury?	Interviews with staff during the tour of the facility indicated that there was one staff member out on workman's compensation. It was indicated that this event, resulting in workman's compensation, was patient related.
Number of staff members responsible for one-to-one coverage during this shift?	Interviews with facility staff during the inspection tour of the units indicated that the only patients on 1:1 status were on the adolescent unit. Of the 12 patients, 3 were on 1:1 staff coverage and 5 were under constant observation status. 1:1 status is identified as "within arms length" of the patient at all times. Constant observation requires that the patient is "within-sight" at all times.

Additional comments regarding staff: There has been a change in administration at SWVMHI since the last inspection conducted by the OIG. Cynthia McClure, PhD was named the Facility Director during Spring 2003 after serving as the Acting Director. Dr. McClure began her career at the facility in 1987 as a psychologist. She also served in the capacity of Clinical Director prior to being appointed to the Acting Director position. Staff were very complimentary of Dr. McClure and her style of leadership, which was characterized as encouraging open communication and staff involvement, with a focus on both problem solving and recognizing excellence.

SWVMHI continues its efforts to enhance treatment through a number of mechanisms. One such mechanism is in the hiring of staff whose credentials offer increased clinical options within the setting. For example, the facility currently has three Master's level social workers. These individuals can provide a broader level of clinical services both within the treatment team and the centralized rehabilitation services.

In addition, the facility continues to increase the number of psychiatrists who are board certified. Since the last inspection, the facility has hired two additional board certified psychiatrists lessening its dependence on locum tenens for psychiatric coverage. There are currently two medical staff positions within the facility, which are not permanently filled. One of these positions is on an acute admissions unit and the other on an extended rehabilitation unit. Two of the six patients interviewed on the extended rehabilitation unit identified the change in psychiatric coverage due to the use of locum tenens as problematic. The patients related that medication changes usually accompany the introduction of each new psychiatrist resulting, from their perspective, in unnecessary delays and changes in their treatment. One person indicated he has had six different physicians in the past year. Interviews with administrative staff confirmed that there had been a number of physician changes within that particular unit during the referred time period. Interviews revealed that administrative staff, particularly the medical director, constantly strives to assure that consumers receive quality care and treatment and that efforts to lessen the number of physician changes are ongoing. The facility has also hired a new pharmacy director whose credentials will provide increased opportunities for medication consultation, monitoring and safety.

Nursing administration at this facility continue to be proactive in staff recruiting and retention efforts. A survey of nursing personnel was conducted in October 2003. One of the purposes of the survey was to assist in the establishment of staffing priorities and actions geared towards addressing issues associated with recruitment and retention. The results of the survey were not available at the time of the inspection. Other efforts have included a limited piloting of the Baylor Plan (a modified schedule), a preceptor and cross-training program, recognition of excellent work through an employee of the month program and limited tuition reimbursement for additional training and credentialing. The facility is also exploring the possibility of offering an attendance incentive as well as shift differentials for direct care staff. Administration is reviewing the current documentation requirements for nursing staff in an effort to lessen the actual paperwork without diminishing the sharing of information necessary for assuring quality care for the patients.

Finding 1.1: Direct observation, interviews and a review of staffing documentation demonstrated adequate staffing patterns consistent with facility policy and providing for treatment, supervision and the safety concerns of the patients.

OIG Recommendation: None

Finding 1.2: SWVMHI places an emphasis on recruiting staff whose credentials and backgrounds offer increased opportunities for enhancing clinical services. Efforts at retaining quality staff are ongoing.

OIG Recommendation: None. Nursing administration among other administrative directors are constantly reviewing ways to recruit and retain quality staff.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

Bed capacity for the unit: Census at the time of the review:

The number of patients on the units during the time of the inspection was 162. This included: 19 patients on A, 14 patients on B, 17 patients on C, 9 patients on D, 19 patients on E, 16 patients on F, 13 patients on G, 12 patients on H, 17 patients on I, 20 patients on J and 3 patients in the infirmary. This represents an increase in the number of patients served by the facility in recent months.

Representatives from SWVMHI have actively participated in the regional reinvestment process. Discussions, which have occurred in five partnership-planning conferences, centered on the identification of the services needs of consumers in this large region. It has been important to those involved to identify these needs in the broader context of other important issues facing this region such as increased unemployment, diminished primary health care options and the increased number of uninsured or under insured residents. Although discussions have also focused on the use of limited private psychiatric facilities for acute admissions, SWVMHI continues to provide an essential service to consumers of this region as a "safety net" for both the adult and adolescent populations.

Number of patients/residents on special hospitalization status.
Interviews with administrative staff indicated that there were not any patients on special hospitalization status during the time of the inspection.

Number of patients/residents on special precautions?
Interviews with staff, on the units toured, indicated that 14 residents were noted to be on special precautions addressing issues such as aggressive and/or self-injurious behaviors, and/or other behavioral issues.

Number of patients/residents on 1 to 1?
Interviews with facility staff during the inspection tour of the units indicated that the only patients on 1:1 status were on the adolescent unit. Of the 12 patients, 3 were on 1:1 staff coverage and 5 were under constant observation status. 1:1 status is identified as "within arms length" of the patient at all times. Constant observation requires that the patient is "within-sight" at all times.

Identify the activities of the patients/residents?
Tours of the units occurred during the early evening hours, which are typically identified as leisure time. The majority of patients on the units were observed quietly resting in their rooms or watching television in the dayroom. Others were engaged in small group activities such as a board game. Scheduled events included activities such as a music

group and a current events discussion group. Recreational activities were available in the gym/gameroom area during the evening hours for the adult patients. Patients were observed playing basketball, walking around the gym area, playing other games and watching a movie in a small group setting. Recreational group activities in the gym area are provided for the adolescent population at alternate times.

Are smoke breaks posted?
Smoke breaks were clearly identified at the facility. Smoking occurs in designated areas and under staff supervision. Unit tours and interviews with patients revealed that smoke breaks were posted, although all of those interviewed did not feel the facility provided adequate time for smoke breaks.

Do patients/residents have opportunities for off-ground activities?
Interviews with facility staff and patients indicated that there are opportunities for patients to participate in off-grounds activities once they have achieved the necessary level, which is addressed between the patient and the treatment team.

As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff indicated that snacks do occur as appropriate for individualized diet plans. Snack times were identified as typically 10:00 am, 2:00pm, 4:00pm and 8:00pm.

Other comments regarding patient activities:
SWVMHI has a Centralized Rehabilitation Services program, which provides an array of group activities designed to assist each patient increase their ability to successfully function within the community. The groups are offered on a twelve-week cycle with a week off in between so that program offerings can be reassessed and adjusted depending on patient needs. There has been an increased effort to integrate the adult population into the groups, as appropriate, instead of offering groups for specific populations at varying times, as was the case in the past. This change enables the treatment teams, with patient input, to have an enhanced menu of program options in which to refer individuals. Unit based activities are still available for those individuals, who for a variety of reasons are identified as not able to participate in the more centralized activities. The facility also offers expanded rehabilitative services through enhanced evening and weekend programming. During the inspection, OIG staff observed two groups. In each, the leader had devised a game to engage the participants in reviewing curriculum material. Patients were actively engaged and responsive. Everyone was provided with an opportunity and encouraged to participate. The groups were relaxed, informative and relevant to the group topics/curriculum.

Vocational opportunities are available currently on a limited basis for patients. This provides individuals with opportunities to gain work experience and awareness of other responsibilities associated with employment such as attendance, arriving on time and successfully completing job tasks.

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Co-occurring mental health and substance abuse disorders often present a significant challenge to public health providers. It is generally accepted that is important to address both issues at the same time because if one area goes unidentified and untreated the other condition will likely worsen. Effective tools for assisting the dually diagnosed (MI/SA) patient are timely screening, assessment and the initiation of, at the least, motivational enhancement services. Since the last inspection, this facility has designated a substance abuse staff person whose primary responsibilities are to assess and begin addressing the needs of these patients. At the time of the inspection, it was noted that approximately 300 patients have received services. In addition to substance abuse assessments, the staff offers both individual and group activities. Those interviewed indicated that this position has been a valuable addition for this facility.

OIG Finding 2.1: Interviews, reviews of programming schedules, direct observation and record reviews demonstrated that persons receiving care and treatment at SWVMHI have access to a variety of programming opportunities designed to enhance their skills for successful community living.

OIG Recommendation: None. SWVMHI administration and clinical directors places value in the development and maintenance of an array of active treatment programs/activities for the patients. Programs were offered as described.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
The common areas are clean and well maintained.	Tours indicated that the residential areas visited were clean and well maintained.
Furniture is adequate to meet the needs and number of patients/residents.	Tours of units indicated that furniture was adequate to meet the needs of the patients.
Furniture is maintained and free from tears.	Tours of the common areas indicated that furniture was free from tears and was well maintained.
Curtains are provided when privacy is an issue.	Tours of the units demonstrated that window coverings are provided for privacy from the outside. There are visual barriers between the adult and adolescent residential units to allow for maximum privacy and confidentiality.

Clocks are available and time is accurate.	Clocks were available in public areas and were noted to have the correct time.
Notification on contacting the human rights advocate are posted.	A tour of each unit and interviews with patients indicated that information on how to contact the Human Rights Advocate was both posted and effectively communicated.
There is evidence that the facility is working towards creating a more home-like setting.	Efforts at making this institutional setting more homelike were noted. Patients indicated that they are allowed to have personal items in their rooms and encouraged to display photos, pictures and other objects.
Temperatures are seasonally appropriate.	Tours of units indicated that temperatures were comfortable. Interviews with patients indicated that staff make every effort to assure that they are comfortable.
Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Interviews with patients revealed that the facility makes every effort to afford privacy when they have visitors. There are areas on each unit that are designated for family visits.
Patients/residents have access to telephones, writing materials and literature.	Interviews with patients indicated that they have access to writing materials, telephones and reading material.
Hallways and doors are not blocked or cluttered.	Hallways, doors and egress routes were not blocked and were free of clutter.
Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.
Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews with patients indicated that staff assist them during fire drills but that they were informed in community meetings as a part of orientation where to go for safe egress.
Fire drills are conducted routinely and across shifts.	Fire drills are conducted once per shift per quarter.
Bedrooms	**Comments and Observations**

Bedrooms are clean, comfortable and well maintained.	All residential units toured were clean and well maintained.
Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Interviews with the patients and observation indicated that each patient has a mattress, sheet, blankets and pillow. Additional blankets are available if requested.
Curtains or other coverings are provided for privacy.	Tours of the units confirmed that curtains and/or other coverings are provided for clients' privacy.
Bedrooms are free of hazards such as dangling blind cords, etc.	In the rooms observed there was not any evidence of hazards resulting from dangling cords, etc.
Patients/residents are able to obtain extra covers.	Interviews with patients indicated that they are able to obtain extra linens and covers. Housekeeping assists them in changing linens weekly or more often if necessary.
Patients/residents are afforded opportunities to personalize their rooms.	Interviews with patients indicated that clients are given the opportunity to personalize their rooms.
Bathrooms	**Comments and Observations**
Bathrooms were clean and well maintained	Bathrooms were noted to be clean and well maintained. Housekeeping maintains these areas.
Bathrooms were noted to be odor free.	Tours of bathrooms indicated that all were odor free.
Bathrooms were free of hazardous conditions.	Tours of bathrooms indicated that all were free of hazardous conditions.
Buildings and Grounds	**Comments and Observations**
Pathways are well lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were well lit and free of hazardous conditions.
Buildings are identified and visitor procedures for entry posted.	Upon entering the center all visitors are greeted by staff and asked to identify themselves with a badge or other form of identification. A sign-in procedure is required and visitors are given a

	visitors pass for identification purposes. Sign-out is required. This includes the return of the pass.
Grounds are maintained.	Grounds are well maintained.
There are designated smoking areas with times posted.	Interviews with patients and observation revealed that the times when smoking breaks occurs were adequately communicated.
Patients/residents have opportunities to be outside.	Interviews with patients and observations revealed that persons with the appropriate privileges regularly go outside.

OIG Finding 3.1: Observations and interviews with patients demonstrated that the facility is well maintained, clean and comfortable.

OIG Recommendation: None.

PART IV: OTHER ISSUES

As with all facilities, SWVMHI is required to forward reports regarding critical incidents to the Virginia Office of Protection and Advocacy (VOPA), DMHMRSAS Central Office as well as this Office. These incidents as defined include events that resulted in injuries that required treatment by a physician or physician extender, loss of consciousness, allegations of sexual assault /rape and deaths, which occur within the facility or within 21 days of discharge. Reports are to be forwarded within 48 hours of occurrence or within 48 hours of discovery, if the time of occurrence is not known. Follow-up reports are also completed on each event that outline the incident, provide the known facts and give an update regarding the status of the patient/resident.

There is a wide continuum of events being reported from minor injuries to those that are more serious in nature due to the availability of physicians for assessment and review of patient care and established treatment protocols.

SWVMHI has a number of mechanisms established for the ongoing review of this information. Department heads and other members of the administration indicated that one of the most effective tools for the dissemination of critical information within the facility is in the daily nursing report. This report provides information relevant to issues of patient safety and treatment, which have occurred during the previous 24-hour period. Among the topics covered are medical conditions, behavioral issues, and critical incidents. The information is made available to program directors and the advocate. In

addition, a review of incidents occurs during Special Management Committee meetings, which are held three times a week.

Finding 4.1:SWVMHI has a several mechanisms established for reviewing critical incidents and other potential areas of risk. The information is presented to key personnel in a timely manner. Performance improvement initiatives and reviews are also on-going.

OIG Recommendation: None.

COMMONWEALTH CENTER FOR CHILDREN AND ADOLESCENTS WILLIAM J. TUELL / FACILITY DIRECTOR OIG REPORT #90-03 SNAPSHOT INSPECTION

Date:	December 16, 2003
Type of Inspection:	Snapshot Inspection / Unannounced
Reviewers:	Cathy Hill, LPC Lolitha Terry

A Snapshot Inspection was conducted at the Commonwealth Center for Children and Adolescents in Staunton, Virginia on December 16, 2003. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and activity of patients.

CCCA is currently undergoing a number of restructuring initiatives designed to enhance the facility's ability to address the needs of both the patients and the employees. These changes are resulting from work completed by facility management and on the recommendations of an external consultant hired by the facility to examine issues of communication, team cohesiveness and other identified staffing issues within the facility.

One of the major changes recently implemented centers around the facility's movement to a service team model, which will allow for increased client-centered and individualized services for the patients focusing primarily on those issues associated with the reasons for hospitalization and the barriers to successful community living. This model provides for the provision of services based on assessed needs regardless of unit placement. Several key positions at the facility are in the process of being filled, which will also add to programming stability and client services, such as the Director of Nursing and Human Rights Advocate positions.

Efforts are underway to address the staff turnover rate and a program of enhanced staff training and development is currently in development. Supervisory structure for direct care workers has been reassigned in order to enhance staff management and deployment.

The facility continues to offer a variety of active treatment programming options for the patients while reviewing ways of enhancing services through the development of facility wide active treatment programming. Activities therapy services will now be delivered through the newly developed AT Department.

Overall, the facility was well maintained, clean and comfortable. Efforts to make this institutional setting appear more homelike were noted. Patients interviewed during the inspection process commented that they felt safe and comfortable within the setting.

PART I: STAFFING ISSUES

Number of staff scheduled for this shift for this unit. DSA= Direct Services Associate	December 16th- 1st shift Unit 1: RN – 1, LPN – 0, DSA – 4 Unit 2: RN – 1, LPN – 0, DSA – 4 Unit 3: RN – 1, LPN – 0, DSA – 3 Unit 4: RN – 1, LPN – 0, DSA – 4
Number of staff present on the unit?	Actual staffing patterns were as identified above except for Unit 1. There were three staff members present on the unit during the time the tour took place instead of the scheduled four members. It had been explained that one staff member had been "pulled" in order to assist on another unit. It was noted that the individual was present on the identified unit.
Number of staff doing overtime during this shift or scheduled to be held over?	During the inspection, it was learned that there were not any persons doing OT on the day shift. Staff interviewed indicated that there had been an increase in the amount of overtime recently due to staff shortages but expressed hope that this would be remedied once the new hires were trained. It was acknowledged that the facility had focused on hiring additional staff but they were not scheduled to begin working until after the holidays.
Number of staff not present due absence because of workman's compensation injury?	Interviews revealed that two of the staff present were on "light duty" status after returning to the facility from absences due to patient related injuries. Staff indicated that there was one staff member who was out on disability as a result of a patient related injury.
Number of staff members responsible for one-to-one coverage during this shift?	At the time of the tour four children were identified as being on "constant observation" status, within the facility.

6. Are there other staff members present on the unit? If so, please list by positions?
Observations and interviews revealed a number of other disciplines were present on the units including activity therapists, social workers, psychologists and psychiatrists.

Additional comments regarding staff:
CCCA is currently undergoing a number of restructuring initiatives designed to enhance the facility's ability to address the needs of both the patients and the employees. One of the changes identified by the facility was the adoption of a Services Team Model. Those interviewed identified this model as one that focuses on the provision of client-centered, individualized services based upon assessed needs regardless of unit placement.

The adoption of this model has also resulted in a number of changes that impact employees. Clinical staff have been reassigned in order to enhance the strengths of each of the clinical teams providing care and treatment. Direct care staff scheduling, orientation, deployment and overall supervision will become the primary responsibility of one of the two current Program Managers. This allows for consistent and uniform supervision and a singular point for addressing the day-to day staffing concerns. The other Program Manager will be responsible for the expansion of a staff development and training program and offer supervision of the newly developed activities therapy department.

Nursing will also be adopting a team approach to service provision. The facility has been down several nursing positions, including the Director of Nursing position. Interviews with both administration and direct care staff identified a nursing shortage as a significant challenge for this facility, not unlike a number of the state facilities. Although team-nursing models are not new, its use at the facility is a new strategy for dealing with limited resources. At the beginning of each shift, nursing staff facility-wide discuss a division of tasks that best addresses the nursing needs of the Center. Nurses may function on any unit depending on where they are needed. Those interviewed were very positive regarding the implementation of this model, which was identified as allowing for the type of flexibility often needed in order to assure that both routine tasks and the needs of the patients are addressed in a timely and effective manner. The facility has been actively recruiting nurses and at the time of this review was in the final phase of selecting a Director of Nursing.

The facility has explored a number of initiatives designed to address the staff turn over rate. Management has been engaging in discussions with the Central Office regarding the introduction of a new schedule for direct care staff, which will enable them to work fewer hours, have more consecutive days off including every other weekend. A shift differential for 2nd and 3rd shifts is under review, particularly as an incentive for retaining persons on the 2nd shift, which is universally determined to be the least desirable shift.

The facility has been actively recruiting persons to fill the vacant direct care positions. A new group of employees will be introduced to services following the holidays. With the introduction of behavioral support teams, consistent supervision and support as well as increased training, the facility is developing a number of initiatives designed to retain a quality pool of direct care staff.

Finding 1.1: Direct observation, interviews and a review of staffing documentation revealed that the facility provided for adequate staffing patterns through a variety of techniques, including an increase in the use of overtime, schedule and deployment changes as well as the hiring of additional staff.

OIG Recommendation: As the facility has implemented several initiatives to address staff shortages and for assuring adequate coverage for addressing the treatment, supervision and safety needs of the patients, the OIG does not have any additional recommendations at this time. Staffing patterns will be monitored.

DMHMRSAS Response*: CCCA has implemented new initiatives to address staff shortages and assure adequate coverage. These initiatives include:*

- *restructuring direct care staff assignments,*
- *creating a new innovative schedule for direct care staff, and*
- *implementing support teams*

The support teams provide on-going assessment of acuity across units in order to support direct care staff and nurses when consumers with challenging behaviors have an exacerbation of those behaviors. Comments from direct care staff and nurses, as well as decreased turnover in direct care staff and nurses over the last three months show that these changes have already had a positive effect. To evaluate the efficacy of these initiatives CCCA will continue to monitor the turnover rate and encourage comments from the direct care staff and nurses.

Finding 1.2: The facility has made provisions for enhancing staff development and training programs within the facility by assigning a program manager to provide oversight to this process. The enhancement of this program is expected to contribute to the successful retention of quality staff.

OIG Recommendation: None. As this process is relatively new in this facility, the OIG looks forward to reviewing its progress in the future.

DMHMRSAS Response: *This assignment is very recent and is in the beginning stages of implementation. To date, CCCA has purchased two child-based direct care staff training packages (Effective Skills for Child-care Workers from Boys/Girls Town Press and New Directions: Essential Skills for Direct-Care Professionals from the Child Welfare League of America in conjunction with the Devereux Foundation). The Center has also purchased the Child Welfare League of America's supervisor training program for supervisors in child residential facilities. All of these materials have been reviewed, but not yet implemented. The Center has implemented TOVA training for all direct care staff, nurses, and other professionals. Sections of TOVA were allocated specifically to the supervisors at the Center. In those sections, we incorporated supervisory perspectives and issues into the TOVA curriculum. CCCA has worked with Human*

Resources in the DMHMRSAS to write a proposal to be involved in a supervisor-training program through the University of Minnesota called Stop the Revolving Door, a program designed to teach frontline supervisors in residential and inpatient programs how to improve staff retention. One of CCCA nurses is a psychiatric Clinical Nurse Specialist who has been given new duties to include building psychiatric nursing competencies and skills for all RNs at the Center. We will continue to develop and implement this new program over the next several months.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

Bed capacity for the unit: Census at the time of the review:

The census on the day of the inspection was 36 patients. This included: 11 patients on Unit 1, 4 patients on Unit 2, 9 patients on Unit 3 and 12 patients on unit 4. The capacity for this facility is 48.

Members of the management staff have participated on the Special Populations Work Group charged with the responsibility of crafting identified needs and strategies for developing services for children and adolescents across the Commonwealth. In addition, management at the facility and with the support and cooperation of Central Office management have engaged in dialogues with other agencies that traditionally relies on the services of CCCA. These open discussions are focusing on ways of developing interagency cooperation in outlining the most effective ways of serving their common populations.

Number of patients/residents on special hospitalization status.
Interviews with administrative staff indicated that there were not any patients on special hospitalization status during the time of the inspection.

Number of patients/residents on special precautions?
Interviews with staff, on the units toured, indicated that residents were noted to be on special precautions addressing issues such as aggressive behavior, self-injurious behavior, elopement and/or other behavioral issues.

Number of patients/residents on 1 to 1?
Interviews with facility staff indicated that during the inspection shift on the units listed above 4 patients were on “constant observation” status, which denotes “within-sight” of staff at all times.

Identify the activities of the patients/residents?
The majority of patients, during the time of the tour, were involved in school programming. Students are provided with educational instruction through the City of Staunton’s public system. The facility was in the process of identifying and establishing alternate instructions and additional active treatment programs for the upcoming holiday period. This year the school break is for two weeks. Both active treatment and seasonal recreational events were being planned. During the early evening hours, the patients are

engaged in active treatment programs both instructional and recreational. These programs have traditionally been unit based. However, the facility is currently reviewing the initiation of a facility-wide coordinated schedule of active treatment programming provided by the Activities Therapy Department. This newly formed department will evaluate center-wide needs and provide services to all children regardless of their unit placement. This should allow for enhanced services and a better use of limited resources.

Do patients/residents have opportunities for off-ground activities?
Interviews with facility staff and patients indicated that there are opportunities for patients to participate in off-grounds activities once they have achieved the necessary level and if staffing patterns allow.

As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff indicated that snacks do occur as appropriate for individualized diet plans. Snacks are typically available three times per day.

Other comment about active treatment:
CCCA is currently providing enhanced substance abuse services. The facility began a formalized program of substance abuse services a little over three years ago. The program began with the hiring of a coordinator and has grown through the use of several grants into a program with additional staff and interns. There are on average six treatment groups offered each week including four substance use/abuse groups, a smoking cessation group and one for children of alcoholics. SA topics are also integrated into programming offered by nursing and activities therapy staff.

The Director of SA Services has been invited to serve as one of four consultants on a project on the national level. CCCA will be working with SWVMHI in enhancing SA services to their adolescent population.

OIG Finding 2.1: Interviews, reviews of programming schedules, and direct observation revealed that children and adolescents receiving care and treatment at CCCA have access to a variety of programming opportunities.

OIG Recommendation: None at this time. The facility is currently in the process of shifting the manner in which it offers several aspects of active treatment programming. This shift of providing facility-wide active treatment programming based on identified needs regardless of unit placement should allow for enhanced services and a better use of limited resources. Progress on the development of center-based services will be monitored.

DMHMRSAS Response*: CCCA has reorganized its Activities Therapy (AT) functions into a separate department effective December 1, 2003. Staff in the department continues to serve as members of the treatment teams and coordinate the provision of activities therapy to each individual child on the team. The AT department is shifting from a unit-based services provision model to a service team model in concert with the organizational changes in the Center. In this new model, staff of the AT Department will*

provide greater focus on the treatment intervention needs of the individual child. Children will be involved in individual and group AT interventions based on their treatment goals and objectives. The AT staff has organized all AT curricular materials and reviewed and modified AT group offerings, and has implemented some cross-unit groups. CCCA will continue to work toward greater flexibility in offerings to provide increased options to match the needs of individuals served.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
The common areas are clean and well maintained.	Tours indicated that the residential areas visited were clean and well maintained.
Furniture is adequate to meet the needs and number of patients/residents.	Tours of units indicated that furniture was adequate to meet the needs of the patients.
Furniture is maintained and free from tears.	Tours of the common areas indicated that furniture was free from tears and was well maintained.
Curtains are provided when privacy is an issue.	Tours of the units demonstrated that window coverings are provided for privacy from the outside.
Clocks are available and time is accurate.	Clocks were available in public areas and the correct time was noted.
Notification on contacting the human rights advocate are posted.	A tour of each unit and interviews with patients indicated that information on how to contact the Human Rights Advocate was effectively communicated. Posters were observed on each unit.
There is evidence that the facility is working towards creating a more home-like setting.	Efforts at making this institutional setting more homelike were noted. Patients indicated that they are allowed to have personal items in their rooms and encouraged to display photos or pictures that might assist in their adjustment to the environment.
Temperatures are seasonally appropriate.	Tours of units indicated that temperatures were comfortable.

Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Interviews with patients revealed that the facility makes every effort to afford privacy when there are visitors to the unit. Each indicated that even though there are recommended visiting hours, visits are not limited at other times particularly since families often have to travel long distances.
Patients/residents have access to telephones, writing materials and literature.	Interviews with patients and staff indicated that there is access to communication materials and literature.
Hallways and doors are not blocked or cluttered.	Hallways, doors and egress routes were not blocked and were free of clutter.
Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.
Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews with patients indicated that staff assist them during fire drills.
Fire drills are conducted routinely and across shifts.	Fire drills are conducted once per shift per month.
Bedrooms	**Comments and Observations**
Bedrooms are clean, comfortable and well maintained.	All residential units toured were clean and well maintained. Bedrooms on the adolescent units were messy. Two patients interviewed indicated that staff make efforts at getting them to keep their rooms clean but that this does not usually occur until in the evenings when they are on the units for longer periods of time.
Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Interviews with the patients and observations indicated that each patient has a mattress, sheet, blankets and pillow and if more is needed can obtain them upon request.
Curtains or other coverings are provided for privacy.	Tours of the units confirmed that curtains and/or other coverings are provided for clients' privacy.

Bedrooms are free of hazards such as dangling blind cords, etc.	In the rooms observed there was not any evidence of hazards resulting from dangling cords, etc.
Patients/residents are able to obtain extra covers.	Interviews with patients indicated that they are able to obtain extra linens and covers. Housekeeping services are provided by Western State Hospital. These individuals are responsible for changing linens weekly or more often if necessary.
Patients/residents are afforded opportunities to personalize their rooms.	Interviews and observations indicated that clients are given the opportunity to personalize their rooms.
Bathrooms	**Comments and Observations**
Bathrooms were clean and well maintained	Bathrooms were noted to be clean and well maintained. Housekeeping maintains these areas.
Bathrooms were noted to be odor free.	Tours of unit bathrooms indicated that all were odor free.
Bathrooms were free of hazardous conditions.	Tours of unit bathrooms indicated that all were free of hazardous conditions.
Buildings and Grounds	**Comments and Observations**
Pathways are well lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were well lit and free of hazardous conditions.
Buildings are identified and visitor procedures for entry posted.	Upon entering the center all visitors are greeted by staff and asked to identify themselves with a badge or other form of identification. A sign-in procedure is required and visitors are given a badge for identification purposes.
Grounds are maintained.	Grounds are well maintained.
There are designated smoking areas with times posted.	Smoking by minors is prohibited at the facility.
Patients/residents have opportunities to be outside.	Interviews with patients and staff revealed that persons with the appropriate privileges have limited opportunities for going outside on and off grounds currently because of staff shortages.

OIG Finding 3.1: Observations and interviews with patients demonstrated that the facility is well maintained, clean and comfortable.

OIG Recommendation: None.

DMHMRSAS Response: *CCCA will continue to be vigilant about its environment by continued coordination of support services through Western State Hospital. Staff will continue to encourage and support children and adolescents, as appropriate developmentally and clinically, to personalize their rooms and keep them neat and orderly. CCCA will continue to monitor the environment and make changes as needed.*

CENTRAL STATE HOSPITAL
CHARLES DAVIS / FACILITY DIRECTOR
OIG REPORT #92-04
SNAPSHOT INSPECTION

Date:	February 12 -13, 2004
Type of Inspection:	Snapshot Inspection / Unannounced
Reviewers:	James W. Stewart, III Cathy Hill, LPC

A Snapshot Inspection was conducted at Central State Hospital in Petersburg, Virginia on February 12 - 13, 2004. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and the activity of patients.

During the Spring 2003, the facility ended its contract with the Liberty HealthCare Corporation to provide additional acute care forensic beds for individuals primarily transferred from the local jails. This resulted in an expansion of forensics services on the main campus, increasing the bed capacity in both Building 39 and 96, which are the two secured forensic buildings. This change did not result in an overall increase in bed capacity for the facility because, as a result of census management and diversion efforts, the facility was able to close one of the civil services buildings. All non-licensed direct care staff were converted and trained as forensic mental health technicians in order for staff to be more effectively deployed campus-wide.

Since the last inspection, the facility has undergone an administrative change. Larry Latham, PhD left his position as Facility Director during the Summer 2003. Following his departure, Vicky Montgomery was named the Acting Director and continued in that capacity during this inspection process. Charles Davis, MD has been recently selected for

the position and is scheduled to begin serving in that capacity on February 25th. He has served as the Medical Director at the facility for a number of years.

Central State Hospital provides an array of active treatment options for patients in a variety of treatment mall settings, depending on each patient's level of functioning, security status and stability. The facility routinely reviews and updates programming activities in order to meet the needs of the populations served.

The environment was noted as being clean and well maintained. There is currently some construction occurring on the grounds of the facility. The construction is associated with the replacing of ground pipes as the heating system is being converted. This has resulted in an increase in security measures for the safety of the staff and patients.

PART I: STAFFING ISSUES

Number of staff scheduled for this shift for this unit. FMHT = forensic mental health technician SFMHT = security forensic mental health technician	**February 12, 2004** Building 39 – 2nd shift Ward 1 1- RN 2- FMHT Building 95- 2nd shift Ward 1 1- RN 1- LPN 3- FMHT Building 95- 2nd shift Ward 4 2- RN 7- FMHT 1- SFMHT Building 94- 2nd shift Ward 1 1- RN 1- LPN 5- FMHT 2- SFMHT Building 94- 2nd shift 1- RN 1- LPN 3- FMHT 1- SFMHT
Number of staff present on the unit?	Observations revealed that the number of staff scheduled to provide coverage were present on the units as identified.
Number of staff doing overtime during this shift or scheduled to be held over?	In all of the units toured, it was learned that one staff member was doing OT during the second shift on 2/12. On the morning of 2/13, six staff members in Building 94 were held over because a similar number of staff members were late arriving to work. This was a source of frustration for the night shift staff because the circumstances were such that they did not know whether the tardiness of the other staff meant they were going to stay over for an hour or an entire shift. Interviews with management indicated that efforts were being made to address staff tardiness through supervision.

Number of staff not present due to absence because of workman's compensation injury?	Interviews revealed that there were not any staff members out due to workman's compensation on any of the units toured during the inspection process.
Number of staff members responsible for one-to-one coverage during this shift?	During the second shift on February 12, there were 6 patients identified as on 1:1 status; 4 were in Building 95-Ward 4 and 2 were in Building 94-Ward 1. In Building 94- Ward 4, 2 patients were on constant observation status from 9:00 p.m. until the following morning at 7:00. This status requires that a designated staff person keep a constant watch on the two patients.

Are there other staff members present on the unit? If so, please list by positions?
The administrator on duty (AOD) and the medical officer on duty (MOD) were noted to be on the units during the evening shift when the tour of the buildings was conducted.

Additional comments regarding staff:
Central State Hospital is the primary facility in Virginia for the adult mentally ill population requiring forensic services in an inpatient psychiatric setting. Stabilization and treatment services are provided for individuals ranging from those referred from the jails with acute symptoms of mental illness that could not be effectively treated in the jail setting to the longer term care needs of individuals adjudicated as not guilty by reason of insanity (NGRI). Each subset of the forensic population requires different treatment modalities and presents a unique challenge to the treatment providers. Like many of the state facilities, Central State Hospital has had to address the issue of providing adequate staff coverage for this very diverse population. In order to more effectively deploy staff to address the security, safety and treatment needs of the entire campus, all non-licensed mental health technicians were converted to forensic mental health technicians. This allowed for, with additional training, staff traditionally assigned to the civil units on campus to be able to work within the more secure forensic buildings when acuity and staffing patterns dictate. Staff received two days of additional training regarding security issues pertinent to working with the forensic population. This training is standard for the facility and correlates with the training received by persons originally assigned to Buildings 39 and 96.

A majority of the staff interviewed (14 of the 19 FMHTs) indicated they did not feel adequately prepared for working on the forensic units in spite of the provision of additional training. Staff voiced concerns with the use of mandatory overtime, the frequency of "call-ins" and the growing practice of staff being held-over due to the tardiness of their peers on the on-coming shift. Staff described these issues as long-standing and reported that they were the cause of decreased staff morale. Interviews with administration revealed that specific steps had been taken to address these issues. Among

the actions taken was a review of overtime practices including the frequency of overtime as a result of "call-ins" and the increased use of contract nursing personnel for scheduled leave events. Management indicated that efforts were underway to address staff tardiness through supervision. The team was provided a copy of a memo forwarded from the Facility Director to the contract agencies outlining the importance of assuring that their staff are punctual and the actions that would result if tardiness continued to be a problem.

Since the last inspection, the facility has undergone an administrative change. Larry Latham, PhD left his position as Facility Director during the Summer 2003. He had served the facility as Director for a little less than five years and had been instrumental in providing stability and leadership following the involvement of the Department of Justice at the facility. Following his departure, Vicky Montgomery was named the Acting Director and continued in that capacity during this inspection process.

Charles Davis, MD has been recently named the Facility Director and is scheduled to begin serving in that capacity on February 25th. He has served as the Medical Director at the facility for a number of years.

CSH has additional personnel in the secure forensic buildings whose primary function is to provide increased security and monitoring of the physical environment. They serve to provide support to the clinical staff in emergency situations regarding unit safety. These individuals are not included in the clinical staffing patterns for the forensic units. These safety and security technicians (SST) wear protective gear similar to law enforcement officers. They may be assigned to a particular unit during a shift or patrol the building.

A similar position exists on the civil wards except these security forensic mental health technicians (SFMHT) have been trained to engage with the patients using behavioral management techniques and interventions. Their duties vary somewhat as the population typically residing in these less restrictive units presents with fewer risks than those in the more secured settings.

Finding 1.1: Direct observation, interviews and a review of staffing documentation revealed that the facility provided for adequate staffing coverage consistent with facility policy.

OIG Recommendation: None.

Finding 1.2: Despite the fact that the administration has taken specific steps to address issues associated with the use of overtime and staff tardiness, the majority of staff interviewed expressed dissatisfaction with these same issues and tardiness continues to be a problem.

Recommendation: It is recommended that the facility determine why the steps taken have not resolved these concerns and develop strategies that will resolve the problem.

DMHMRSAS Response: *In order to more fully understand the problems underlying staff discontent CSH is pursuing the following approach. A new Director of Nursing Services (DON) will be hired imminently. An Acting DON has filled the position since last summer. Reorganization of the Department of Nursing Services in order to improve the quality of supervision of direct-care staff will be considered as soon as the new DON is on board. In March 2004, the Director chartered several hospital-wide quality improvement teams. There is a Staffing QI Team, lead by Vicki Montgomery and a Recruitment/Retention QI Team whose leader is Daniel Herr. The mission of these teams is to collect and analyze data regarding all aspects of CSH staffing, and then to develop potential solutions to problems that are discovered. The hospital also is in the process of actively requesting specific feedback from staff regarding what they believe to be problems as well as their suggested solutions to those problems. This approach has been announced to staff in the current hospital-wide newsletter. As these approaches give us additional information CSH will be able to respond positively to the problems that are discovered so that staff discontent can be reduced significantly.*

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

Bed capacity for the unit: Census at the time of the review:

The census on the units toured during the inspection process were as follows:

- Building 39 Unit 1 had 14 patients on the unit and 2 additional patients were identified as on special hospitalization status. Bed capacity for the unit is 23.
- Building 94 Unit 1 had 23 patients in-house and 1 patient on a pass. The bed capacity for the unit is 25 patients
- Building 94 Unit 4 had 21 patients on the unit, 2 were on special hospitalization status and 1 was on a pass. The unit has a bed capacity of 25 patients.
- Building 95 Unit 1 had 24 patients with a bed capacity of 25.
- Building 95 Unit 4 had 24 patients and 1 patient on a special status. The bed capacity for the unit is also 25.

Number of patients/residents on special hospitalization status.
Interviews with administrative staff indicated that there were four patients on special hospitalization status during the time of the inspection.

Number of patients/residents on special precautions?
Interviews with staff, on the units toured, indicated that 12 patients were noted to be on special precautions addressing issues such as aggressive behavior, self-injurious behavior, elopement and/or other behavioral issues.

Number of patients/residents on 1 to 1?
Of the units toured, 95-Unit 4 had four patients and 94-Unit 1 had 2 persons on 1:1 status. This status requires staff remain within “arms length” of the patients at all times. Patients are placed on this status when the attending physician, in conjunction with the treatment team, determines that the person either needs the additional support or is displaying at risk behaviors such a suicidal or aggressive behaviors.

Identify the activities of the patients/residents?
Tours of the residential units occurred during the evening shift. Patients were noted to be engaging in a variety of activities including playing games, watching television, interacting in small groups and resting in their rooms. Structured activities were available in the evening in the gym. Building 114, the treatment mall building, was open in the evening for patients in the civil services units. Patients can engage in a number of activities in that setting such as a structured recreational activity.

Do patients/residents have opportunities for off-ground activities?
Interviews with facility staff and patients indicated that there are opportunities for patients on the civil wards to participate in off-grounds activities once they have achieved the necessary level and if staffing patterns allow. During the inspection process, it was noted that three of the units toured were unable to offer off-unit activities because of the staffing patterns.

As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff indicated that snacks do occur as appropriate for individualized diet plans.

Other comment about active treatment:
Central State Hospital provides an array of active treatment options for patients in a variety of treatment mall settings, depending on each patient's level of functioning, security status and stability. The facility routinely reviews and updates programming activities in order to meet the needs of the populations served.

Building 39 is the maximum-security building on the campus. This setting provides for both residential and programming services. Ward 2 has been designated as the treatment mall area. This area has undergone some environmental improvements since the last inspection including the addition of carpeting in order to "soften" the unit's appearance as well as to enhance soundproofing. Lighting in the unit has been improved. The unit currently houses six computers, which provides for increased opportunities for patients to engage in self-expression and other creative activities. The team observed a group activity designed to increase the patients' awareness of legal issues. The team leader actively engaged each person in the group activity in a manner consistent with each individual's ability. Materials were provided which were designed to enhance the learning while encouraging active involvement.

There is also a modified treatment mall program in Building 96. Many of the same topics are included in the active treatment programming for persons residing in this building as in the other mall programs such as medication education, legal issues, stress management and interpersonal skills. The team observed a mental illness education group, which was occurring simultaneously and in the same general day room area as an anger management group. The group observed was being conducted by a staff member who is normally not the assigned group facilitator. The leader asked the group to update her on the activities of the group and to describe group objectives. Two of the seven members present were very verbal and provided the requested information.

The proximity of the two groups was viewed as a drawback by the review team as it hampered group effectiveness and confidentiality. Staff explained that efforts had been made to divide the area in order to enhance the treatment activities but that to-date all efforts had presented an increased security risk and as such were prohibited.

There have been several noteworthy changes to active treatment programming at this facility since the last OIG inspection. Spiritual Care groups have been added, which were reported as being very popular groups. In addition, the chaplains facilitating the groups have also increased the number of non-denominational services on grounds, which was also noted as well received and appreciated by the population at-large. The availability of music therapists is another addition to the clinical services offered the patients.

The facility has implemented an interdisciplinary evaluation process for reviewing the groups and the facilitators. This peer review provides real-time feedback to each facilitator regarding issues of both group content and process while offering suggestions on how to improve the group experience for the consumers. In addition, the program

leaders have been working on the development of a Master Course description, which outlines the learning objectives of each group, the long and short-term goals and the activities that will be used to address the objectives. This information will provide some additional structure to the programming while providing the treatment teams with a clearer understanding of the group objectives in order to enhance the referral process.

The availability of resource materials has been expanded so that the group facilitators have additional tools for communicating with the group participants and enhancing the learning environment.

OIG Finding 2.1: Interviews, reviews of programming schedules, and direct observation revealed that Central State Hospital provides an array of active treatment options for patients in a variety of treatment mall settings, depending on each patient's level of functioning, security status and stability.

OIG Recommendation: None.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
The common areas are clean and well maintained.	Tours of Buildings 39, 96, 95 and 94 indicated that the residential areas visited were clean and well maintained.
Furniture is adequate to meet the needs and number of patients/residents.	It was observed that furniture was adequate to meet the needs of the patients. Small groupings of furniture were arranged so as to encourage patient interactions, particularly in the civil services buildings. It was noted that safety was a consideration when the selecting of furniture occurred. Items in the common areas such as the tables and chairs were heavy and made of materials that would be difficult to break.
Furniture is maintained and free from tears.	Tours of the common areas indicated that furniture was free from tears and was well maintained.

Curtains are provided when privacy is an issue.	Tours of the units demonstrated that window coverings are provided for privacy from the outside.
Clocks are available and time is accurate.	Clocks were available in public areas and the majority was noted to display the correct time.
Notifications on contacting the human rights advocate are posted.	A tour of each unit and interviews with patients indicated that information on how to contact the Human Rights Advocate was effectively communicated. Posters were observed in each of the buildings toured.
There is evidence that the facility is working towards creating a more home-like setting.	Efforts at making this institutional setting more homelike were noted even though with the changes in the population served in Building 96 some of the previous items used for decorations had to be removed for security reasons. Interviews with staff and patients revealed that for the most part, the majority felt like the facility made an effort to help patients feel as comfortable as possible in the setting.
Temperatures are seasonally appropriate.	Tours of units indicated that temperatures were comfortable. Interviews with six patients in Buildings 94 and 95 revealed that they felt comfortable with the room temperatures.
Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Interviews with patients revealed that the facility makes every effort to afford privacy when there are visitors to the unit. Visiting rooms were noted in the buildings toured.
Patients/residents have access to telephones, writing materials and literature.	Interviews with patients and staff indicated that there is access to communication materials and literature.
Hallways and doors are not blocked or cluttered.	Hallways, doors and egress routes were not blocked and were free of clutter.
Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.
Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews with patients indicated that staff assist them during fire drills. Each of the six patients interviewed in Buildings 95 and 94 were aware of what they were expected to do during a drill.

Fire drills are conducted routinely and across shifts.	Fire drills are conducted monthly.
Bedrooms	**Comments and Observations**
Bedrooms are clean, comfortable and well maintained.	All residential units toured were clean and well maintained. Housekeeping staff assists the patients in maintaining their rooms. There is storage space allotted for each patient so that additional clothing items can be maintained in an area outside of their bedrooms in order to lessen the potential for clutter.
Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Interviews with the patients and observations indicated that each patient has a mattress, sheet, blankets and pillow and if more are needed, the items can be obtained upon request.
Curtains or other coverings are provided for privacy.	Tours of the units confirmed that curtains and/or other coverings are provided for clients' privacy.
Bedrooms are free of hazards such as dangling blind cords, etc.	In the rooms observed there was not any evidence of hazards resulting from dangling cords, etc.
Patients/residents are able to obtain extra covers.	Interviews with patients indicated that they are able to obtain extra linens and covers. They need to ask staff in order to obtain these items from storage rooms located on the living units.
Patients/residents are afforded opportunities to personalize their rooms.	Interviews and observations indicated that clients are given the opportunity to personalize their rooms. This is particularly the case in the civil services buildings.
Bathrooms	**Comments and Observations**
Bathrooms were clean and well maintained	Bathrooms were noted to be clean and well maintained. Housekeeping maintains these areas.
Bathrooms were noted to be odor free.	Tours of unit bathrooms indicated that all were odor free.

Bathrooms were free of hazardous conditions.	Tours of unit bathrooms indicated that all were free of hazardous conditions.
Buildings and Grounds	**Comments and Observations**
Pathways are well lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were well lit. Efforts to limit the potential for hazardous conditions were noted in spite of construction currently underway on the campus.
Buildings are identified and visitor procedures for entry posted.	Upon entering the units all visitors are greeted by staff and asked to identify themselves with a badge or other form of identification. In the secured buildings a more rigorous security procedure is in place.
Grounds are maintained.	Grounds are well maintained. There is some construction occurring on the grounds. Staff interviewed indicated that the construction is associated with the replacing of ground pipes as the heating system is being converted.
There are designated smoking areas with times posted.	Smoking is prohibited at the facility in Buildings 39 and 96. It is allowed for those residing in the civil services buildings. This was an issue for some of the persons residing in Building 96, which used to have smoking privileges until the population re-distribution occurred, following the end of the contract with Riverside Jail.
Patients/residents have opportunities to be outside.	Interviews with patients and staff revealed that persons with the appropriate privileges have opportunities for going outside on and off grounds. Off-grounds activities are offered depending on staff availability.

Other environmental issues:
There have been several environmental changes since the last inspection. The changes have been primarily associated with the ending of the contract with Liberty HealthCare Corporation, which provided additional acute care forensic beds for individuals primarily transferred from the local jails. This change resulted in an expansion of forensics services on the main campus, increasing the bed capacity in both Building 39 and 96, which are the two secured forensic buildings. This change did not result in an overall increase in bed capacity for the facility because, as a result of census management and diversion efforts, the facility was able to close one of the civil services buildings. 120 patient moves occurred as a result of the closures, which required concentrated communication, coordination and planning among facility management, staff and the patients.

Persons previously residing in Building 39, the maximum security building on the campus were moved to Building 96 requiring the implementing of increased security measures in a setting that was seen as more of a "step-down" unit in the past. This introduction of persons presenting additional security risks to that setting necessitated environmental changes such as the removal of artificial plants and other decorative items, which presented potential security breeches. The building was re-designated as a smoke-free environment and some outside privileges were curtailed. According to the Human Rights Advocates, these restrictions have resulted in several complaints of rights violations from persons who had resided in the building when it was seen as a medium security setting.

Outside activities campus-wide have been limited due to some construction currently occurring on the grounds. Staff interviewed indicated that the construction is associated with the replacing of ground pipes as the heating system is being converted. Building 93 was the civil services building closed during this transition period. It was noted that this building has been acquired for use by Southside Virginia Training Center and is currently undergoing renovations.

OIG Finding 3.1: Observations demonstrated that the facility is well maintained, clean and comfortable. Efforts at making this institutional setting more comfortable were noted in spite the increased requirements due to security precautions. A focus on safety was evident with the construction currently underway across the campus.

OIG Recommendation: None.

CENTRAL STATE HOSPITAL
CHARLES DAVIS / FACILITY DIRECTOR
OIG REPORT#93-04
SECONDARY INSPECTION

This Inspection relied, in part, upon information provided by committees at Central State Hospital that reviewed, evaluated and made recommendations on the adequacy and quality of services provided. The Inspection included a review of precipitating factors and a clinical review of the acute management of the incident. In accordance with Virginia code, §8.01-581.16 – 17, this report is not available for public release in order to protect the privacy of the patients and/or personnel referenced in the report concerning this incident and the privilege for peer review documents.

CATAWBA HOSPITAL
JACK WOOD / FACILITY DIRECTOR
OIG REPORT #94-04
SNAPSHOT INSPECTION

Date: February 20, 2004

Type of Inspection: Snapshot Inspection / Unannounced

Reviewers: Cathy Hill, LPC

INSPECTION SUMMARY

A Snapshot Inspection was conducted at Catawba Hospital in Catawba, Virginia on February 20, 2004. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and the activity of patients.

Staffing patterns at the facility were, as outlined by facility policy, designed for the safety, supervision and treatment of the patients. Interviews with administrative staff revealed that Catawba Hospital is currently experiencing a nursing shortage, which was reported as primarily the outcome of budget shortfalls. It was maintained that the combination of previous budget reductions; a recent change in reimbursement practices for outpatient consultation services, including CT scans and X-rays; a growing competitive regional market and increasing healthcare costs have resulted in a shortage of funds. Facility management has consulted with the Central Office regarding strategies for successfully recruiting and retaining qualified staff.

The hospital provides active treatment programming at an off-unit treatment mall as well as on selected units depending upon the stability and level of functioning of the patients. Program selections on the date of the inspection included a medication education group, an illness education and management group and community reintegration skills group. Catawba Hospital has been dedicated over the past year in creating an environment that supports a culture of safety. An on-going focus on the reduction of the use of seclusion and restraint as well as the implementation of a suicide prevention program serve as markers of this effort.

A tour was completed of the four residential units. Overall the physical environment was clean, bright, comfortable and well maintained with evidence that efforts had been exerted toward providing a home-like, cheerful atmosphere.

PART I: STAFFING ISSUES

Number of staff scheduled for this shift for this unit. RN = registered nurse LPN = licensed practical nurse NA = nursing assistants HM= hall monitors	**February 20, 2004 – Day Shift** <u>Acute Admissions Unit</u> 2 RNs 1 LPN 3 NAs 1 HM <u>Adult Long-term Rehabilitation Unit</u> 1 RN 1 LPN 2 NAs Additional RN scheduled to come on the unit at noon <u>Geriatric Admission Unit</u> 3 RNs 1 LPN 5 NAs 1 HM The 5th aide was scheduled on the unit until 11:30 am <u>Geriatric Long-term Rehabilitation Unit</u> 2 RNs 3 NAs 1 HM
Number of staff present on the unit?	Observations revealed that the number of staff scheduled to provide coverage were present on the units as identified.
Number of staff doing overtime during this shift or scheduled to be held over?	In all of the units toured, it was learned that two staff members were doing OT during the day shift on 2/20. On the acute admissions unit, 1 of the nursing assistants was scheduled for overtime coverage from 7:30am to 10:00 am. On the Geriatric Admissions Unit, one of the nursing assistants was scheduled for overtime coverage from 7:30am to 11:30am.

Number of staff not present due absence because of worker's compensation injury?	Interviews revealed that there were not any staff members out due to worker's compensation on any of the units toured during the inspection process. 18 members of the nursing staff were out on either short or long term disability.
Number of staff members responsible for one-to-one coverage during this shift?	During the day shift on February 20tth, there were 2 patients identified as on 1:1 status; both were on the Geriatric Admissions unit. The 1:1 monitoring was implemented for safety and unpredictable behaviors.

Are there other staff members present on the unit? If so, please list by positions.
During the time that the tour of the residential areas was conducted a number of disciplines were noted as being on the various units including psychiatrists, psychologists, social workers and ward clerks. Members of the housekeeping staff were observed completing their duties on each of the units.

Additional comments regarding staff:
Interviews with administrative staff revealed that Catawba Hospital is currently experiencing a nursing shortage, which was reported as primarily the outcome of budget shortfalls. It was maintained that the combination of previous budget reductions; a recent change in reimbursement practices for outpatient consultation services, including CT scans and X-rays; a growing competitive regional market and increasing healthcare costs have resulted in a shortage of funds. This shortage, reportedly, has over the past six months begun to negatively impact direct care services and staff morale.

According to data provided at the request of the reviewer, there are 35 position vacancies in the nursing department. Of the 42 available registered nursing positions, 24 are currently filled leaving 18 positions vacant; of the 19 LPN positions, 15 are filled and 4 vacant and out of the 83 nursing assistant positions, there are 71 filled and 12 vacant. This leaves 34 vacant positions in nursing direct care positions.

An additional complicating factor for this facility is the number of staff out on disability. As of February 2004, there were 18 members of the nursing staff on either short or long term disability, including 8 RNs, 2 LPNs and 8 NAs. When staff are out on disability, their positions are considered "filled" leaving nursing administration to provide coverage during their absence through the use of mandatory overtime, part-time employees or contract staff. The number of mandatory overtime hours was noted to be significant for the licensed practical nurses, in particular, mainly because of their availability. In accordance with data submitted monthly to the OIG by the facility, the number of overtime hours for the LPNs has been steadily increasing since July 2003, with the hours being 491.5 hours in July, 619.4 in August, 765.9 in September, 1092.1 in October, and 1365.3 in November. The December data showed a decrease to 898.2 hours of overtime

for this same group. Interviews with staff indicated that the increased use of overtime has had a negative effect on morale.

The facility has recently been impacted by a very competitive regional market, which diminishes the facility's ability to be fiscally aggressive in recruiting and retaining qualified personnel. The facility has been working with the Central Office Human Resources Department in developing and implementing strategies designed to address these issues.

Several strategies for addressing the nursing shortage include the following:

- The facility implemented a hall monitoring training program for those members of the housekeeping and dietary staff, that would be interested in transferring internally to nursing services. The monitors are positioned in the halls for the purpose of observing the interactions of the patients, for increased safety (such as monitoring those at risk of falling), and conducting visual checks on each of the patients. One of the unforeseen benefits of implementing this project has been the desire of several of the staff entering these positions to increase their education to become licensed practical nurses and registered nurses.
- The facility has increased opportunities for practicum experiences for persons enrolled in nursing programs for both registered nurses and licensed practical nurses. The facility also offers work experiences through area high schools for persons interested in nursing assistant experience. It is hoped that exposure to the program will encourage individuals to consider the hospital as a positive place to work.
- Staff have opportunities to negate occurrences of "call-ins" by volunteering to do a determined amount of overtime.

Finding 1.1: Catawba maintains a staffing pattern that is consistent with facility expectations and provides staff to patient ratios designed to meet the safety, supervision and treatment needs of the patients. This is accomplished through overtime, schedule adjustments and the implementation of other nursing personnel initiatives.

Recommendation: Because maintaining an adequate workforce is such a critical challenge facing this facility, the OIG requests quarterly updates regarding the progress the facility is making in addressing this issue.

DMHMRSAS Response: *Some progress has already been made in recruiting and retaining nursing staff in the two months since this inspection. Catawba has had net gains of 1 RN and a net gain of 6 with other nursing positions including Direct Care Associate IIs, and LPNs. Vacancies are currently 28 versus the 34 in February 2004.*

Likewise, there was some reduction in the number of nursing staff on Short-Term Disability/Long-Term Disability (STD/LTD). In February there were 18 nursing staff on STD/LTD; currently there are 12 (6 in LTD and 6 in STD/Sick leave, not working). Catawba still has a number of nursing staff with some limitations/restrictions but who are working limited hours: 6 RNs and 8 Direct Care Associates IIs. Catawba has been proactively working with the disability administrator and the staff members' physicians in an effort to bring staff back to full-duty as soon as possible.

Vacant positions and unproductive employee hours (those out on STD/LTD or with restrictions) continue to be covered by employees working overtime and limited use of wage employees. The Department is aware that the use of pre-scheduled overtime and mandatory overtime directly impacts morale, retention, recruitment, and potentially patient safety. Efforts to hire RNs are being maximized with attempts at recruitment fairs and through advertising. The Department's division of Facility Operations is working in tangent with Human Resources towards future planning and development of a statewide comprehensive strategy to address recruitment and retention which is essential to achieving Catawba's mission and vision.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

Bed capacity for the unit: Census at the time of the review:

The operating bed capacity for the facility is 110 beds. The total census on the date of the tour was 103 patients.

The census on the units toured during the inspection process were as follows:

- The Acute Admissions Unit had a census of 25. The bed capacity on the unit is 30.
- The Adult long-term rehabilitation unit had a census of 19. The bed capacity for the unit is 20.
- The Geriatric Admissions Unit had a census of 29, with one person on special hospitalization status. The bed capacity on the unit is 30.
- The Geriatric Long-term Rehabilitation Unit had a census of 30. The bed capacity for the unit is 30.

Number of patients/residents on special hospitalization status.
Interviews with administrative staff indicated that there was one patient on special hospitalization status during the time of the inspection. The individual was residing on the Geriatric Admissions Unit.

Number of patients/residents on special precautions?

Interviews with staff, on the units toured, indicated that seven residents within the facility were noted to be on special precautions addressing issues such as falls risk, safety and unpredictable behavior.

Number of patients/residents on 1 to 1?
During the day shift on February 20th, there were 2 patients identified as on 1:1 status; both were on the Geriatric Admissions unit. The 1:1 monitoring was implemented for safety and unpredictable behaviors.

Identify the activities of the patients/residents?
Tours of the residential units occurred during the day shift. The hospital provides active treatment programming at an off-unit treatment mall as well as on selected units depending upon the stability and level of functioning of the patients. Program selections on the date of the inspection included a medication education group, an illness education and management group and community reintegration skills group.

A music therapy group, comprised of approximately 15 members and four staff, was observed during the tour of the geriatric long-term rehabilitation unit. The group activity involved group participation in the selection of the type of music to be sung. The leader, a practicum intern, played a guitar and led the group in singing. The activities observed were designed to enhance group interaction, vocalization and gross motor skills. The leader interacted with all the patients and actively engaged them in the process. All the patients were observed either singing or keeping time to the music with movement or light clapping.

Do patients/residents have opportunities for off-ground activities?
Interviews with facility staff and patients indicated that there are opportunities for patients to participate in off-grounds activities once they have achieved the necessary level.

Are smoke breaks posted?
The buildings on campus are designated as smoke free. Smoke breaks, which are established for each unit, occur in designated areas only. There are two gazebos on campus where smoking on the grounds can occur.

Other comment about active treatment:
Catawba Hospital actively engages in reviewing the active treatment programming activities offered both in the treatment mall and the units. It is currently reviewing programming for the fourth time in as many years. This system is consistent with the philosophy of the facility in providing active treatment that is based on best practices and with the input of the consumers. The facility has implemented several self-help/peer programs for consumers, which are designed to serve as a conduit to their personal growth in the recovery process. An example of this is the development of a Drop-In Center for the geriatric population. This enables persons to interact with their peers, to learn more about services and to become engaged in therapeutic activities.

Program offerings are designed to assist persons with gaining skills for managing themselves and developing meaningful interactions within the community including skills for enhancing vocational opportunities and experiences. The program has developed a community gardening project. This project has several benefits. Participants enter the community to plant flower gardens at the local Adult Homes. This provides them with increased skills while providing them with exposure to potential residential settings following discharge. This good-will project benefits the homes by creating a more pleasing setting for residents. A computer education program has also been developed in order to enable patients to gain rudimentary computer skills.

Active treatment programming curriculum is on a two-month cycle and program activities have been expanded from 45-minute sessions to 50 minutes.

Catawba Hospital has been dedicated over the past year in creating an environment that supports a culture of safety. An on-going focus on the reduction of the use of seclusion and restraint as well as the implementation of a suicide prevention program serve as markers of this effort. The facility conducted a FMEA (Failure Mode Effect Analysis) review of risks factors at critical stages in the treatment process including the discharge process phase. The outcome of this was the creation of risk assessment processes and risk reduction initiatives. Evidence of this effort was noted in the review of three discharge records. Assessments at the time of discharge for the patient's ongoing level of risk included a review of both professional and natural community supports available for the patient as a mechanism for maintaining stability immediately after discharge. Natural community supports include family members, neighbors, social groups, faith communities, etc. Staff assisted the patients in thinking through strategies for dealing with re-emerging feelings that were coupled with the circumstances associated with hospitalization (often suicidal plan or attempt), which are likely to be problematic upon discharge. By articulating this formally in the form of a crisis plan with the patient, and appropriate supports, it increases the likelihood that the person will use these supports constructively.

The hospital will be presenting its initiative and outcomes in two areas during the 2004 American Psychiatric Association meeting in Atlanta. Topics for presentation and discussion include Suicide Prevention in State Hospital Psychiatry: Risk Assessment to Risk Reduction and Treatment Malls: State Hospital Psychiatry Psychosocial Rehabilitation and Recovery.

OIG Finding 2.1: Interviews and observation revealed that Catawba Hospital provides active treatment programming in a variety of settings, depending on each patient's level of functioning and stability, which are designed to enhance skills acquisition for successful community living.

OIG Recommendation: None.

IG Finding 2.2: Catawba Hospital has implemented a suicide prevention program designed to determine patient risk throughout critical stages of treatment, including the discharge process. This process has resulted in the development of discharge plans that provides the patient and their natural supports with guidance in the event that a crisis would occur.

Recommendation: Develop a mechanism for sharing this risk reduction program with the other facilities and Community Services Boards.

DMHMRSAS Response: *Catawba Hospital is in the process of working on a Failure Mode and Effect Analysis (FMEA) related to Suicide Prevention. Once the FMEA project has been completed, training will occur. A component of the implementation plan includes sharing the improvements with other facilities and Community Services Board (CSB) staff.*

Catawba Hospital is interested in providing an opportunity for sharing this risk reduction program with other facilities and Community Service Boards through formal training. Potential training focuses include suicide risk screening, risk assessment, risk reduction and relapse prevention across the continuum of mental health services for adults. The audience would potentially include psychiatrists, colleagues in professional organizations such as the Virginia Association of Community Psychiatrists, CSB staff, private and public sector mental health clinicians; as well as program administrators.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
The common areas are clean and well maintained.	It was observed during the tour of the four treatment units that the residential areas were clean and well maintained.
Furniture is maintained and free from tears.	Tours of the common areas indicated that furniture was free from tears and was well maintained.
Curtains are provided when privacy is an issue.	Tours of the units demonstrated that window coverings are provided for privacy from the outside.
Clocks are available and time is accurate.	The clocks on the residential units displayed the correct time.

Notifications for contacting the human rights advocate are posted.	Posters were observed on the residential units.
There is evidence that the facility is working towards creating a more home-like setting.	Efforts at making this institutional setting more homelike were noted. Murals are painted on the walls in the geriatric units. Borders decorate the hallways and other decorative items were noted.
Temperatures are seasonally appropriate.	Tours of units indicated that temperatures were comfortable.
Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Interviews revealed that the facility makes every effort to afford privacy when there are visitors to the unit. Visitors were noted on one of the units. They were signed in and escorted to a visitor's room.
Patients/residents have access to telephones, writing materials and literature.	Interviews and observations demonstrated that there is access to communication materials and literature.
Hallways and doors are not blocked or cluttered.	Hallways, doors and egress routes were not blocked and were free of clutter.
Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.
Patients/residents are aware of what procedures to follow in the event of a fire.	Staff assist the patients during fire drills. Patients are provided with information regarding drills during their orientation to the facility and during community meetings.
Fire drills are conducted routinely and across shifts.	Fire drills are conducted once a month so that each shift is covered at least once quarterly.
Bedrooms	**Comments and Observations**
Bedrooms are clean, comfortable and well maintained.	All residential units toured were clean and well maintained. Housekeeping staff assists the patients in maintaining their rooms.

Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Observations of patient rooms indicated that each patient has a mattress, sheet, blankets and pillow and if more are needed, the items can be obtained upon request.
Curtains or other coverings are provided for privacy.	Tours of the units confirmed that curtains and/or other coverings are provided for clients' privacy where needed except when contraindicated for behavioral reasons.
Bedrooms are free of hazards such as dangling blind cords, etc.	In the rooms observed there was not any evidence of hazards resulting from dangling cords, etc.
Patients/residents are able to obtain extra covers.	Patients are able to obtain extra linens and covers. They need to ask staff in order to obtain these items from storage rooms located on the living units.
Patients/residents are afforded opportunities to personalize their rooms.	Interviews and observations indicated that clients are given the opportunity to personalize their rooms.
Bathrooms	**Comments and Observations**
Bathrooms were clean and well maintained	Bathrooms were noted to be clean and well maintained. Housekeeping maintains these areas.
Bathrooms were noted to be odor free.	Tours of unit bathrooms indicated that all were odor free.
Bathrooms were free of hazardous conditions.	Tours of unit bathrooms indicated that all were free of hazardous conditions.
Buildings and Grounds	**Comments and Observations**
Pathways are well lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were free of hazardous conditions. The inspection occurred during the day so it was not determined whether the areas were well lit.
Buildings are identified and visitor procedures for entry posted.	The staff entered the facility through the administration building and was escorted on the residential units. It was observed that upon entering the unit, visitors are greeted by staff and asked to sign in before being escorted to the visiting area.

Grounds are maintained.	Grounds are well maintained.
There are designated smoking areas with times posted.	Smoking is prohibited in the buildings at the facility. There are designated outside smoking areas.
Patients/residents have opportunities to be outside.	Interviews revealed that persons with the appropriate privileges have opportunities for going outside on and off grounds.

OIG Finding 3.1: Observations demonstrated that the facility is well maintained, clean and comfortable.

OIG Recommendation: None.

NORTHERN VIRGINIA TRAINING CENTER
MARK DIORIO / FACILITY DIRECTOR
OIG REPORT #95-04
SNAPSHOT INSPECTION

Date: March 3-4, 2004

Type of Inspection: Snapshot Inspection / Unannounced

Reviewers: Cathy Hill, LPC

INSPECTION SUMMARY

A Snapshot Inspection was conducted at Northern Virginia Training Center in Fairfax, Virginia on March 3-4, 2004. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and activity of patients.

NVTC is one of five training centers dedicated to providing residential and active treatment services to persons with mental retardation. This approximately 200-bed facility primarily serves individuals from the Northern Virginia area.

NVTC maintains a staff to client ratio that provides for the training, care and safety needs of the residents it serves. The facility has initiated a number of training opportunities designed to enhance the retention of staff including involvement in an ESL (English as a

Second Language) in the Workplace Program. A newly operational supervisory workgroup has been established for identifying and addressing workforce issues.

Residents at NVTC are provided with opportunities to participate in active treatment programming in a variety of settings depending upon their level of functioning.

Tours of the residential areas and the campus throughout the inspection revealed that overall the facility was clean, comfortable and well maintained.

STAFFING PATTERNS **Number of staff scheduled for this shift for this unit?** DSA= Direct Service Assistant Med Aide= medication assistant	**Evening shift – March 3rd** Unit 7 4 DSAs 1 Med Aide Unit 7C 5 DSAs 1 Med Aide Unit 8A 4 DSAs 1 Med Aide Unit 8C 4 DSAs 1 Med Aide Unit 1 4 DSAs 2 Med Aides **Day Shift – March 4th** Unit 6 8 DSAs 1 Med Aide One staff member was doing 1:1, 2 were escorting residents to the skills training program or to appointments Unit 5A 6 DSAs Unit 5C 5 DSAs Unit 3A 5 DSAs Unit 3C 5 DSAs 1 Med Aide Unit 3D 5 DSAs
Number of staff present on the unit?	Observations and interviews revealed that staff presence was as noted above. During the day shift, several staff members were off the units transporting residents to programming or appointments.
Number of staff doing overtime during this shift or scheduled to be held over?	Interviews with staff and staffing counts indicated that 1 staff member, during the day shift on March 4th, was working overtime. Interviews indicated that the facility has staggered scheduling in order to maximize staff availability during hours when direct client care is greatest.

Number of staff not present due absence because of worker's compensation injury/disability?	Interviews with Staff indicated that 15 staff members were out on short-term disability, 5 were out on long term disability and 2 were out on long term disability/Worker's Compensation status. Of the 22 positions effected, 17 were direct care positions.
Number of staff members responsible for one-to-one coverage during this shift?	Interviews with staff indicated that 1 staff member was responsible for 1:1 on the units. There were five individuals that required 1:1 supervision when off the unit.

Are there other staff members present on the unit? If so, please list by positions. During the day shift, unit staff reported that RNs routinely make rounds on each unit. It was also reported that physical therapists, social workers and psychologists frequent the units. The presence of unit supervisors was also noted.

Additional comments regarding staff: Interviews were conducted with staff both in a formalized interview process and while touring the units. All staff indicated that it was the helping relationship that they were able to establish with the residents that made their work experience rewarding. Direct care staff indicated that management provided a mechanism for them to offer ideas regarding scheduling and activities within their respective units. A supervisory workgroup designed to identify, dialogue and address workforce issues was holding its first meeting on the day of the inspection. One of the goals in establishing this workgroup is to build a supervisory core for sharing information, ideas, solutions and support.

Of the 16 interviewed, 12 staff expressed concern regarding several aspects of the facility wide on-call system established to assure coverage. A staff member is scheduled for being on-call during a scheduled day off. The person is required to call their unit one hour prior to the beginning of the shift to determine whether they are needed for coverage. On-call is required on a rotating basis. Those interviewed indicated that supervisory staff have informed them that they had to flex the schedule during the pay period in order to compensate for the hours worked as a result of being called-in, instead of scheduling the person for an additional day off. It was explained that this practice was less than satisfactory because having a few hours off several days in a row does not really compensate for having an entire day off. Interviews with two supervisory staff revealed that it was the practice to arrange flextime off because it was very difficult to schedule in an additional day off. The supervisors also indicated that the facility did not have to pay overtime if schedules were flexed, which had the added benefit of being a cost savings measure.

As noted during previous inspections, NVTC has both the benefit and challenge of having a number of individuals from various countries serve on the staff. The task of assuring that personnel are adequately trained and effectively understand the materials needed for providing the care required for persons with severe and profound mental retardation is one responsibility of the staff training office. Several programs have been offered facility wide to enhance the skills of these valuable staff members. The facility is

developing an ESL (English as a Second Language) in the Workplace program in cooperation with the Fairfax County Adult Education Program. At the time of the inspection, there were ten members among the residential, foodservice and housekeeping staff interested in participating.

NVTC is one of two facilities that will participate in the College of Direct Support Program. The 11-course curriculum is designed to enhance staff knowledge and skills. Among the courses are the following topics: positive approaches to challenging behaviors, rights and choices, community inclusion, documentation and record keeping, and direct support professionalism. Staff involved in the pilot program will serve as mentors to other staff on their respective units following the successful completion of this web-based course.

The Center has implemented TOVA training for members of the administrative, program, and clinical staff. The training has been incorporated in the pre-service training and orientation for new staff since October 2003. Staff hired prior October 2003 are scheduled to cycle through this updated training during their annual re-certification.

OIG Finding 1.1: NVTC maintains a staff to client ratio that provides for the training, care and safety needs of the residents it serves.

OIG Recommendation: None.

OIG Finding 1.2: The facility is currently providing a mechanism for identifying and addressing staff concerns regarding scheduling and the use of flextime through the establishment of a workgroup of supervisory staff.

OIG Recommendation: As this workgroup was newly established, the OIG does not have any recommendation at this time.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

Bed capacity for the unit:	**Census at the time of the review:**
Unit 1 - 16	Unit 1 - 15
Unit 3A- 20	Unit 3A - 19
Unit 3C – 20	Unit 3C - 19
Unit 3D - 16	Unit 3D - 16
Unit 5A – 16	Unit 5A - 16
Unit 5C - 16	Unit 5C - 16
Unit 6A&C - 16	Unit 6A&C - 15
Unit 7A – 20	Unit 7A – 19
Unit 7C – 17	Unit 7C – 15

Unit 8A – 20	Unit 8A – 19
Unit 8C – 20	Unit 8C - 17

The census on the date of the review was 186.

Number of patients/residents on special hospitalization status
Interviews with staff indicated that no patients were on special hospitalization status.

Number of patients/residents on special precautions?
Interviews with staff indicated that due to the complexity of clients, most are informally on a special precaution for medical or behavioral issues.

Number of patients/residents on 1 to 1?
Interviews with staff indicated that 5 patients are on 1:1 when off their unit. There was one person on 1:1 in Unit 6.

Identify the activities of the patients/residents. Residents at NVTC are provided with a number of activities both on and off campus. Staff in at least three units discussed plans for taking some residents to the beach this summer. Outings into the community to the mall, parks, ballgames and other recreational events occur routinely. During the day, residents either work off grounds, go to the Skills Training Center (STC), or the Developmental Day Program (DDP).

What scheduled activities are available for patients/residents during this shift?
Eighty-six residents at the facility were identified as actively engaged in off-site programming. Those that are involved in active programming on campus included 49 persons receiving unit based programming, 29 persons in the Skills Training Center (STC), 21 persons in the Developmental Day Program (DDP) and 1 resident was noted as officially in retirement.

In the Skills Training Center, residents have opportunities to engage in a variety a work related activities to which they are assigned and for which they receive fair market value compensation. The activities have included: can-crushing, bulk mail stuffing, silverware rolling, managing the vending machines on campus, and facility ground maintenance. Assignment is based on each person's level of functioning and is consistent with goals established in the treatment plan. The DDP is designed for residents that are not ready for the STC or for participating in community-based programs. Some activities that are offered in the DDP program are paper shredding and cardboard recycling.

Are smoke breaks posted?
Interviews with staff revealed that none of the clients at the facility smoke.

Do patients/residents have opportunities for off-ground activities?
All clients have the opportunity for off grounds activities, either through work projects or fieldtrips. Fieldtrips include going to the park, airport, mall, zoo, restaurants, local basketball games, movies, bowling, miniature golf, musical events and overnight trips.

As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff indicated that snacks are offered as appropriate, according to a resident's diet.

Other comments regarding patient activities:
Interviews and observation revealed that for residents that are unable to be a part of an off grounds work program, STC or DDP, staff work with them on the units or they attend physical therapy at the Gym, the Pool, or the Sensory Stimulation Room.

OIG Finding 2.1: Residents at NVTC are provided with opportunities to participate in active treatment programming in a variety of settings depending upon their level of functioning. They are provided with multiple opportunities for participating in outings into the community.

OIG Recommendation: None.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
The common areas are clean and well maintained.	Tours of all the living units indicated that the common areas on the units were clean and well maintained. Efforts to make the units comfortable and home-like were noted.
Furniture is adequate to meet the needs and number of patients/residents.	Observations during tours of all units indicated that the furniture was adequate in number and design to meet the needs of the clients. Residents at the facility require a number of pieces of adaptive equipment, which is designed to meet treatment associated with physical management.
Furniture is maintained and free from tears.	Observations made during the tours indicated that the majority of furniture was well maintained.

Curtains are provided when privacy is an issue.	Observations indicated that curtains were provided for privacy.
Clocks are available and time is accurate.	Observations during tours indicated that all clocks were set to the accurate time of day.

Notifications regarding ways of contacting the human rights advocate are posted.	Observations during tours revealed that a poster indicating the human rights advocate's name and phone number was hanging in the entrance of each building.
There is evidence that the facility is working towards creating a more home-like setting.	Tours and observations confirmed that the staff is working hard to create a more homelike setting in all living areas of each unit.
Temperatures are seasonally appropriate.	Tours and observations confirmed that the temperature was set to be seasonally appropriate and the residents appeared to be comfortable.
Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Tours revealed that each building had an area for families to visit. Visiting hours are posted.
Patients/residents have access to telephones, writing materials and literature.	Interviews with staff revealed that patients have access, at any time to telephones, writing materials and literature.
Hallways and doors are not blocked or cluttered.	Tours confirmed that hallways and doors are not cluttered or blocked.

Egress routes are clearly marked.	Tours confirmed that egress routes are clearly marked and not blocked.
Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews with staff indicated that residents understand the procedure to follow in the event of a fire, except for those whose capacity to understand precludes them from being considered effectively informed.

Bedrooms	**Comments and Observations**
Bedrooms are clean, comfortable and well maintained.	Tours and observations of all living units indicated that bedrooms are clean, comfortable and well maintained.
Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Tours and observations confirmed that bedrooms are furnished with a mattress, sheets, pillow and a blanket. The facility is currently testing several bed models to determine which might provide the necessary protections for the residents without unduly restricting freedom of movement.

Curtains or other coverings are provided for privacy.	Observations during tours indicated that curtains were provided for privacy.
Bedrooms are free of hazards such as dangling blind cords, etc.	Observations revealed that vertical blinds were not used at the facility; therefore there were not cords to be a hazard. Other cords such as those associated with electronics were secured so as to not present a hazard.
Patients/residents are able to obtain extra covers.	There is a linen closet on each unit in which extra pillows and blankets can be secured.

Patients/residents are afforded opportunities to personalize their rooms.	Tours and interviews indicated that residents were given the opportunity to personalize their own rooms. Some examples of personalized items were: family pictures, posters, dolls, and stuffed animals.
Seclusion Rooms	**Comments and Observations**
Seclusion and/or time out rooms are clean.	On the units, where time out rooms are utilized, they were noted to be clean.
Seclusion and/or time out rooms allow for constant observations.	Time-out rooms were all designed for constant observation.
Bathrooms are located close to the seclusion or time-out areas.	Tours of the units indicated that none of the units are designed to have the bathroom located near the time out room.
Bathrooms	**Comments and Observations**
Bathrooms were clean and well maintained	All the bathrooms toured were clean and well maintained.
Bathrooms were noted to be odor free.	All bathrooms toured were odor free.
Bathrooms were free of hazardous conditions.	Tours of all bathrooms indicated that all bathrooms were free of hazardous material.
Buildings and Grounds	**Comments and Observations**
Pathways are well lit and free of hazardous conditions.	Tours of all residential units indicated that all pathways were well lit and free of hazardous conditions.

Buildings are identified and visitor procedures for entry posted.	Tours and observations verified that NVTC has worked hard to post signs to indicate procedures for visitors entering the building. Staff routinely asked the reviewer for proper identification.
Grounds are maintained.	Tours and observations of the grounds indicated that NVTC works to create an attractive outdoor environment. The nature trail was closed at this time because of damage associated with severe weather. The facility is in the initial stages of clearing out the debris. Plans are to add exercise stations along the restored trail.
There are designated smoking areas with times posted.	OIG staff were informed that as there are not any residents that currently smoke this is not an issue. In the past, there was no specific time allocated for smoking and as the need arises it would be handled on an individual basis.
Patients/residents have opportunities to be outside.	Interviews with staff indicated that patients are outside often, either for leisure or activities, especially when the weather is pleasant.

OIG Finding 3.1:Overall, the facility was clean, comfortable and well maintained. There was evidence that the facility had worked to make this institutional setting appear more home-like.

OIG Recommendation: None.

PIEDMONT GERIATRIC HOSPITAL
WILLIAM PIERCE / FACILITY DIRECTOR
OIG REPORT #96-04
SNAPSHOT INSPECTION

Date: March 9, 2004

Type of Inspection: Snapshot Inspection / Unannounced

Reviewers: James W. Stewart, III
Cathy Hill, LPC

INSPECTION SUMMARY

A Snapshot Inspection was conducted at Piedmont Geriatric Hospital in Burkeville, Virginia on March 9, 2004. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas of review. The areas are as follows: safe environment as manifested through the general conditions of the facility, staffing patterns and the active clinical treatment provided for patients.

This 130-bed facility is solely dedicated to the evaluation and treatment of persons over the age of sixty-five and the only state operated geriatric facility. Piedmont has been actively recruiting nursing personnel and has initiated several scheduling changes in order to provide RN coverage during the nights, evening and weekend shifts. A review of staffing patterns for the day and evening shifts revealed scheduled coverage consistent with facility policy and expectations.

Active treatment programming was observed in the SMILE (Skills Mastery for Individual Living Enhancement) program, which is primarily offered to patients residing on 1 West but several patients from the other units participate in the day treatment activities depending on their level of functioning. Piedmont has established an on-grounds activities program similar to a community-based Senior Center where patients can participate in a variety of recreational and leisure activities.

Tours on all the units revealed the facility to be overall clean, comfortable and well maintained.

PART I: STAFFING ISSUES	
Number of staff scheduled for this shift for this unit? RN = Registered Nurse LPN = Licensed Practical Nurse DSA= Direct Service Assistant	**Day Shift – March 9** <u>Ground Unit</u> 2 RN's 2 LPN's 8 DSA's **Unit 1 – Admissions** 1 RN 1 LPN 2 DSA **Long Term Care** 1 RN 2 LPN 7 DSAs <u>Unit 2</u> 2 RN's 2 LPN's 8 DSA's <u>Unit 3</u> 2 RN's 3 LPN's 6 DSA's There was one RN completing orientation to the facility on 2 West but she was not counted in the staffing patterns.
Number of staff present on the unit?	Interviews and observations of unit staffing revealed that staffing was as indicated above.
Number of staff doing overtime during this shift or scheduled to be held over?	No staff members were reported as doing overtime at the time of the inspection.
Number of staff not present due absence because of worker's compensation injury/disability?	Interviews revealed that there were eight staff members out on short-term disability Five were members of the direct care staff including 3 HSCWs and 2 RNs.
Number of staff members responsible for one-to-one coverage during this shift?	Review of staffing indicated that one staff member was responsible for 1:1 coverage during the time of the inspection.

Are there other staff members present on the unit? If so, please list by positions. Throughout the day shift, members of the recreational staff, music therapy staff, psychiatrists as well as social workers were noted on the units. During the evening and night shifts, unit nursing coordinators and the house-nursing supervisor make rounds.

Additional comments regarding staff: Interviews conducted with administrative and direct care staff revealed that the facility has made progress in recruiting and retaining nursing personnel in a very competitive regional market. Several initiatives were implemented that have helped the facility in accomplishing its goal of maintaining staffing patterns that include the presence of at least one RN per unit per shift.

The Director of Nursing reviewed staffing configurations and adjusted staffing deployment in order to successfully increase RN coverage during the evening and night shifts across the weekdays and more consistently on the weekends. A review of staff scheduling demonstrated that there were several shifts that did not maintain the desired coverage patterns, however, it was also noted that the frequency of RN coverage difficulties compared to last year has been significantly decreased.

Interviews revealed that Central Office management, particularly Rosemarie Bonacum, Director of Facility Operations and Quality Improvement, assisted the facility in developing a facility-wide staff coverage contingency plan. In addition to the facility plan, each unit has also developed plans that allow self-scheduling and the use of flextime in order to limit the use of mandatory overtime. Overall, direct care staff expressed appreciation of nursing administration in allowing them opportunities for working out coverage issues among themselves, which enables them to balance the demands both of their professional and personal lives. Changes in coverage have allowed for an increased presence of nursing personnel in active treatment programs. This is also a change from the previous inspection.

This facility functions as a safety net for patients that have very complex psychiatric and medical concerns, which the majority of nursing homes and assisted living facilities are unable to manage effectively. PGH administration and staff prioritize patient care and have made the necessary adjustments to assure that this often-challenging population has the benefit of the on-going screening and assessment associated with the expertise of registered nurses.

PGH is also in the development stages of creating a career track within the facility for direct care staff that are currently in the human services care worker position. The positions will provide increased responsibility and as a result some pay benefits. These positions are analogous to restorative rehabilitation specialists used in the community to assist patients regain mastery of skills, which have been diminished due to illness or physical decline. Restorative programs maximize and maintain the highest level of functionality for residents of long-term care. Central to the philosophy of restorative care is the concept of promoting functionality, skill sets and maximizing independence by

motivating residents to perform as many of the tasks of daily living as possible while encouraging them to make choices whenever possible.

OIG Finding 1.1:The facility has implemented a number of strategies, which have supported achieving the goal of one RN per unit per shift.

OIG Recommendation: Continue to work towards the successful completion of the goal of consistently maintaining a staff complement that allows for a minimum of one RN per unit per shift.

OIG Finding 1.2: The facility is developing a restorative program that will enhance not only programming options but serve as a career track for direct care staff.

OIG Recommendation: None. The OIG looks forward to learning more of this career opportunity program as it is implemented.

DMHMRSAS Response Finding1.1*: Piedmont Geriatric Hospital has recruited RN's assigned to work permanent night shift on each unit. Even with recent resignations and long-term illnesses, there has been a marked improvement in RN coverage on all shifts. Currently, two RN vacancies remain on 2W, two on 3W, and two on Ground Floor.*

Piedmont Geriatric Hospital is actively assessing RN salaries in comparison to local competition and the fiscal feasibility of meeting ongoing and future employment opportunities. The hospital has also sponsored RN open houses, attended job fairs and made personal contacts to increase the applicant pool
.

DMHMRSAS Response Finding 1.2*: Piedmont's current plans include the selection of two HSCW's on each unit for on-the-job training by OT staff to work as Restorative Aides. Piedmont will gladly share information on progress of this endeavor*

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

Bed capacity for the unit: **Census at the time of the review:**

Out of the 137 beds available, the census was 128 on the day of the inspection. Unit capacity and census were reported as follows:

Capacity:	**Census:**
Ground Unit: 35	**Ground Unit:** 32
Unit 1: 32	**Unit 1:** 30 (6 in admissions and 24 in long-term)
Unit 2: 35	**Unit 2:** 34
Unit 3: 35	**Unit 3:** 32

Number of patients/residents on special hospitalization status

Interviews with facility staff indicated that one patient was on special hospitalization status during this review. Four patients were out of the facility on placement visits within the community.

Number of patients/residents on special precautions?
Interviews with staff on all units, across all indicated that due to the complexity of the clients served, most are under informal special precautions such as falls risks, elopement risks and for maladaptive behaviors.

Number of patients/residents on 1 to 1?
Interviews with staff regarding staff patterns indicated that 2 patients in the facility for each shift were on 1:1 status on the day of the inspection.

Identify the activities of the patients/residents?
Immediately following lunch, which is when the tours of the units occurred, many patients on Units 1, 2 and 3 were observed relaxing before the onset of afternoon programming. Staff were assisting others with the completion of some of their ADLs while many were in the dayroom areas watching television. On the Ground floor or the Skills preservation unit, the majority of patients were observed to be either in the hallways or resting in their rooms.

What scheduled activities are available for patients/residents during this shift?
A tour of the SMILE (Skills Mastery for Individual Living Enhancement) program occurred during this visit. Facility literature describes the program as one that " provides basic adapted therapeutic/recreational activities in order to meet the needs of patients with multiple levels of cognitive, physical and mental functioning." Some of the primary tasks associated with the program are symptom stabilization, skills acquisition, treatment engagement and community readiness. It was learned that approximately 25 patients actively participated in the SMILE program.

The tour occurred during early afternoon programming. Three music groups were taking place as well as a discussion group. The music groups were co-led by trained members of the direct care staff. Observations and interviews revealed that the groups were designed to correspond with the active treatment tasks of readiness and engagement. The groups varied in size with an average of seven patients in each. All included pre-recorded music, movement and a variety of engagement activities. One group focused on relaxation activities while another used dance steps to foster increased movement and exercise in these often-sedentary patients.

The remaining patients participated in either unit based activities and/or the Senior Center depending on the individual's cognitive abilities and level of functioning. Unit based activities include assisting the patients in completing their tasks of daily living, as well as craft activities for enhancing fine and gross motor skills, socialization groups, and playing games. Bible study groups are held on each unit and are reportedly one of the more popular activities.

Are smoke breaks posted?
Interviews with staff indicated that formalized "smoke breaks" are not utilized at this facility, rather it is based on individual treatment plan. Interviews indicated that very few of the patients smoked because of medical complications.

Do patients/residents have opportunities for off-ground activities?
Interviews with staff indicated that patients do regularly travel off grounds to the store, mall, or even just to go on a drive. Groups of patients attend activities such as musical events at Longwood College. The facility hosts a number of events for the entertainment of the patients in the facility auditorium. One of the reportedly popular events is an Elvis impersonator. High school performing and jazz bands regularly give concerts at the facility.

As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff indicated that snacks are afforded for this medically complicated population on an individual basis.

Other comments regarding patient activities: Several members of the patient community participate in the PGH voice and hand-bell choirs. The group recently had the opportunity to perform in the community for civic and social groups.

OIG Finding 2.1: The facility provides an array of active treatment programs for its patients depending upon their levels of functioning.

Recommendation: None.

Environmental Issues

AREA OF REVIEW: Common Areas	Comments and Observations
The common areas are clean and well maintained.	Tours of all common areas of this facility confirmed that each area was clean, free of odors and well maintained. The facility is planning to have the half walls separating the day room areas from the hallways extended to become full walls.
Furniture is adequate to meet the needs and number of patients/residents.	Tours of each unit indicated that furniture in bedrooms and in common areas was adequate to meet the needs and numbers of patients on each unit.
Furniture is maintained and free from tears.	Tours of each residential area indicated that furniture is free from tears and is well maintained.

Curtains are provided when privacy is an issue.	Tours of residential units demonstrated curtains and blinds were provided for privacy from the outside.
Clocks are available and time is accurate.	It was noted that clocks, in the public areas, had the correct time.
Notification on contacting the human rights advocate is posted.	Posters providing information on how to contact the Human Rights Advocate were evident throughout the facility.
There is evidence that the facility is working towards creating a more home-like setting.	Tours of each residential unit provided evidence that the facility is working to create a more homelike atmosphere.
Temperatures are seasonally appropriate.	Tours of each unit confirmed that temperatures were seasonally appropriate and geared towards the preferences of the geriatric population.
Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Tours of visiting area and observations of families visiting with clients indicated that the areas designed as visiting areas were set up to allow for privacy. Even though it is preferred that visits occur outside programming hours, families are encouraged to visit and accommodations are made whenever this occurs.
Patients/residents have access to telephones, writing materials and literature.	Interviews with staff indicated that clients have access to communication materials and literature.
Hallways and doors are not blocked or cluttered.	Tours of units indicated that hallways and doors are not blocked and cluttered.
Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.
Patients/residents are aware of what procedures to follow in the event of a fire.	Staff are designated to assist the patients during fire drills.
Fire drills are conducted routinely and across shifts.	Interviews with staff indicated that fire drills are conducted once per shift per quarter.

Bedrooms	Comments and Observations
Bedrooms are clean, comfortable and well maintained.	Tours of all residential units indicated that all bedrooms are clean, comfortable and well maintained.
Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Tours of bedrooms on all units indicated that each client is furnished with a mattress, sheets, blankets and a pillow and there is a linen storage area on each unit if extras are required or requested.
Curtains or other coverings are provided for privacy.	Tours of all residential units confirmed that curtains and blinds are provided for the clients' privacy.
Bedrooms are free of hazards such as dangling blind chords, etc.	Tours indicated that though there are blinds with cords in each room, the cords are not dangling in a hazardous manner.
Patients/residents are able to obtain extra covers.	Interviews with staff indicated that clients are able to obtain extra linens and covers.
Patients/residents are afforded opportunities to personalize their rooms.	Interviews with staff and tours of bedrooms indicated that clients have opportunities to personalize their rooms.
Seclusion Rooms	**Comments and Observations**
Seclusion and/or time out rooms are clean.	This facility does not utilize seclusion or time out rooms.
Seclusion and/or time out rooms allow for constant observations.	This facility does not utilize seclusion or time out rooms.
Bathrooms are located close to the seclusion or time-out areas.	This facility does not utilize seclusion or time out rooms.
Bathrooms	**Comments and Observations**

Bathrooms were clean and well maintained	Tours of unit bathrooms revealed that all were cleaned and well maintained.
Bathrooms were noted to be odor free.	Tours of unit bathrooms indicated that all were odor free.
Bathrooms were free of hazardous conditions.	Tours of unit bathrooms revealed all were free of hazardous conditions.
Buildings and Grounds	**Comments and Observations**
Pathways are well lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were free of hazardous conditions.
Buildings are identified and visitor procedures for entry posted.	Upon entering the hospital all visitors are required to check in and receive a visitors badge.
Grounds are maintained.	A driving tour of the grounds confirmed that they were well maintained.
There are designated smoking areas with times posted.	Piedmont is a smoke free environment.
Patients/residents have opportunities to be outside.	Interviews with staff indicated that clients regularly go outside on and off grounds, weather permitting.

OIG Finding 3.1: Tours of the facility revealed that the hospital was clean, comfortable and well maintained.

OIG Recommendation: None.

ACTIVE FINDINGS
CATAWBA HOSPITAL
OIG Report #26-00
Updated April 2004

SECTION TWO: PATIENT ACTIVITY AND ACTIVE TREATMENT

Finding 2.3: Record review did not reflect the treatment as verbally described by the staff interviewed.

Recommendation: Revisit with staff the process of documenting so that the chart reflects current treatment.

DMHMRSAS Response: Concur. The Facility Clinical Director and Chief of Staff have begun training all treatment teams in the importance of documenting in patient charts appropriately, accurately and in a timely fashion. Treatment plans are reviewed according to policy (i.e., every 7 days, every 14 days, and every 30 days as indicated) for priority needs and include a discussion of resolved issues. Discrepancies will be resolved as teams review diagnoses, treatment plans and discharge plans at each meeting. This will ensure the record reflects the most current plan of treatment.

In addition, the treatment planning policy for documentation relative to the treatment plans (Catawba Hospital Policy and Procedure 20.01) has been distributed. The Chief of Staff has directed the head of each treatment teams to act upon the policy and training, immediately.

The head of each treatment team will review the records monthly to ensure that the treatment plans and all documentation is accurate and consistent with the client's needs and treatment decisions.

6 Month Status Report: 7/1/01
COMPLETED 08/00 There were no recommendations regarding treatment plans at the time of the 2000 JCAHO and Medicare surveys. A Treatment Plan Workgroup is working on the development of an automated treatment planning system. Once implemented, this should improve the accuracy and quality. Treatment Plans more accurately reflect the provision of treatment. Training of staff in the new system will include documentation requirements. Refer to June, 1999 report # 3.3 Documentation training is provided to clinical staff during new employee orientation.

Monthly chart reviews are performed on a sample of records to ensure compliance with documentation requirements.

OIG Comment - *During the June 2001 visit, record reviews demonstrated some improvements in the treatment plans. A performance improvement team has been working on this process and expects to implement a new, automated system within the next quarter. This finding remains* ***ACTIVE.***

6 Month Status Report: 01/01/02

During the past six months, Catawba Hospital staff have been involved with, and provided leadership for, specific areas of the DMHMRSAS system-wide project on the development or acquisition of a computer based treatment-planning program, which would be utilized throughout the facilities, and ultimately would be part of an automated medical record. This is an ongoing workgroup, which is continuing to review and evaluate existing treatment planning systems.

Catawba Hospital's Treatment Plan Workgroup has concurrently continued working on the development and operationalization of a computer-based treatment planning program that would address all of the requirements of the Departmental Instruction on Treatment and Habilitation Planning while incorporating the practical information and applications often generated by the Treatment Teams. During the next six months, Catawba Hospital plans to finish development of this software and begin testing prior to potential full implementation.

OIG Comment- *Interviews and record reviews revealed that this facility continues in its efforts to revise the treatment plans. As noted, the automated process is not completed at this time. This finding remains ACTIVE.*

6 Month Status Report: 07/01/02

Catawba Hospital staff continues to be involved in the DMHMRSAS project involving the development or adaptation of a computer-based treatment planning system as an ultimate part of an automated medical record. This part of the project is ongoing at this time.

The software has been developed for Catawba Hospital's computer-based automated treatment plan. At this time, the workgroup is in the process of finishing the content of this plan, which involves the definition of problem areas and associated objectives and interventions. We have been recently working toward improving Treatment Plans for high-risk events, including aggression and falls. The content involving aggression has been added to our existing computer-based treatment-planning program. The content involving falls should be added to the program within the next six weeks. Both of these will also be utilized in the new treatment plan structure. We plan on piloting and refining and, if successful, utilizing the new treatment planning program within the next six months.

OIG Comment (February 2004) *The facility has developed and implemented the computerized treatment plan. A review of three discharge records indicated that the plans were consistent with the completed assessments and reflected individualized goals for care.* ***This finding is INACTIVE.***

ACTIVE FINDINGS
CENTRAL STATE HOSPITAL
OIG Reports #29-00, #52-01
Updated April 2004

A. OIG REPORT # 29-00

SECTION THREE: STAFFING PATTERNS

Finding 3.4: Staff relates that the use of mandatory overtime for Human Service Care Workers (psych tech) had increased recently.

Recommendation: Please forward the current assessment of and plan for the psych tech overtime situation in building 39 at CSH. If there is not a current working plan, please forward the date by which one will be completed.

DMHMRSAS Response: See above plan, "CSH Action Plan for Direct Staffing" (Response to Finding 3.3).

6 Month Status Report: 7/1/01
The FMHT overtime hours during the IG visit in July 2000 were extraordinarily high at approximately 7200 hours for that month. The number of FMHT overtime hours have decreased to the point that during the most recent quarter, the monthly hours have averaged approximately 2600 hours. The Nursing Department developed a specific deployment plan to ensure that consistent coverage across the wards and across the days of the week. In addition, a number of the vacant FMHT positions have been filled. Overtime continues to be monitored for patterns and trends by job categories (MHT, FMHT, SST). Identified problems will be immediately referred to Nursing for correction/ improvement.

OIG Comment – The administration has been attending to issues related to overtime hours and have developed a system to track and reduce mandatory hours. This finding is ***ACTIVE.***

6 Month Status Report: 01/01/02
We continue to monitor overtime usage on the wards and during the most recent 3-month period, the monthly overtime hours have averaged approximately 2600. This remains substantially below the approximately 7200 hours during the month of July 2000 when the Inspector General visited. The hours of overtime have leveled off, with forensic usage remaining higher than that of the civil wards. In an effort to address the forensic overtime hours, additional P-3 and P-14 FMHTs have been hired. Much of the overtime usage remains tied to one-to-one coverage for special precautions and suicide precautions necessary for patient safety. Nursing Management and the Medical Staff continue to monitor the use of 1:1 staffing for necessity and appropriateness. Efforts to minimize mandatory overtime have been active by using voluntary and P-14 before utilizing mandatory overtime. Mandatory overtime is used only in situations where other efforts to provide coverage have failed. In an effort to ensure safety of our clients, voluntary overtime has been limited to 16 hours per pay period per employee.

OIG Comment *– Interviews indicated that the use of mandatory overtime has declined within the past quarter. The facility has instituted a process to monitor overtime that reflects a direct management priority in which the Assistant Directors of Nursing review the overtime shifts on a daily basis to address and justify the number of overtime hours worked. The facility continues to put effort into the recruitment and retention of DSA and nursing staff. The facility has a recruitment and retention committee, which is exploring the possibility of creating a campus wide daycare program onsite as well as providing educational courses on campus, bringing the classroom to the staff so that opportunities for enhancing knowledge and skills are more readily available. The facility has made great progress on addressing this issue, but because of the new ideas in addressing this issue and the historic tenure of this issue, the OIG will continue to follow the facility's progress. This finding is* ***ACTIVE.***

6 Month Status Report: 7/1/02
Overtime use continues to be monitored for necessity and appropriateness by Nursing Management and the Medical Staff. The number of hours in December 2001 was extremely high due to all the holiday coverage that had to be provided. While it has come down from that high level, it continues to be somewhat high due to 1:1 coverage for special precautions and suicide precautions deemed necessary for patient safety. There have also been a number of special hospitalizations outside of Hiram W. Davis Medical Center that require round-the-clock coverage. We continue to minimize the use of *mandatory* overtime, using P-14 coverage and voluntary overtime as much as possible. SVTC's Workforce Development Director is working with the three facilities on the Southside Campus on a dynamic workforce development plan. She worked with a

committee on the development of a Workforce Fair. Workforce Development Day was held May 21, 2002. (Please see ATTACHMENT A.) The purpose of the fair included: giving both present employees and members of the community information about careers here; providing time for people from the community to complete job applications; providing information about educational opportunities we hope to provide in the future (GED, workforce training, college classes held on this campus) to assess interest; and, allowing our community partners (community college, VEC) to be here in contact with our employees and people from the community. All the facilities were pleased with the excellent turnout. The outcome information is still being analyzed to determine the next steps in our workforce development.

OIG Comment – (February 2004) *The use of overtime has been a significant issue for this facility and is acknowledged by management staff on all levels as an important challenge. Management has addressed this issue in a variety of ways in the past including the use of agency and contract licensed and non-licensed personnel to assure adequate coverage. Overtime is a result of a number of variables such as position vacancies, inclement weather, employee absenteeism, patient acuity and the implementing of special procedures such as 1:1 patient clinical supervision.*

All of the direct care staff members interviewed indicated that mandatory full-shift overtime decreased with the closing of the civil building and the re-absorption of the staff assigned to those units in other settings across the campus. Monthly data forwarded to the OIG from the facility indicated that the use of overtime had decreased with 5468 hours noted in September 2003 and 4410 hours in October 2003. The number of hours increased both in November (7680) and December 2003 (7023) but this was attributed to weather related events. A review of a complaint during the course of this inspection revealed that the complainants concerns regarding overtime were unfounded. The review revealed that the administration had taken an active approach to deal with tardiness, mandatory overtime and staff training. Overtime currently is at the level when the original finding was cited. Although the facility has worked to address this issue, it remains a significant concern. The finding remains ***ACTIVE.***

Status Report April 2004
A recent overtime analysis indicated the use of overtime to compensate for staffing vacancies as the primary factor, followed by coverage of 1:1's and staffing for patients on special hospitalization. With four facilities on the Southside campus and three other hospitals in the tri-cities area currently competing for the same pool of employees, CSH continues to try to develop strategies for effective recruitment and retention in the current market. While February 2004 total overtime hours of 6299 showed a decrease from the January total of 7209 and a decrease of 1381 hours from the six-month high total that occurred in November 2003, it is difficult to determine whether this is a significant improvement or simply an artifact related to holidays and weather factors in those months preceding. CSH will continue to monitor and analyze overtime use to try to

identify patterns or trends, which could afford the opportunity for improvement. Nursing Administration is in the process of developing a larger more competitive P-14 pool. They are also looking at centralizing the staffing office and utilizing a qualified clinician to oversee the 24-hour staffing operation to improve its efficiency and efficacy. The School at Work (SAW) program has been adopted on the Southside campus to encourage direct care staff to return to school in preparation for pursuing LPN or RN careers. Preliminary plans for a daycare center on the campus have been developed in an effort to provide a benefit that could impact recruitment/retention. DMHMRSAS Office of Human Resource Development and Management is currently working with all facility human resource and nursing departments to systemically analyze the recruitment and retention issues and develop strategies for better dealing with them.

B. OIG REPORT #52-01

SECTION ONE: GENERAL INFORMATION

Finding 1.4: Interviews with direct care staff indicated that on-going and updated communication is the most effective tool for providing security for both the patients and residents.

Conclusion: There is currently inadequate clinical information exchange between shifts for staff, particularly direction care staff.

Recommendation: Review and make necessary revisions to current procedures for enhanced communication between shifts in forensics units.

DMHMRSAS Response: Effective January 10, 2002, shift times at CSH have been adjusted to allow a full 30-minute overlap of staff at shift change. The previous 15-minute overlap had not allowed oncoming FMHT staff to stay for the entire report secondary to their being required to assume their posts in order to relieve the departing staff. With the new 30-minute overlap, all arriving staff are being required to attend the verbal shift report. Shift report will continue to be recorded for staff being pulled to the ward after the beginning of the shift.

Information regarding a patient being placed on restrictions will continue to be shared face-to-face, included in shift report, documented in the 24-hour report and posted in the nursing station to augment communication.

6 Month Status Report: 07/01/02

The staff communication book, patient information book, verbal and recorded shift reports, increased shift overlap and the posting of patient precautions/restrictions in the nursing station

all remain in effect. Special attention is being paid to ensuring that the patient information books are kept up-to-date and contain all specific alerts and management issues for each patient. In addition, when a patient has been identified as having a medical condition, the record is flagged with a medical alert sticker.

The Quality Council chartered a ward-based Performance Improvement project on Bldg. 39-6 focused on effective nursing communication exchange between shifts. It is hoped that the outcome of the project will provide a prototype for use on all the wards.

OIG Comment – (February 2004) *Interviews with 19 staff indicated that 12 continued to feel that they were not adequately informed regarding the issues associated with the patients before having to work on the units in Building 39. Those interviewed were staff from the civil units typically "pulled" from their normally assigned units to work in either Building 39 or Building 96. They indicated that report is usually over by the time they are stationed on the units and once the shift begins it is extremely difficult to determine the client's status by other mechanisms. Given that this continues to be identified as a concern, this finding remains* ***ACTIVE.***

Status Report April 2004
Nursing department records indicate that the regular ward staff from the civil buildings are infrequently re-assigned to forensics. Whenever possible, P-14s are assigned instead. However, all staff that are pulled to forensics have received the requisite training. Nevertheless, it is understood that any staff person reassigned at the beginning or during a shift from one ward to another feels themselves to be at a disadvantage, potentially having missed report and/or not being familiar with the patients. As indicated in the previous responses, a number of methods have been developed and implemented to ensure adequate communication from shift to shift. The CSH Director of Nursing will send out a reminder to all staff of the various methods available for updating their knowledge of the patients and their plans of care. The reminder will include instructions in the use of the patient information book for patient-specific issues and plans of care, the use of the taped report if they missed the verbal report and the use of direct communication with the charge nurse regarding ward routines and activities.

ACTIVE FINDINGS
COMMONWEALTH CENTER FOR CHILDREN AND ADOLESCENT
OIG REPORTS #23-00, #56-02 AND #72-02
UPDATED MARCH 2004

A. OIG REPORT # 23-00

SECTION THREE: PATIENT ACTIVITY

Finding 3.2: Plans to operationalize a new psychosocial rehabilitation program are expected to be implemented by June 19, 2000.

Recommendation: None at this time. We look forward to reviewing the progress of this program.

DMHMRSAS Response: DMHMRSAS appreciates the Inspector General's acknowledgement of DeJarnette's creation of a new psychosocial rehabilitation program. The proposed steps to ensure the development of activities that have a clear treatment focus (as outlined above) will assure ongoing progress in implementing psychosocial rehabilitation activities.

6 Month Status Report: 7/1/01
The Activities Staff of the Center implemented a modified treatment mall during the Summer 2000. This approach was very successful in providing active treatment offerings to all children of the Center. This program was modified in the Fall 2000 to adjust for the individual needs of clients served by the Center. The AT staff adjusted their schedules in order to provide active treatment in the evenings and on weekends. AT staff continue to implement a variety of therapeutic activities specific to the needs and treatment goals of each child.

OIG Comment: *The facility has tried different models for improving active treatment. It did initially offer a modified treatment mall during the summer of 2000, and continued the schedule of recreation and rehabilitation services once the school year resumed, during evenings and weekends. Review of materials and staff interviews, during the May 2001 follow-up inspection; reveal that the Center has returned to a unit-based model whereby regularly scheduled activities are operating the evening and weekend hours. Instead of offering these activities during the upcoming summer of 2001, the Center has contracted with local school personnel to provide an enrichment program focusing on the arts and sciences. Administration informed the team that the Activities Therapy department has ordered curriculum materials, and staff mentioned that they have been reviewing a Life skills curriculum that has been purchased by the facility by the SA coordinator. One concern about this menu of activities is that no structured curriculum has been formulated which outlines the goals and objectives for each topic. This creates*

difficulty in accurately evaluating whether and which of the services delivered can be demonstrated as having a useful effect on a consumers' identified problems. There is ongoing concern that these activities do not have a clear mental health acute care therapeutic focus and may not be individually tailored to meet the unique needs of a particular child. This finding is ***ACTIVE;*** *see finding 3.2 (OIG report # 1-99); finding 3.3 (OIG Report # 10-99); finding 2.4 (OIG report #17-00); 3.1 (OIG Report # 22-00).*

6 Month Status Report: 1/1/02
In the Summer 2001, the Center continued to operate the active treatment program during the evening and weekend hours as well as provide individual active treatment and group interventions during those hours so that children received the full array of interventions needed for their quick stabilization and return to their families and communities (see Finding 3.1 Status Report above). The academic enrichment program offered was to provide a school-based link for children during the month of July so that they had opportunities to build academic skills (somewhat likened to adults being provided continuing job skills development at adult facilities). The staff of this program provided a wide variety of structured, positive, and proactive groups around the topics of art (and art therapy), social studies and peer relations, language arts and cooperative learning, science/math and academic skill development, and physical education and physical health skill development. This was a very successful program with extremely positive feedback given by both children and clinical staff. Along with the Summer Enrichment Program, groups continued to be offered that were both unit-based and cross-unit in order to provide many simultaneous opportunities for individual children to receive the groups they need or request. Activities therapy staff continue to work evenings and weekends to provide a full array of relevant active treatment inter-venations outside of school hours. The Center is now developing a manual that will outline the goals and objectives of each active treatment group (completion date is March 2002).

OIG Comment - *The March 2002 inspection included interviews with administrative and direct care staff; tours and observation of the activities involved in the PSR; interviews with six patients; review of educational materials; and documentation in records. The direct care staff, which perform the majority of the active treatment program functions, have a lot of enthusiasm and a willingness to learn new skills. Those interviewed questioned whether they had been adequately trained or skilled to provide the level of intervention required in active treatment.*

The amount and quality of documentation of the activities has improved. The records contain a brief description of the individual patients participation or lack thereof. The treatment plans delineate which activities are prescribed and these are related to assessment and diagnosis. All of the patients interviewed had difficulty verbalizing how the various activities in which they were engaged were linked back to their treatment plans or the reasons for their hospitalization. In comparison with the remainder of the mental health facilities throughout the Commonwealth, the psychosocial rehabilitation

component of active treatment is far less individualized. When treatment is not individualized it becomes less beneficial in terms of discharge preparedness and successful community adaptation. This finding remains ***ACTIVE.***

6 Month Status Report: 7/1/02
CCCA will continue to build the active treatment programs offered to the children and adolescents served according to their individual treatment needs in coordination with the goals established by the treatment teams. CCCA strives to provide a wide array of groups that include specific interventions related to the individual treatment plans. The group interventions are determined for each individual child by the members of the treatment team, including the unit clinical director, the psychiatrist, nurses, activities therapy staff, social workers, direct care staff, and teachers in joint treatment planning and review meetings. CCCA will work with its clinical teams to develop a process to help children more clearly understand and articulate how the various treatment activities are linked to their treatment plans.

OIG Comment *– (November 2002) Interviews with administrative, clinical and direct care staff indicated that the facility provides active treatment programming that is primarily unit-based during afternoon and early evening hours as the patients are required to attend academic programming during the day. Recreational therapists are assigned to the units during the evening hours and are the primary providers of active treatment. Active programming has not evolved at this facility in the same manner as the other facilities, which is in part due to the differences in population served. Particularly given the focus on and recent implementation of cognitive behavioral therapy, it would be reasonable to expect that more children be able to more clearly articulate their treatment goals and have a basic understanding as to how the Center meet these goals. It is clear that good work has been done in this area, however this finding remains* ***ACTIVE*** *until increased individualized treatment opportunities are available.*

Status Report: 2/28/03
CCCA will continue to develop a program wherein each individual is assessed as to what the needs are and a treatment plan is developed around this assessment that includes active treatment that is focused on person needs. To facilitate coordination with the academic schedule, by September, 2003 CCCA will implement a program that clearly identifies what activities each child is scheduled to attend (Individualized Activity Treatment schedule for each patient) that is directly related to what the treatment team has identified as the primary needs and is communicated in a developmentally appropriate manner to the client.

OIG Comment – (December 2003) *Interviews with administrative, clinical and direct care staff revealed that the facility is currently reviewing the initiation of a facility-wide coordinated schedule of active treatment programming provided by the Activities Therapy Department. This newly formed department will evaluate center-wide needs and provide services to all children regardless of their unit placement. This should allow for enhanced services and a better use of limited resources. These active treatment programs will be in addition to already established substance abuse treatment and educational groups as well as active treatment programming provided by nursing. As the facility is currently in the process of shifting the manner in which it offers several aspects of active treatment programming, this finding will remain* ***ACTIVE*** *pending further review.*

Update March 2004
CCCA has reorganized its Activities therapy (AT) functions into a separate department effective December 1, 2003. Staff in the department continues to serve as members of the treatment teams and coordinate the provision of activities therapy to each individual child on the team. The AT department is shifting from a unit-based services provision model to a service team model in concert with the organizational changes in the Center. In this new model, staff of the AT Department will provide greater focus on the treatment intervention needs of the individual child. Children will be involved in individual and group AT interventions based on their treatment goals and objectives. The AT staff has organized all AT curricular materials and reviewed and modified AT group offerings, and has implemented some cross-unit groups. CCCA will continue to work toward greater flexibility in offerings to provide increased options to match the needs of individuals served.

B. OIG REPORT #56-02

SECTION THREE: ACTIVE TREATMENT

Finding 3.1: Patients have access to education and evening activities.

Recommendation: Enhance evening activities designed to meet the individual treatment needs of the patients. Review the practice admitting adolescents to the children's units.

DMHMRSAS Response: DMHMRSAS is committed to the provision of active treatment and age-appropriate treatment for all clients in our system. CCCA provides active treatment in the form of psycho-educational groups, recreation therapy, music therapy, and substance abuse groups in the evening and during weekends. CMS (formerly HCFA) guidelines require a minimum of 21 hours of active treatment per child per week (not including individual and family therapy). The Center consistently exceeds that 21- hour minimum of active treatment hours. The staff members involved in planning and leading active treatment groups are also members of the clinical teams for the children served. They determine the need for groups based on treatment goals and objectives written for each individual child as established by the clinical team. Because the Center serves a wide variety of children of different ages, including children with mental retardation and (at times) autism, it has been necessary to plan a wide variety of interventions for all children at the Center. The CCCA Activities Therapists and their supervisors have developed a comprehensive listing of all the types of groups currently offered at the Center. They plan additional groups as indicated by the changing needs of the children. The Center will continue to monitor the number and types of active treatment groups offered to children. New groups will be formed as needs arise.

CCCA has two units with 12 beds each for a Children's Program and for an Adolescent Program, for a total of 48 beds. Placement on these units is determined by age, developmental level, and bed availability. The Admissions staff consults with program staff to the extent possible in determining where a child should reside while at the Center. Sometimes, when beds on specific units are full, the Center will place a child on a unit with an available bed. This may mean that a 16-year-old adolescent may reside on the pre-adolescent unit that typically serves children from ages 12 to 14. Likewise, if the Children's Program units are full, a 13-year-old child may need to reside on an Adolescent Program unit which typically serves children ages 14 to 17. When these mixes occur, the clinical team for the child works with the other teams to plan group interventions and activities with his/her chronological peers to the extent possible. Children admitted to a different age unit may be relocated to a more age appropriate unit when a vacancy occurs, as determined by needs of the child and therapeutic progress. This occurs in communication with the child, the family, and others involved in the care of the child.

6 Month Status Report: 07/01/02
The CCCA Activities Therapy and other staff continue to provide more than the minimum of 21 hours of active treatment per child per week. The AT staff continues to discuss treatment needs of individual children with clinical treatment team members and plan interventions for individuals that are appropriate to their needs. The Clinical Staff Executive Committee has reviewed and made recommendations to the comprehensive

listing of all groups offered by the Activities Therapy and Nursing staff of the CCCA. This list serves as a menu of options available for group and individual interventions with children as determined by their respective treatment teams The management team of CCCA will continue to monitor though quarterly reviews by the Clinical Program Services staff.

Admissions staff continues to work with unit clinical teams in determining the best placement of newly admitted children and adolescents. In the infrequent event when the CCCA must place a child or adolescent on a unit with different aged children or adolescents, the staff consult with one another to provide the best therapeutic care that meets the needs of the individual. The staff of CCCA assess the individual's needs for safety and security as well as assess the level of dangerousness toward others. The staff determines the best placement option taking into account multiple variables.

OIG Comment *– (November 2002) Interviews with administrative, clinical and direct care staff indicated that the facility provides active treatment programming that is primarily unit-based during afternoon and early evening hours as the patients are required to attend academic programming during the day. Recreational therapists are assigned to the units during the evening hours and are the primary providers of active treatment. Active programming has not evolved at this facility in the same manner as the other facilities, which is in part due to the differences in population served. Particularly given the focus on and recent implementation of cognitive behavioral therapy, it would be reasonable to expect that more children be able to more clearly articulate their treatment goals and have a basic understanding as to how the Center meet these goals .It is clear that good work has been done in this area, however this finding remains* ***ACTIVE*** *until increased individualized treatment opportunities are available.*

Status Report: 02/28/03

CCCA will continue to develop a program wherein each individual is assessed as to what the needs are and a treatment plan is developed around this assessment that includes active treatment that is focused on person needs. To facilitate coordination with the academic schedule, by September, 2003 CCCA will implement a program that clearly identifies what activities each child is scheduled to attend (Individualized Activity Treatment schedule for each patient) that is directly related to what the treatment team has identified as the primary needs and is communicated in a developmentally appropriate manner to the client.

OIG Comment – (December 2003) *Interviews with administrative, clinical and direct care staff revealed that the facility is currently reviewing the initiation of a facility-wide coordinated schedule of active treatment programming provided by the Activities Therapy Department. This newly formed department will evaluate center-wide needs and provide services to all children regardless of their unit placement. This should allow for*

enhanced services and a better use of limited resources. These active treatment programs will be in addition to already established substance abuse treatment and educational groups as well as active treatment programming provided by nursing. As the facility is currently in the process of shifting the manner in which it offers several aspects of active treatment programming, this finding will remain ***ACTIVE*** *pending further review.*

Update March 2004
CCCA has reorganized its Activities Therapy (AT) functions into a separate department effective December 1, 2003. Staff in the department continues to serve as members of the treatment teams and coordinate the provision of activities therapy to each individual child on the team. The AT department is shifting from a unit-based services provision model to a service team model in concert with the organizational changes in the Center. In this new model, staff of the AT Department will provide greater focus on the treatment intervention needs of the individual child. Children will be involved in individual and group AT interventions based on their treatment goals and objectives. The AT staff has organized all AT curricular materials and reviewed and modified AT group offerings, and has implemented some cross-unit groups. CCCA will continue to work toward greater flexibility in offerings to provide increased options to match the needs of individuals served.

Finding 3.2: The observed use of restraints was inconsistent with the current D.I. recommendations that restraints either be utilized for acute emergency management or as a formalized part of an approved behavioral Management program.

Recommendation: Reconcile the existing the Departmental Instruction on Seclusion and Restraint with practice at CCCA. Consider consultation on particularly challenging individuals with in-state resources such as behavioral consultation teams in place at other facilities.

DMHMRSAS Response: The Department appreciates the concern expressed regarding the use of mechanical restraint with a specific adolescent. The Departmental Instruction on seclusion and restraint was written primarily for adult populations served at the psychiatric hospitals in the DMHMRSAS system. Federal standards for seclusion and restraint for children differ. Therefore, the Center was granted a waiver from the Departmental Instruction in 2001. The seclusion and restraint policy of the Center was developed with Central Office staff and includes all of the requirements established by JCAHO, the State Human Rights Regulations, and the federal government.

In November 2001, the DMHMRSAS issued a revision of the State Human Rights Regulations. In February 2002, the Center admitted the adolescent referenced in the OIG report. This adolescent had an extremely violent history both at the Center and at the adult jail in which he resided prior to his admission to CCCA. When determining the intervention needs for this individual, the Center determined that mechanical restraint would be used on an emergency basis to protect others from this actively psychotic and assaultive adolescent. When the level of dangerousness of this adolescent did not subside, the treatment team found the need to continue the use of restraint with the individual. The safety of others as well as the rights of others to be protected from harm were strong clinical considerations since significant physical injury to others had resulted from previous assaults by this adolescent.

The Center's internal seclusion and restraint policy prohibits the use of seclusion or restraint as part of a behavior management plan. Therefore, when the treatment team brought forth a draft behavior management plan that used restraint, the Center's behavior management committee rejected it. In exploring the requirements of the new State Human Rights Regulations, the Center determined that use of mechanical restraint could continue if the team followed regulation 12 VAC 35-115-110.C which provides three options for the use of seclusion or restraint: 1) emergency use; 2) use as determined and documented by a qualified professional involved in providing services to the individual; or 3) as part of a behavior management plan. The Center staff determined that the situation for this adolescent fit the criteria stipulated under 12 VAC 35-115-110.C.2. a through d. The unit psychiatrist and other members of the clinical team initiated mechanical restraint based on these criteria as well as a comprehensive assessment of his functioning. All monitoring and documentation of the use of the intervention meets the requirements established by CCCA policy, JCAHO and federal standards, and the State Human Rights Regulations. Over time, as this adolescent's condition improved, he was slowly released from mechanical restraints. This adolescent was ultimately discharged back to the adult jail. The Center will continue to strive toward the reduction of the use of seclusion and restraint with its patient population and will continue to meet the requirements for the use of these procedures for its specific population of clients.

6 Month Status Report: 07/01/02
Through the Restrictive Interventions Committee, a standing committee of the Clinical Staff, CCCA will continue to monitor the use of seclusion and restraint and will continue to meet state, federal, and JCAHO requirements for use. Recent record reviews of cases involving use of seclusion and restraint were made by Dr. Jeffery Geller, consultant to the DMHMRSAS, as part of a comprehensive assessment of Center services and processes requested by the DMHMRSAS; and through a scheduled 'mock' JCAHO survey by a state expert. Both site visit reports stated that the Center demonstrated significant compliance to state, federal, and accreditation requirements for the use of seclusion and restraint. Dr. Geller's report indicated that CCCA has a seclusion and restraint policy that meets professional standards. He suggested that CCCA fine tune the process for tracking threshold requirements for reviewing seclusion and restraint contemporaneous with treatment. The Restrictive

Interventions Committee at the CCCA has responsibility for monitoring this suggestion.

OIG Comment: *Members of the OIG team meet with Dr. Reinhard to discuss this case and to request clarification. This finding will remain* ***ACTIVE*** *until clarification regarding this interpretation of near continuous restraints without the development of a behavioral management plan is reviewed.*

Status Report: 02/28/03

CCCAs policy for seclusion and restraint is set at a higher standard than required by the DMHMRSAS DI on seclusion and restraint in that it does not recognize the use of seclusion or restraints as part of a behavior management program. It has been the intent of CCCA to convey a philosophy reflective of the idea that seclusion and restraints is used only as an emergency response where less restrictive alternatives have failed. CCCA understands that there are occasions when seclusion or restraints must be used for the safety of all parties as outlined in the DMHMRSAS State Human Rights Guidelines, Departmental Instruction and in compliance with federal Medicaid regulations. The Center has worked hard to reduce the use of seclusion and restraint while providing a safe environment both for the patients and staff and is committed to continuing these efforts. The recent JCAHO survey resulted in a score of 99% compliance with no type 1 recommendation is one testimony to the continuing efforts to decrease seclusion and restraints.

OIG Comment (December 2003) – *Discussions occurred between the OIG and CO management regarding the use of continuous restraints with adolescents that demonstrate the severe aggressive behavior noted in the case identified during the March 2002 inspection. As noted above, the Center determined that use of mechanical restraint could continue if the team followed regulation12 VAC 35-115-110.C including the ongoing and rigorous review of the clinical status of the patient. It was recommended that this case and others be referred to an established quality committee so as to assure that the on-going right of the patient to treatment in the least restrictive setting possible is maintained. This finding remains* ***ACTIVE.***

Update March 2004

CCCA continues to actively reduce the use of seclusion and restraint. The Center has formed a multidisciplinary Clinical and Administrative Review Team (CART). This Team provides a rigorous review of all individual patients with any prolonged use of seclusion or restraint that meets the threshold established in the Departmental Instructions on seclusion and restraint. The team's review has lead to the reduction or elimination of seclusion or restraint in each reviewed case. CCCA will continue to use this important review process. As has always been the

goal of CCCA, the rights of the consumers will be ensured through oversight and diligent internal review whenever a restrictive procedure is implemented to maintain the safety of the consumers and employees.

C. OIG REPORT #71-02

SECTION ONE: ACTIVE TREATMENT

Finding 1.1: Overall, staffing patterns were consistent with facility expectations.

Recommendation: None. This facility has had the good fortune to be able to attract many individuals with at least a Bachelor's Degree in the position of direct care assistants. It is often difficult for facilities to be able to maintain staff with this level of education within these positions because of the nature of the work and the associated compensation. The Commonwealth Center provides staff with opportunities to increase both their experience and knowledge base, which enables them to enhance their skills.

DMHMRSAS Response: DMHMRSAS appreciates the OIG's recognition of CCCA 's effort to attract the best-qualified individuals available for all staff vacancies.

OIG Comment (December 2003) *- CCCA has historically been an excellent training ground for a person entering the mental health system with a bachelor's degree. It was not uncommon for individuals to stay at the facility for up to two years while either continuing their education or gaining the necessary skills for making them more competitive in the field. Today, however, more staff are leaving the facility after having stayed for a period of often less than six months. Interviews indicated that staff are able to move to entry level positions in other local state facilities or the local community services board and experience increased pay, fewer or no requirements for working on the weekends and be exposed to less risk for harm.*

The facility has also experienced a decrease in the number of applications of persons with at least a bachelor's degree. 16 of the 24 recent hires have a high school degree. Having a high school diploma does not imply that the persons selected are not qualified for the positions, it serves as an indicator of changes within the employment market facing the facility in terms of the patterns of hiring for direct care staff. In recognizing these trends, the facility in conjunction with the Central Office is reviewing ways of enhancing staff training and development programs in order to provide staff with opportunities for increasing their skills and knowledge. One of the current program managers has been charged with the responsibility of developmental additional staff training activities. As this is a new program for the facility, this finding becomes ACTIVE.

Update March 2004

CCCA has implemented new initiatives to address staff shortages and assure adequate coverage. These initiatives include:

- restructuring direct care staff assignments,
- creating a new innovative schedule for direct care staff, and
- implementing support teams

The support teams provide on-going assessment of acuity across units in order to support direct care staff and nurses when consumers with challenging behaviors have an exacerbation of those behaviors. Comments from direct care staff and nurses, as well as decreased turnover in direct care staff and nurses over the last three months show that these changes have already had a positive effect. To evaluate the efficacy of these initiatives CCCA will continue to monitor the turnover rate and encourage comments from the direct care staff and nurses.

ACTIVE FINDINGS
HIRAM W. DAVIS MEDICAL CENTER
OIG REPORT # 65-02

UPDATED IN AUGUST 2003 BUT NOT REPORTED ON UNTIL THIS REPORT

GENERAL ENVIRONMENTAL ISSUES

Finding 1.1: The facility was clean, comfortable and well maintained.

Background: Hiram W. Davis Medical Center (HWDMC) is the only state operated freestanding medical center. It is an eighty-bed facility designed to meet the often intensive medical needs of persons stable enough to be discharged from acute care hospitals but requiring a level of care not typically provided by the other state-operated mental health facilities or the training centers. Currently there are 60 beds designated for skilled care, 10 intermediate care beds and 10 medical/surgical beds. Consequently, the majority of patients at the facility require intensive nursing care.

Even though most of the referrals to the facility (48 of the 69 patients in the facility on the date of the inspection) come from Central State Hospital and Southside Virginia Training Center, the facility serves persons from the other facilities throughout the Commonwealth.

Members of the inspection team conducted a tour of the facility. This included a tour of treatment and residential areas. The majority (95%) of the patients were in their beds. The team was informed of the facility's on-going efforts at increasing the degree of stimuli offered to each patient by assuring that access to music with radios or visual stimuli

through televisions is made available in each room. Plans are to complete this project as soon as possible. Since the completion of previously noted renovations, the facility has been working on making this institutional setting more home-like and personalized for the patients. The team noticed curtains, pictures, family photos, stuffed animals, and bed-sets. A parent of a patient interviewed during the course of the inspection indicated that he was pleased with the overall maintenance of the facility. Despite his initial reservations regarding the enclosing of the "socials", he indicated that the degree of stimuli offered his son has been maintained.

Facility housekeeping staff are assigned to each shift to assure that the environment is clean and odor-free. One of the primary functions of the daytime housekeeping supervisor is to assure that proper disposal of wastes occurs and appropriate care has been given to provide a sanitary environment.

Recommendation: Continue with planned efforts to provide increased opportunities for stimuli to be available for all patients at the facility.

DMHMRSAS Response: *One plan to increase opportunities for stimuli, the Patient Pavilion has been completed and will be inaugurated with a Patient-Family Picnic September 25, 2002. The pavilion will increase opportunities for patients to be outside in a covered shelter. A workgroup has met twice to develop plans for using the pavilion.*

To increase opportunities for increased stimuli inside the facility, the staff office space in the 3rd floor Therapeutic Recreation Room is being consolidated to increase patient use of the room. Nursing takes patients to this room when it is not in use by Recreation. This increases patient socialization and allows the patients increased time out of their rooms. To increase patient interaction and to normalize mealtimes, part of the room is being used for patient dining. This eliminates the need for patients eating in the hallway as they had previously done due to space limitations.

Other efforts to increase patient activities and mobilization include:

- *Two volunteers who focus on reading to patients and assisting with patient transport to activities.*
- *A music group run by the Social Services Department supplements regularly scheduled Recreation groups.*
- *Rehabilitative Services and Nursing Service work cooperatively to find the most appropriate wheelchairs or other mobility aids for getting patients out of bed.*
- *Rehabilitative Services contacts the home facility of any new admission to have any custom wheelchairs transferred to HWDMC for the patient's continued use.*
- *Rehabilitative Services is works cooperatively with the SVTC Wheelchair Evaluation Team and Wheelchair Shop to ensure that patients have the most appropriate mobility aid.*

OIG COMMENT (August 2003) This finding was determined INACTIVE during the POC response process.

STAFFING ISSUES

Finding 2.1: Staffing patterns were consistent with facility staffing expectation despite only one RN providing coverage for both units on the 3rd Floor.

Background: A staff schedule was obtained and verified during the tour of the wards. The team's observations were that these staffing levels were appropriate for providing care to the patients. As the majority of patients at this facility are identified as needing skilled care, staff is composed of RNs, LPNs and CNAs. The staffing patterns during the day shift were as follows:

2 North	1RN	2 LPNs	5 CNAs	to 16 patients
2 South	1RN	2 LPNs	3 CNAs	to 12 patients
3 North	.5RN	2 LPNs	3 CNAs	to 20 patients
3 South	.5RN	3 LPNs	3 CNAs	to 21 patients

It was noted that the RN on the third floor rotated between the two wards. This practice does not meet the intent of nursing requirement as established by the DOJ in other facilities and is disconcerting for a population that requires intensive nursing interventions and on-going assessments.

Recommendation: Review current practice of staffing RNs to assure that adequate coverage is maintained for these complicated patients.

DMHMRSAS Response: *Four Registered Nurses have been employed since this survey was conducted. All are currently in the process of completing clinical orientation. These additional Registered Nurses will assist in alleviating the issue of one RN covering for both 3rd floor units. One RN may be used to provide coverage for both units on the 3rd floor in the following situations:*

1. *The patient acuity level is low.*
2. *There are enough Licensed Practical Nurses on duty (minimum of 8-9 LPN's) to support the Registered Nurse.*
3. *The RN assignment frees her to circulate and make frequent rounds.*
4. *The Nursing Supervisor on duty (on-call) gives approval, and makes the determination that one RN will not jeopardize the patients.*

OIG Clarification Request to DMHMRSAS Response: Provide additional information regarding utilization of an acuity-based system for nursing staffing.

DMHMRSAS Response to OIG Clarification request: *HWDMC Nursing department uses hours per patient day (HPPD) formula as a guideline for staffing rather than an acuity-based system. For a census of 70 to 74 patients, the minimum HPPD is 5.4.*

Clinical activities, however, are closely evaluated when making staffing decisions. Examples of clinical activities that are taken into staffing considerations are:

1. *More than two intravenous medications via IV therapy or via heplock.*
2. *Patient admission that requires close supervision and assessment such as post-operative patients, and pneumonia.*
3. *Unstable medical condition.*
4. *Use of restraints.*
5. *Anticipated complex admission to coming from other DMHMRSAS facility.*
6. *More than 2 critical patients such as unstable respiratory conditions, chest pain, cardiac condition, abdominal distention, and persistent vomiting.*

OIG COMMENT (August 2003) Interviews were completed with both administrative and direct care staff members. HWDMC has been diligent in its efforts to maintain an adequate staffing pattern consistent with facility policy. The Director of Nursing conducts ongoing administrative reviews regarding the maintenance of an appropriate number of staff for the safety and supervision of the residents.

This finding is INACTIVE.

Finding 2.2: Use of mandatory overtime has been very limited during the past six months.

Background: HWDMC has been working on decreasing the use of mandatory overtime since it was initially noted by the OIG in November 1999. This has been accomplished through several mechanisms such as the use of nursing contract agencies and the hiring of additional permanent nursing positions. Interviews with 10 nursing staff members indicated that mandatory overtime was very limited and not considered a significant issue. During the inspection, the team was informed that no one was working mandatory overtime during the day shift.

Recommendation: Continue to discourage the use of mandatory overtime as a remedy for staffing shortages.

DMHMRSAS Response: *The facility will continue to monitor, and analyze the mandatory overtime data collected monthly; continue to hire Float Pool staff (P-14), as supplemental staffing; use patient acuity as the baseline for staffing decisions rather than using the mandatory overtime to meet the numbers; continue to enforce the Nursing staffing adjustment policy, wherein employee time schedules are posted for a six -week period with requests for planned absences after posting is granted only if the employee requesting off switches days off with another staff member. This maintains appropriate numbers of staff to accommodate any unplanned absences, thereby reducing mandatory overtime use.*

OIG COMMENT (August 2003) *This finding was determined* ***INACTIVE*** *during the POC response process. Interviews with direct care staff indicated that the use of mandatory overtime has been very limited during the past six months. Staff indicated that even opportunities for voluntary overtime have been limited, which was disconcerting for several persons interviewed. Staff, on a whole, attributed the decrease in the use of mandatory overtime to the facility's success in hiring LPN and CNA staff for the evening shift. Having a full complement of staff allows for greater flexibility in arranging coverage and maintaining routine scheduling.*

Finding 2.3: HWDMC coordinates internally and with surrounding facilities to offer a variety of supports to staff seeking to pursue advanced training.

Background: A review of administrative documents and interviews with employees indicated that HWDMC offers a variety of supports to employees seeking advanced career training. Currently, HWDMC is benefiting from a federal grant received by Southside Virginia Training Center (SVTC) to partner with John Tyler Community College (JTCC) to provide classes on the SVTC campus. The classes offered would include a variety of topics, such as nursing and computer courses and could be taken for credits that would transfer to programs at JTCC. The facility dedicated $2500 for tuition reimbursement in FY2002 and intends to do the same in FY2003. In FY2002, the 3 staff that benefited from the tuition reimbursement were 2 Direct Care Associates and 1 support services employee.

The facility also conducts in-services for all staff and offers the opportunity for staff to attend seminars. Staff that do attend seminars are required to disseminate information to others that would benefit. In FY2002 the facility dedicated $7,880.29 to in-services and seminar funding and anticipate spending $5000 in FY2003.

Recommendation: Continue to fund and facilitate opportunities for staff to receive advanced career training.

DMHMRSAS Response: *HWDMC encourages employees to attend school for upward mobility. Funding for school is based on the criteria set forth in the HWDMC Employee Educational Assistance Instructions. Currently, thirteen nursing staff are pursuing advanced nursing careers. Two Licensed Practical Nurse are enrolled in Registered Nurse Programs, ten Certified Nurse Aides are enrolled in Licensed Practical Nurse programs, and one RN is enrolled in a Bachelor of Science in nursing program. Four other non-nursing staff are pursuing advanced careers in fields such as computer science, business management, healthcare and social work. In addition, one of the nursing staff successfully completed the transitional LPN to RN program in 2000,*

utilizing the Educational Leave and the educational assistance provided by HWDMC. The work schedules of the employees who are enrolled in advanced career classes are accommodated based on their class schedule, which results in an approved special shift schedule. The employees enrolled in school are also exempted from the mandatory overtime during their class days. Although these special work schedule accommodations are provided to these employees, appropriate coverage for patient care is still the main priority.

The Petersburg campus (HWDMC, SVTC and CSH) has been pursuing Workforce Development initiatives. SVTC is leading these initiatives that include the School –at – Work Program, and community college classes on campus. Governor Warner has officially designated the DMHMRSAS Petersburg Campus as the "Workforce Development" demonstration and pilot site. Classes will include RN, LPN, or any other college courses including computer technology, HVAC, and childcare. Twenty-nine employees took the John Tyler Community College admissions test last August 2002. There are plans to apply for several Grant programs for funding. A meeting was held on September 20th with a representative of the Capital Compassion Fund.

OIG COMMENT (August 2003) This finding was determined INACTIVE during the POC response process.

Finding 2.4 HWDMC has experienced a change in psychiatric consultant.

Background: For the last several years that has been consistent access to a psychiatrist for the patients at HWDMC. Due to inability to reach mutual financial agreement, this has changed such that there is a new contract with an MCV psychiatrist to work at HWDMC. At the time of this inspection the new physician had not had an actual clinical consultation day at HWDMC. This is reported as a finding and will be monitored because it represents an area wherein patients at HWDMC have been vulnerable in the past.

Recommendation: Continue to support access to psychiatrist for those patients in need at HWDMC.

DMHMRSAS Response: *Until recently, psychiatric consultations for those patients permanently assigned to HWDMC are provided by locum tenens physicians who had experience managing patients similar to our patient population. Contract psychiatrists from the Virginia Commonwealth University, Medical College of Virginia Section (MCV) are now used. There are many advantages to further developing relationships with MCV. Instead of one locum tenens physician, there are several board certified psychiatrists involved with patients in an academic setting and full time coverage is available if*

questions arise when the contract psychiatrist is not physically present at HWDMC. The academic setting also provides current and developing medical knowledge.

Patients transferred from Central State Hospital to HWDMC on special hospitalization status for medical problems, continue to be followed by their attending psychiatrists.

OIG COMMENT (August 2003) *Interviews with administrative staff indicated that the facility has a contract psychiatrist from the Virginia Commonwealth University, Medical College of Virginia (MCV) to provide coverage for patients within the facility who could benefit from psychiatric interventions. Interviews indicated that the psychiatrist has become a valuable team member and a welcomed addition to the staff. This finding is* ***INACTIVE.***

ACTIVITY OF PATIENTS

Finding 3.1: Active treatment is challenging for this complex and medically fragile population.

Background: Providing an active treatment program for the populations served at HWDMC has been a challenging endeavor for this facility as the profile of patients served are different than that of the other state-operated facilities. 52 of the 69 patients hospitalized were identified as being bed bound, non-ambulatory and needing total care in the normal activities of daily living. Literature indicated that often these individuals have little or no voluntary movement. Many were described as "having spasticity or rigidity and are osteoporotic". The majority of patients at the facility require intensive nursing interventions for basic physical maintenance. The medical and rehabilitation staffs are frequently assessing appropriate levels of care for this complex and medically fragile population. Nursing staff conduct daily assessments of the patients. The level of care provided includes constant individualized physical management to maintain skin integrity, overall hygiene and support of activities designed to preserve the patients' current level of functioning. The parent interviewed indicated that one significant measure regarding the quality of care within the facility is the fact that his bed bound child has not has a "bed sore" in the nine years he has been a patient.

Daily morning rounds are conducted. During these rounds a number of professional staff tour the wards as a group discussing the current status of each of the patients. Not only does this allow for staff involved in the care of each patient to discuss treatment objectives and interventions, many immediate care issues are identified and addressed at that time. For example, PT and OT staff are able to observe the positioning of the patients and make corrections or recommendations for proper physical management. Physical therapy staff, occupational therapy staff and speech therapy staff complete formal quarterly assessments.

During the inspection, it was noted that at least 90% of the patients were in their beds. Continued efforts are needed to assure that those individuals capable of being engaged in activities are afforded every opportunity to do so. This effort will enhance each person's ability to maintain and/or improve their current level of functioning.

Recommendation: Continue efforts at assuring that each person has the opportunity to engage in appropriate levels of activity in order to maintain and/or improve their current level of functioning.

DMHMRSAS Response: *The Restorative Team continues to guide planning and implementing patient restorative programs. Policies and procedures for a Bowel and Bladder program and Splinting and Positioning program have been developed including staff training and Team review. Future programs include Range of Motion and Dining.*

The Therapeutic Recreation Department has started using a new Die-Cut machine with patients. This machine enables patients to create many paper craft projects.

With more patients getting out of bed in specialized wheelchairs, more patients are able to go on rides or travel to outings in the facility's wheelchair lift van.

Social Services, Therapeutic Recreation, and Occupational Therapy are exploring ways to implement an Assistive Technology Program for patients. HWDMC patients may be transported to the SVTC Technology Lab when not in use by SVTC patients.

OIG COMMENT (August 2003) *This facility continues in its efforts to maximize the degree of functioning of its patients through activities, intensive nursing interventions and the introduction of restorative programs This finding will remain* ***ACTIVE.***

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
ACTIVE FINDINGS
OIG REPORTS #49-01. #63-02
UPDATED APRIL 2004

SECTION THREE: ACTIVITY OF PATIENTS

Finding 3.2: Discharge planning continues to be a significant challenge for this facility.

Recommendation: Continue to strive for successful linkages for all patients at the time of discharge.

DMHMRSAS Response: DMHMRSAS concurs. The discharge planning process at NVMHI has been in place for 14 months since revision in November 2000. Performance monitoring continues to show sustained improvement, scoring above threshold for the past 5 monitoring periods. Monitoring of the discharge planning process continues to show strong integration between the CSBs and the treatment teams. CSB Aftercare workers continue to demonstrate a consistent presence at CTPs, TPRs, weekly meetings with patients, and family meetings.

In late December 2001, an educational program on "Discharge Protocols for CSBs and State Mental Health Facilities" was presented by DMHMRSAS staff. New Departmental Discharge Protocols were reviewed to ensure standardization of the process across facilities. Two sessions were conducted and 59 staff were in attendance, including: psychiatrists; psychologists; nurses; social workers; CSB Aftercare workers; utilization management staff; and the patient advocate.

6 Month Status Report: 07/01/02
NVMHI has developed and published an updated discharge planning policy to implement the statewide "Discharge Protocols for Community Services Boards and State Mental Health Facilities". The CSBs are committed to successfully implementing both the state performance contract and the "Discharge Protocols for Community Services Boards and State Mental Health Facilities". Both of these documents directly address the need for consistent direction and coordination of those activities that result in the successful linkages for all patients at the time of discharge. The results of the newly developed NVMHI Discharge Planning Quality Monitor have exceeded the 90% threshold during the first two months of monitoring. This data demonstrates that there continues to be successful linkages for all patients at the time of discharge, as evidenced by the strong integration between the CSBs and the NVMHI treatment teams.

OIG Comment (November 2003) – *Interviews with staff, patients and a review of five discharge records demonstrated that the facility has made progress in providing appropriate and timely discharge linkages for patients. Record reviews noted the active involvement of facility treatment providers with community providers in the discussions of levels of care needed by the patients for successful community reintegration following discharge including follow-up care and medication management. There was evidence in the records that family members and significant others were also involved in the discharge planning process as appropriate and with the permission of the patient. Involvement of the patient in the discharge planning process was less evident in the documentation reviewed. Only one of the four patients interviewed was able to identify to any degree details regarding discharge planning. Even though this could be attributed to a variety of reasons, active patient involvement and understanding to the degree possible*

is an important component of recovery-based model of care. This finding will remain ***ACTIVE.***

B. OIG REPORT # 63-02

GENERAL ENVIRONMENTAL ISSUES

Finding 1.1: Overall, the facility was generally clean, comfortable and well maintained.

Background: Members of the review team completed a tour of the facility, including the treatment mall and living areas. Overall, the facility was noted to be generally clean, comfortable and well maintained. Patient bedrooms on all the units were noted to be in varying degrees of neatness while several rooms on the F Unit and K Unit were noted to have dirty clothes on the floor and/or the dressers. Housekeeping staff were present and observed changing linens and completing basic housekeeping functions. The units are designed so that patients either have a private bath or the bathroom is shared between a "suite" of rooms. All the bathrooms toured were noted to be clean and odor free. Common areas were clean, although the placement of furniture around the walls, limits interactions among the patients in smaller groups. Games tables were noted to be available. A wheel was missing from one of the legs on a game table on Unit I-1. Access to games, magazines and other leisure time activities were noted. Efforts to maximize the independent functioning for patients, as much as possible, was particularly noted on the K unit, which functions as the primary community integration unit.

Efforts to make this institutional setting more comfortable and "home-like" were evident. Personal effects were noted in a majority of the bedrooms; these items included drawings, photos, radios, and several musical instruments. It was observed that the admitting unit lacked many of the personal effects and "homey" qualities of the other areas, which may simply be the result of the shorter-term function of this unit.

Recommendation: Continue to maintain the facility and maximize efficient use of limited space.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates the Inspector General's recognition of NVMHI's efforts. NVMHI continues to maintain the treatment environment with both preventive and corrective housekeeping and engineering programs. Regular rounds are conducted to monitor the environment, and work orders are promptly submitted for any required repairs.

OIG Comment (November 2003) As identified in the inspection report#88-03, the facility was well maintained, clean and comfortable. This finding was noted as being INACTIVE at the time of the POC.

STAFFING ISSUES

Finding 2.1: Staffing patterns for nursing services were adequate.

Background: A staff schedule was obtained and verified during the tour of the units. The team's observations were that these staffing levels were appropriate for providing care to the patients.

Staffing patterns for the units were as follows:

Day shift (0700 – 1615)

F unit	23 patients to	3 RNs, 1 LPN and 4 DSAs.
I-1 unit	26 patients to	3 RNs, 1 LPN and 3 DSAs.
I-2 unit	31 patients to	5 RNs, 1 LPN and 4 DSAs
K unit	43 patients to	5 RNs, 1 LPN and 6 DSAs.

Evening shift (1530 – 2400)

F unit	23 patients to	5RNs and 3 DSAs
I-1 unit	26 patients to	5RNs and 5 DSAs
I-2 unit	31 patients to	5RNs and 3 DSAs
K unit	43 patients to	4RNs and 5 DSAs

Staff was noted to treat patients with dignity and respect. Observations of the interactions between the staff and the patients appeared positive. Some consumers commented that the nursing staff were particularly helpful in their recovery process.

Recommendation: Continue to provide adequate staffing patterns.

DMHMRSAS Response: DMHMRSAS concurs. Adequate staffing patterns will continue to be provided.

OIG Comment – (November 2003) as identified in inspection report #88-03, the facility provides for staffing patterns that are adequate to address patient supervision, safety and treatment. This finding was noted as being INACTIVE at the time of the receipt of the POC.

Finding 2.2: Seven of eight staff members interviewed did not understand the reporting structure for abuse and neglect.

Background: A structured interview was completed with eight members of the nursing staff. This interview covered a variety of topics with a significant number of questions

relevant to issues related to abuse and neglect. Though the interviewer took extra time to define specific words during the interview, seven out of eight persons did not understand the reporting structure for abuse and neglect as outlined by the facility's policy. This policy calls for the reporting of abuse and neglect allegations directly to the Facility Director. These individuals indicated that they would report to their direct supervisor. This was noted as problematic in a previous OIG report (OIG report #49-01).

Recommendation: Retrain all staff regarding the correct reporting process and procedures as outlined in this policy. Review current mechanism within the facility through which allegations are reported to assure that all allegations are properly handled and addressed.

DMHMRSAS Response: DMHMRSAS concurs. New Employee Orientation and Annual Update Training currently include a Human Rights video explaining the Reporting and Investigation of Abuse, Neglect and Exploitation. Effective immediately, the Training Coordinator will assess via verbal interaction, individual understanding of the procedure involved in the different processes as part of the training program. The training Department also will provide a presentation based on the facility policy, *Reporting and Investigating Abuse and Neglect of Patients*, as a hospital wide in-service to staff. This presentation will be available for staff meetings and as an on-line training module. In addition, nursing leadership will regularly test staff competencies on the reporting process through interviews and role-playing a variety of scenarios. Nursing Unit Managers will re-test staff knowledge in three (3) months via verbal reviews and role-play situations on each nursing units.

The Nursing Managers will discuss the abuse and neglect reporting structure within the nursing unit and department-wide meetings in order to better understand the sources of confusion and/or barriers. Using the information gained, strategies will be developed to assure compliance with the direct reporting requirement. These strategies will encompass ways to provide direct report as well as to notify the supervisor that coverage must provided for the employee leaving the unit as well as allow supervisor opportunity to take immediate action to protect the patient.

OIG Comment (November 2003) – Four randomly selected staff members were asked to outline the reporting process in the event that they suspected abuse or neglect of a patient. All were able to provide the appropriate answer. This finding is INACTIVE.

Finding 2.3: NVMHI offers a variety of supports to staff seeking to pursue advanced training.

Background: A review of administrative documents and interviews with employees indicated that NVMHI offers a variety of supports to employees seeking advanced career training. These supports include: flexibility in scheduling, funding for conferences and tuition reimbursement. In FY2002, $25,143.00 was used for conference and seminar costs and it is projected that $30,150.00 will be used in FY2003. Interviews were conducted with eight employees and seven indicated that they felt the facility would

support their endeavors to seek higher education in their field through schedule flexibility. The facility also provided annual and monthly orientation and recertification training and approximately 130 in-service trainings during FY 2002 in which employees of all shifts participated. This is not expected to change for FY 2003.

Recommendation: Continue to provide a variety of supports for staff to advance. Make sure that supports and training opportunities are made known to staff.

DMHMRSAS Response: DMHMRSAS concurs. Scheduling adjustments to support staff participation in training will continue to be provided. Financial support will be consistent with facility budget and guidance from Central Office.

OIG Comment – (November 2003) This finding was noted as being INACTIVE at the time of the receipt of the POC.

ACTIVITY OF PATIENTS

Finding 3.1: NVMHI continues to monitor and revise the active treatment program in
response to patient functioning, experience and individual treatment goals.

Background: NVMHI continues to monitor and revise the active treatment programming offered for their patients. The psychosocial rehabilitation program or treatment mall activities are offered between 10:00am and 3:00pm. Unit based activities are offered during the evening and the weekends. Patients from all the units are able to participate in the treatment mall programming. It was noted that on the day of the inspection only one of the individuals from the admissions unit was participating currently.

It was clear that the active treatment program has a systematic flow and appears to integrate individual consumers into skill building activity groups that are related to their specific treatment needs. This was in contrast with the activity observed in the unstructured area of the acute admission unit, which appeared more disorganized and in which a few patients appeared to be less supervised. This may be due to the instability of newly admitted consumers who have greater difficulty engaging in structured interactions. Staff interviewed indicated that there were not any structured activities scheduled for the unit in the afternoon.

A member of the review team accompanied the staff on the unit check. This consisted of checking on the whereabouts of each patient and checking the security of the unit. Patients in the admissions units were observed as follows: nine were outside on a smoke break; seven were in their bedrooms with the doors closed, two of which appeared to be sleeping; two were roaming the halls; one was engaged in a conversation with a staff member and three were sitting in the dayroom. The census for the admission unit was 24, which is at capacity. One patient was identified as on special hospitalization.

Recommendation: Continue to offer active treatment that is designed to meet individualized needs. Review methods for incorporating the model of active treatment noted on the mall on the admissions unit.

DMHMRSAS Response: DMHMRSAS concurs. All discipline directors will discuss barriers to increased individual and group activities to support newly admitted patients to achieve treatment goals. Based on findings, the PSR Director and the Director of Psychiatry will provide leadership for unit based program development. The Clinical Leadership Group will discuss paradigms for recovery-based programs on all units.

Since the treatment mall integrates individuals into groups that are related to their specific treatment needs, the number of F unit patients attending treatment mall programming varies from hour to hour depending on the patients' needs and the groups being offered that hour.

Therapeutic activities are scheduled on F unit throughout each afternoon. Some of these activities include: aftercare meetings with the community liaison, psychotherapy groups, leisure education groups, substance abuse groups, and music therapy. In addition, the Performance Improvement Team (see Response 3.2) is exploring more efficient ways of capturing other elements of active treatment provided in addition to groups.

Nonetheless, the clinical leadership acknowledges the unique challenge of providing active treatment and engaging patients on an admissions unit where the average length of stay is 14 days. The need to develop a different programming model is under consideration. This issue will added to the charter of the Performance Improvement Team as noted in Response 3.2.

OIG Comment (November 2003) – The facility provides treatment programming for patients residing on the admissions unit as appropriate. Programming being offered on the date of the inspection included a Wellness Group, an exercise group, Stress Management and Art therapy. Participation was limited and based on the patient's stability and acclimation to the environment. Individual treatment is also offered. Program offerings and the challenge of engaging patients in treatment are being addressed by a number of mechanisms within the organization. This finding remains ACTIVE.

Finding 3.2: Tracking of active treatment participation was identified as inconsistent.

Background: Interviews with staff following OIG observations of the treatment mall activities and record reviews revealed that the facility plans on developing a performance improvement initiative regarding the functioning and participation of the psychosocial rehabilitation program. Interviews revealed that the facility's recent experience was consistent with the observation made by the OIG staff, including a question of whether there had been a significant decline in the degree of patients' participation in active

treatment and/or whether the tracking of participation hours is being consistently completed.

Patients have the opportunity to participate in a variety of treatment options both on-site and in the community. A number of the patients preparing for community re-integration participate in clubhouse or other community-based day treatment programs. Several NGRI patients of appropriate status work off-site. The team was informed patients' participation in these other activities are inconsistently documented. It was also suggested that the participation in evening and weekend activities are not as reliably documented as day activities.

It was noted that during the 2:00pm treatment mall programming 43 patients were observed in the treatment mall areas not actively engaged; several appeared to be sleeping, one woman reading, and twenty just setting in the dayroom area. This number seemed fairly significant particularly when it was explained that a number of patients left the facility to participate community based treatment options and 22 of the admissions unit's census of 23 were on the unit. It was significant to note that the same observations were made the following day.

Although it was stated that the facility could not "force" persons to participate in active treatment, there were not adequate explanations regarding strategies utilized by the facility to actively engage the patients. One of the cornerstones for the development of psychosocial rehabilitation models is the implementing of programming that is designed to meet the individual at whatever stage they are in the recovery process. This requires the completion of a readiness assessment, then identifying with the consumer how to best proceed in moving towards their established goals by offering groups in the various stages of recovery from readiness development through engagement to achieving. This pathway of treatment opportunities were not evident in the programming currently offered at NVMHI.

Recommendation: The OIG supports the convening of the performance improvement team to review current status of the active treatment program, including patient participation, strategies for actively engaging persons in their recovery process and effective, consistent documentation of participation both individually and collectively. NVMHI is encouraged to dialogue with Central State Hospital and Southwestern Virginia Mental Health Institute on strategies engaged by the facilities in these areas.

DMHMRSAS Response: DMHMRSAS concurs. A Performance Improvement Team focused on patient attendance at programming began work in June 2002. One sub-group is working specifically on putting mechanisms into place that will ensure consistent tracking of all active treatment, including off-site programming (such as attendance at community PSR programs) and evening and weekend activities. A second sub-group of the Performance Improvement Team is working on identifying strategies that treatment

teams can utilize to encourage more active participation by patients in their treatment. Additionally, the PSR Director has been in direct contact over the last month with the PSR Directors at CSH, ESH and WSH to investigate successful strategies utilized at those facilities. After review of those strategies by the NVMHI Performance Improvement Team, one or more of these strategies will be pilot-tested with the goal of determining the most effective strategy(ies) appropriate to the facility's population.

OIG Comment (November 2003) – Interviews indicated that a performance improvement team was formed for reviewing strategies for increasing patient involvement in active treatment. One of the recommendations from this process involved the formation of the Treatment Mall Council. This group will focus on a variety of recommendations and issues relevant to programming within the facility including attendance. As this council is relatively new (less than six months) this finding remains ACTIVE.

OTHER AREAS

Finding 4.1: Record reviews reflected that the overall treatment provided patients, including the treatment and discharge planning process, was individualized; linking the initial assessments, treatment planning and discharge needs to identified barriers.

Background: Five completed discharge records were reviewed. In all the records reviewed, the treatment goals and interventions were clearly linked to the initial assessments and reflected an emphasis on individual barriers to discharge. Treatment plans addressed strategies for dealing with both medical and psychiatric concerns that were to be focused on during the course of the hospitalization. Progress notes generally provided patient's progress in goal areas and identified new areas of concern, which enables the team to make timely adjustments to care to maximize patient recovery and ultimately return to the community whenever possible. Discharge planning was evident in the records reviewed with adequate supports/follow-ups clearly identified.

Interviews with five patients indicated that there are opportunities provided for the patients to actively participate in the development of their treatment goals. Three of the five were able to state treatment goals and identify barriers to discharge.

Recommendation: Continue to document the clinical process of linking assessments to treatment and discharge.

DMHMRSAS Response: DMHMRSAS concurs. NVMHI will continue to monitor the documentation of the clinical process linking assessments to treatment and discharge to ensure that gains are maintained in this area.

OIG Comment – (November 2003). This finding was noted as being INACTIVE at the time of the receipt of the POC.

NORTHERN VIRGINIA TRAINING CENTER
ACTIVE FINDINGS
OIG REPORTS #48-01, #55-02
UPDATED APRIL 2004

A. OIG REPORT # 48-01

SECTION ONE: TREATMENT WITH DIGNITY AND RESPECT

Finding 1.3: The Facility Risk Manager also functions as the Quality Assurance Director, and serves as the facility Abuse and Neglect Investigator.

Recommendation: The facility needs to review with the Central Office the nature of these functions with serious consideration given to the separation of each of these three tasks to assure that the protection of the residents are foremost.

DMHMRSAS Response: It is anticipated that in the next several months, DMHMRSAS will be centralizing all abuse/neglect positions to assure that Abuse/Neglect investigations are not undertaken by persons serving multiple and/or conflicting roles in the facility. They will serve and be trained in the singular function of Abuse/Neglect Investigations.

At present, two different NVTC staff are responsible for the risk management function and the quality assurance function. However, one of these persons has supervisory responsibility over both functions. The Director of NVTC will review the supervisory function performed by the Risk Manager relative to the Quality Assurance staff to determine if this role is a conflict of interest. A decision will be made by December 31, 2001 and forwarded to the Central Office for review.

6 Month Status Report: 01/01/02
DMHMRSAS will be centralizing all abuse/neglect investigations to assure that persons serving multiple and/or conflicting roles do not undertake such investigations. NVTC continues to maintain a Risk Manager with supervisory authority over the Quality Assurance manager. The Risk Manager reports directly to the NVTC Director. The NVTC Director reviewed the supervisory relationship of the Risk Manager relative to the Quality Assurance manager and determined that Risk Management is a key part of the organizations dedication to improved performance,

safety, efficiency and productivity. Although the NVTC risk manager is supervising the functions of the quality assurance manager the two staff work in tandem to integrate quality control management and quality assurance. The two positions work closely to assess the various types of risks that exist across the center and to identify strategic control and improvement plans. The quality assurance manager reports on the quality of care to the clients, the systems to improve performance and the protections in place to protect individuals. The Director of NVTC requires the relationship between the two positions to continue in the complimentary fashion with which they have existed.

OIG Response*: Interviews demonstrated that the facility continues to use the risk manager in the role of the primary abuse investigator. The facility provided a copy draft DI 201, which outlines proposed changes in the investigative process. This finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02

Until such time as the DMHMRSAS proposed centralization of all abuse/neglect investigations occurs, the NVTC Risk Manager continues to function as the primary abuse investigator. However, during any Abuse/Neglect Investigation, the Risk Manager is directly accountable to the Central Office Manager of Abuse/Neglect Investigations during the entire investigation process, and not to facility management. The Central Office Abuse/Neglect Investigation Manager supervises the process until a thorough and complete investigation is concluded.

In recent months, due to staff turnover, NVTC has been reduced to two certified investigators at the center. To address the need for additional investigators, NVTC will select candidates from existing staff to obtain the next statewide Investigation Certification Training, which is planned for October of 2002. NVTC will enroll at least one staff member to become a certified investigator; and additional staff may attend depending on the availability of openings at the training. As more NVTC staff are certified to investigate allegations of abuse/neglect, the Risk Manager can delegate the investigations, thereby reducing the dual role.

OIG Comment – (January 2003) *Interviews with administrative staff revealed that the Risk Manager at NVTC continues to also function in the role of primary abuse and neglect investigator. This is in conflict with the plan of correction submitted by the Central Office in a report at another facility with a similar finding in which it was stated that the Department anticipated that by August 2001, a statewide plan would be developed to assure that each facility has a designated investigator whose role did not conflict with an institutional operations role.*

NVTC has four staff members excluding the Risk Manager, who have completed the abuse and neglect investigator training and could assure that these individuals are

assigned to complete this function until this issue is resolved. Until action has been completed by DMHMRSAS, this finding remains ***ACTIVE.***

6 Month Status Report: 03/01/03
NVTC has four trained DMHMRSAS Abuse and Neglect Investigators in addition to the Risk Manager. As of 10/1/02, NVTC elected that the Risk Manager shall no longer conduct abuse/neglect investigations. All investigations shall be performed by one of the other trained investigators. The last investigation conducted by the NVTC Risk Manager was completed on 9/24/02. The Risk Manager will continue to provide over site and monitoring of investigations as part of his job duties to assure adherence to policy and procedures and timely follow-up of recommendations.

OIG Comment: During the March 2004 review, it was noted that the facility has established a process for assuring that the four trained investigators complete the abuse and neglect investigations. The Office of Risk Management provides oversight to the process. As the facility has designated investigators whose role did not conflict with an institutional operations role, this finding is INACTIVE.

B. OIG REPORT # 55-02

BI-ANNUAL UPDATE – JULY 2002

SECTION TWO: STAFFING ISSUES

Finding 2.1: There is inconsistent information regarding the projected completion of the new human rights regulations training for direct care staff.

Recommendation: The new human rights regulations served as an important framework for assuring that residents are treated with dignity and respect free from neglect, abuse and exploitation. As staff are held accountable to the regulations, timely training is imperative. Facility staff in conjunction with the Central Office needs to establish a timeframe for the successful completion of this important training.

DMHMRSAS Response: The Department's Office of Human Rights (OHR) has provided training to specific NVTC staff on two occasions: at a site visit on December 13, 2001 and via poly-com (along with other facilities) on February 7, 2002. At those times, NVTC administrators, program managers and clinical staff participated in the training. The OHR also is developing videotapes of those trainings for use by all facility administrators, program managers and clinical staff for training. NVTC requested copies of those tapes in March 2002.

In addition, five comprehensive OHR training sessions, to be made available to all staff, are scheduled at various sites on a regional basis and will be videotaped. Videos of those five trainings will be available to the facilities by request. This OHR training process will be completed by June 30, 2002.

The Office of Human Rights is also assisting the training directors in developing competence-based training materials. The projected completion date is June 30, 2002.

The NVTC Advocate will continue to train new staff during pre-service and current staff in annual re-training. In addition, the Advocate has begun providing unit-based training to residential staff across all shifts. The NVTC Executive Director will continue to work with his training staff and the Advocate to expedite training to all direct care staff.

6 Month Status Report: 07/01/02

Training in the Human rights regulations promulgated on November 22, 2001 has been and continues as follows:

- Effective 7/1/02, the Human Rights training will be conducted by the NVTC Social Work Department.
- Designated clinical staff attended local training on the new regulations in May 2002. We have requested a videotape of that session for future use, if necessary.
- The NVTC Advocate scheduled unit-based in-services for current employees during the month of April 2002. Attendance at these sessions has been taken and submitted to the Training Department.
- All NVTC clinical management staff attended training on the new regulations in December 2001 provided by the Office of the Attorney General and the Office of Human Rights. We have requested a videotape of that session for future use, if necessary.
- New employee training: The curriculum was modified to include the new regulations in February 2002. The NVTC Advocate has conducted this training to date. Effective July 2002, a Social Worker will present Human Rights training.
- Current employee training: Annual Retraining is conducted once a month; staff are scheduled to attend during their "hire month". Therefore, training of all current staff, hired prior to February 2002, will be completed by March 2003. Information on the new regulations has been included in the Human Rights annual retraining session since March 2002. The NVTC Advocate has conducted this training to date. Effective July 2002, a Social Worker will present Human Rights training.
- The State is developing a videotape/workbook training program for all staff. This will have vignettes and exercises to help convey the information.
- The NVTC Director's Office has publicized and distributed the facility policy on informal complaints to all employees. All units have a copy of the revised Human Rights Regulations. A memo dated June 20, 2002 explaining the new complaint process was sent to all NVTC employees and all clients' Authorized Representatives. In addition, a flyer that contains a simple flow chart of the new

process accompanied that memo. This flyer has been posted on all client living units. These written materials will serve as another training method to ensure that staff have current information on the Human Rights regulations.

- The NVTC policies have been revised and reviewed by the facility Advocate, who determined that these policies met the requirements for compliance with the new Human Rights Regulations by July 1, 2002.

OIG Comment – *During the follow-up inspection, which occurred at the facility in January 2003, it was determined through interviews and a review of training records that NVTC has provided for the training of staff regarding the current human rights regulations. Beginning July 2002, members of the Social Work Department became the designated facility human rights trainers for both new employees and for the annual re-certifications. Other staff members provide corresponding training regarding issues associated with human rights, such as abuse and neglect. Modifications to the training have occurred throughout the year as both administrative and advocacy staff review the information. The facility provided evidence that modifications to policies were submitted to the LHRC in July 2002. At the time of this inspection that committee had not addressed these policies.*

The OIG was provide with a copy of a complaint that had been identified through the informal complaint process as one to be addressed by the Director. A review of complaint cases handled through the administrative management process revealed that of the twelve cases (from 1/1/02 to the date of the inspection) eleven had been resolved at the Director's level. The one case was still pending completion.

For the purposes of this finding the OIG will designate this finding ACTIVE even though NVTC has completed the tasks identified in the progress note.

The OIG is concerned with the delay the facility has experienced in having their submitted policies reviewed and returned by the LHRC. In addition, the facility indicated it continues to await the proposed videotape/workbook training program for all staff the Central Office is developing as outlined in the plan of correction progress note of 7/1/02.

Follow-up on this finding during the March 2004 review revealed that the policies and procedures identified as a concern have been reviewed and approved. Staff have been trained and this information is an integrated part of the facility's pre-service and annual training. This finding is INACTIVE.

PIEDMONT GERIATRIC HOSPITAL
ACTIVE FINDINGS
OIG REPORT #28-00
UPDATED APRIL 2004

SECTION THREE: STAFFING PATTERNS

Finding 3.1: There is inadequate RN coverage for this facility on weekends, during evening and night shifts as well as weekdays on night shift.

Recommendation: Facility management and Central Office develop a plan to correct this deficiency in RN staffing.

DMHMRSAS Response: Concur. Piedmont will continue its recruitment and Retention efforts of the RN staff. Current efforts include ongoing advertisement, sign-on bonuses, flextime, weekend/shift differentials, paid relocation expenses and continuing education/nursing scholarships. Piedmont will include the nursing staff in the development of a more fully developed Nursing Retention Plan. This plan proposing recommendations will be submitted to the Central Office by September 30, 2000.

6 Month Status Report: 7/1/01
There are three RNs on the evening shift on weekends as well as weekdays. One (1) RN is on the Admission Unit and two (2) supervisors to cover the remaining four shifts. On the night shift on the weekend there is one (1) RN on the Admission unit and one (1), sometimes two (2) supervisors to provide coverage for the other four units. PGH will work with the Director of Human Resources in Central Office to develop a budget plan to hire the additional RNs. To meet the DOJ requirements the facility will need 3 additional RNs with a ratio of 1:19 on the evening, weekend and night shift.

OIG Comment - *Interviews indicated that the facility does not have per unit RN coverage consistently during the non- day shifts. There is an RN supervisor available but LPN's attends to unit care. The knowledge base for making on-going assessments and clinical judgments for this vulnerable population often with multiple health-related issues is critical and requires at the least the expertise of a registered nurse. This finding is* ***ACTIVE.***

6 Month Status Report: 01/01/02
The facility's current nursing staff has been deployed to cover the evening, night and weekend shift. (Please refer to the July 1, 2001 response) The Nursing Director continually works with the existing Nursing staff in balancing the coverage and retaining the present nurses and making the best combination of unit/shift assignments possible to maintain coverage. The facility will continue to deploy Nursing staff in an attempt to provide adequate unit coverage across shifts. And the facility will continue to downsize to meet DOJ staffing coverage.

OIG Comment- *Interviews with administrative staff indicated that the facility continues to function without an RN available on each unit on each shift. Efforts have been made by the facility to secure additional funding to hire the complement of nurses necessary to meet this requirement. This is a critical concern in addressing the medical needs of this complicated population. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
The Nursing Director continues to work with the existing Nursing staff in balancing the coverage and retaining the present nurses and making the best combination of unit/shift assignments possible to maintain coverage. The facility will continue to deploy Nursing staff in an attempt to provide adequate unit coverage across shifts. Also, Piedmont has continued to schedule a RN on each of the five units for the evening shift when RNs are available. At this time, PGH maintains a minimum of two RNs on the night shift in the hospital. PGH will continue efforts to enhance RN staffing on the night shift. It is hoped that the market adjustment plan for primary nurses being implemented will enhance recruitment and help with retention of nurses.

OIG Comment-(March 2004) *PGH has made considerable progress on accomplishing the goal of one RN per unit per shift through the implementation of a number of strategies.*

The Director of Nursing reviewed staffing configurations and adjusted staffing deployment in order to successfully increase RN coverage during the evening and night shift across the weekdays and more consistently on the weekends. A review of staff scheduling demonstrated that there were several shifts that did not maintain the desired coverage patterns, however, it was also noted that the frequency of RN coverage difficulties compared to last year has been significantly decreased. This finding remains ***ACTIVE.***

PIEDMONT GERIATRIC HOSPITAL
RESPONSE TO SNAPSHOT INSPECTION
FEBRUARY 4-5, 2003
OIG REPORT #75-03

UPDATE MARCH 2003

SECTION ONE: STAFFING PATTERNS

Finding 1.1: Progress has been made toward the goal of one RN per unit per shift.

Recommendation: Pursue the plans for a minimum of one RN per unit per shift. The OIG requests updates regarding the progress in addressing this staffing issue.

DMHMRSAS Response:

The following are being implemented to increase RN coverage on the evening and night shifts:

Rotation of all RNs who have previously worked predominately day shift to night when RN positions are filled and 2 shift effective Feb./March schedule. (2W and Ground Floor to start rotation positions were filled 3/10/03)

Assigned shift supervisors (3) to night shift on 3W, Gr. Fl. and to the evening shift on 2W who will be providing direct care. (These shift supervisors provide relief coverage for the Night and Evening Coordinators.)

Assigned RNs from 2E (Consolidated Unit):

1 Unit Coordinator to Gr. Floor (provides direct care)
2 to Ground (rotating)
1 to 2 West (rotating)
2 to 1 West (1 West has the Admission Suite and JCAHO mandates 24hour RN coverage)

RN recruiting is done continuously

1 new hire 3/10/03 for Gr. Floor
1 new hire 3/10/03 for 2 West
Awaiting acceptance to offer to applicant for night shift –2 West
Advertising for evening and night shift RNs

Recruitment and retention of RN's continues to be a facility priority as the shortage of RN's continues to grow nationally.

OIG Comment-(March 2004) *PGH has made considerable progress on accomplishing the goal of one RN per unit per shift through the implementation of a number of strategies.*

The Director of Nursing reviewed staffing configurations and adjusted staffing deployment in order to successfully increase RN coverage during the evening and night shift across the weekdays and more consistently on the weekends. A review of staff scheduling demonstrated that there were several shifts that did not maintain the desired coverage patterns, however, it was also noted that the frequency of RN coverage did difficulties compared to last year has been significantly decreased. This finding remains ***ACTIVE.***

SECTION TWO: ACTIVITIES OF THE PATIENTS/RESIDENTS

Finding 2.1: PGH has implemented a new program for patients on 1 West. Limited therapeutic programming was available for the patients on the other three units.

Recommendation: PGH needs to assure that programming is provided for all patients depending upon their level of functioning. Scheduled actives were reportedly not occurring due to staffing shortages. This needs to be reviewed.
DMHMRSAS Response:

For clarification purposes, it needs to be noted; the hospital has reviewed its Psychosocial Rehab staffing which is as follows:

3W – RT & MT (2 FTE)
2W – RT & MT (2.5 FTE)
1W – SMILE program
2 RT & 1 MT (2.0 FTE)
GF – AT & MT (1.5 FTE)
2 OT's going to all units (.5 FTE per unit)
Contracted Physical Therapy

On March 3, 2003 one of the RT's was absent and there was no coverage for his groups. We are reviewing coverage and how to provide coverage for activities in the event of staff absences.

In addition to the above staffing, each unit has group treatment programs provided by Nursing, Social Work and Psychology. During the past 60 days the Director of Rehabilitative Services has been working closely with the Nursing Department by having Rehabilitation Staff work cooperatively with the Clinical Nurse Specialists and Unit Coordinators on the other Units to plan and continue to schedule appropriate treatment Modalities, activities, and events for the patients. The Senior Recreation Center has been added to the Program Schedule for each Unit. The Occupational Therapist (2) will also plan and conduct psychosocial groups (Sensory Stimulation, ADL Training and Horticulture) in addition to assisting the CNS's with Feeding Programs. The Clinical Leadership Team does quarterly review of Active Treatment hours and adjustments are made to meet any deficits. (A copy of the report on active treatment hours is available for the date of the follow-up visit on March 3, which confirms the OIG observations.)

Individual Treatment Plans are developed by Multi-disciplinary Treatment Teams and implemented with consideration of the patients' level of physical and cognitive functioning.

NOTE: As indicated above, PGH has recently implemented a new Senior Recreation Center where patients can get off the unit and attend various programs. The Center modalities are available one day a week to patients from all units. In addition, forensic patients (housed on 3-West) attend every day. The program is designed to allow patients the freedom of choice in recreational, diversional / music and special events**.** The Center provides the opportunity for patients to interact with others outside of their present

environment, similar to centers in the community. A Sensory Stimulation Room is being developed with sensory lights and a large aquarium, which should be completed by the end of March. There will be four rooms set-up with activities scheduled and carried out in each of the rooms daily, based on patient's level of functioning. Pet Therapy, Gardening, and outside Entertainment Groups will be forthcoming. Unit based Program staff also have the opportunity to plan or request their own special activities or events for their patients on their scheduled days at the Center.

April 21, 2003 is our projected date to have completed the modification of our psychosocial treatment programs throughout the facility. We continually evaluate the effects of these programs on the outcome on their treatment goals.

OIG Comment – (March 2004) *Piedmont provides unit based active treatment programming as well as the SMILE program. In addition, the facility has started an on campus Senior Center, which provides recreational and diversional activities. Several of the patients are able to attend a day treatment program operated by the local community services board. This finding is* ***INACTIVE.***

SECTION THREE: ENVIRONMENTAL ISSUES

Finding 3.1: Tours of the facility revealed that the hospital was clean, comfortable and well maintained.

Recommendation: None.

DMHMRSAS Response: The Department appreciates the OIG findings related to the environment of care at this facility.

OIG Comment (March 2004) *– This finding was determined to be* ***inactive*** *at the time of the 2003 review.*

SECTION FOUR: APPLICATION OF PRINCIPLES OF BEHAVIORAL MANAGEMENT

Finding 4.1: PGH is currently reviewing and revising policies regarding behavioral treatment.

Recommendation: The OIG requests that this policy be forwarded for review upon its completion.

DMHMRSAS Response:
The draft of Behavior Treatment Policy (Hospital Instruction #47) is in final review with the Clinical Leadership Team. (Draft copy attached.) An Implementation date of April 1, 2003 has been set. The facility and the Department would welcome the comments of the OIG regarding this policy.

OIG Comments- (March 2004) *The OIG had the opportunity to review the policy and comments were submitted to the facility for consideration. This finding is* ***INACTIVE.***

SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
ACTIVE FINDINGS
REPORTS #62-02
UPDATED APRIL 2004

GENERAL CONDITION OF THE FACILITY

Finding 1.1: Tours of the facility demonstrated that the environment was clean, comfortable and well maintained.

Background: Members of the OIG staff completed a tour of the Bagley Building. This building houses both residential and treatment units for adolescents and adults. Since the OIG inspection in December 2001, the facility has successfully moved the 16-bed adolescent unit from the C Building. Staff reported that many positives have resulted from this move, such as a significant decrease in the use of seclusion or restraint.

The Bagley Building is nicely designed, and was noted to be clean, comfortable and well maintained. Patients reside in single or double rooms that share a bathroom with the adjoining suite. There are a number of rooms available for visitor meetings, small and larger group sessions, as well as a variety of activity spaces. Patients interviewed expressed feeling safe and believed the staff worked hard at meeting their needs.

Recommendation: Continue to focus on the provision of providing a safe and comfortable therapeutic environment.

DMHMRSAS Response: Southwestern Virginia Mental Health Institute will continue to focus on providing a safe, secure environment for the clients. The Security Enhancement

System, fully implemented last year, continues to provide enhanced patient safety. Security staff makes regular rounds on all shifts with emphasis placed on patient care and treatment areas. Security staff spend additional time in patient areas where acuity is the highest. Ensuring patient safety and comfort are maintained are areas of major focus at SWVMHI.

OIG Comment (November 2003) – Tour of the facility demonstrated that SWVMHI maintains its commitment to provide a safe, secure, comfortable and well maintained environment. The six patients interviewed all indicated that they felt safe within the environment and that staff, in general, and nursing in particular worked hard to address their needs. This finding was determined to be INACTIVE at the time of the POC response.

STAFFING ISSUES

Finding 2.1: Staffing patterns were noted to be consistent with facility expectations.

Background: Interviews and observation revealed that the facility was operating with staffing levels that met the facility expectation for adequate coverage on all of the units.

Staffing patterns noted during the day shift were as follows:

A/B Unit	4 RNs	5 CNAs	for 36 patients
C/D Unit	4 RNs, 1 LPNs,	6 CNAs	for 29 patients **(5 on constant observation)**
E/F Unit	2 RNs, 3 LPNs,	7 CNAs	for 38 patients
G Unit	1 RN	1 CNA	for 7 patients
H Unit	1 RN	3 CNAs	for 3 patients
I Unit	2 RNs, 2 LPNs,	3 CNAs	for 20 patients
J Unit	2 RNs	4 CNAs	for 19 patients

The review team's observations were that the staffing levels were appropriate and therapeutic for providing quality care to the patients. All of the 14 nursing staff interviewed indicated that overtime was noted to be minimal for August 2002. Staff were appropriately engaged in their duties and the interaction between staff and patients appeared positive and natural. Patients interviewed reported having opportunities to discuss concerns and problems with the staff. Nursing staff were identified as the most helpful by 14 of the 16 patients interviewed. Two indicated that they found social work staff to be the most helpful.

Recommendation: Maintain staffing patterns that meet facility expectations for patient safety and therapeutic involvement.

DMHMRSAS Response: This year, all staffing patterns for each unit at SWVMHI were reviewed and revised to establish adequate levels of appropriate nursing staff on a consistent basis across the week. This has assisted in more efficient use of nursing staff resources as well as enabling the Staffing Nurse Coordinators to deploy available staff to areas of highest acuity. A task force of direct care staff and nurse managers was formed two months ago and has met three times thus far to assist scheduling practices. **Several goals of this group are:**

- To promote staff ability to "self schedule" within certain parameters
- Maintain the needed staffing patterns.
- Consider weekend duty incentives as budgetary demands allow.

A standing Nursing Staffing committee continues to meet monthly membership includes:
- Facility Director
- Human Resources Manager
- Nursing/Human Resource employees.

OIG Comment (November 2003) – Direct observation, interviews and a review of staffing documentation demonstrated that the facility provides adequate staffing patterns consistent with facility policy. These provide for the treatment, supervision and safety concerns of the patients. The facility places an emphasis on recruiting staff whose credentials and backgrounds offer increased opportunities for enhancing clinical services. This finding was determined to be INACTIVE at the time of the POC response.

Finding 2.2: SWVMHI celebrated Nurses Appreciation Week through a variety of creative activities and events.

Background: SWVMHI celebrated Nurses Appreciation Week through a variety of creative activities and events designed to showcase the many talents of the nursing staff as well as demonstrate the facility's gratitude. Activities included poetry and other writings, a poster contest and a ward decoration competition among the nursing staff, daily snacks for each shift by private organizations and a reception in honor of nursing. A newsletter was issued outlining the activities and publishing several of the writings.

At the conclusion of the week, nursing management requested feedback from nursing staff. Although, nursing staff expressed an appreciation of the effort made by the facility, many took that opportunity to provide constructive criticism, which was reviewed by administration.

Recommendation: Continue to find ways of recognizing and supporting the nursing staff.

DMHMRSAS Response: **DMHMRSAS encourages the celebration of Nurses Week. At SWVMHI, employee work profiles for nurse managers are being revised to include an element related to positive recognition of staff that will be evaluated annually. An employee pole determined the following recognitions to be meaningful:**

- **"Employee of the month" plaques**
- **Letters published in the newsletter**
- **Food recognition events**
- **Opportunities in meetings to acknowledge achievements**

Quarterly Nursing Forums continue to be held, and staff input is acknowledged as appropriate.

OIG Comments (November 2003- Nursing administration does a commendable job in recognizing and supporting staff. They consistently initiate activities designed to recruit and retain qualified staff. This finding was determined to be INACTIVE at the time of the POC response.

PATIENT ACTIVITIES

Finding 3.1: SWVMHI continually reviews and implements programs that will enhance the principle of the recovery model throughout the facility.

Background: This facility offers a wide array of treatment activities throughout the day to best accommodate the needs of clients and limited space available. OIG team members observed five morning treatment activities. Four of the five were enrichment activities that had a goal of developing an interest of a patient, such as woodwork, horticulture, arts and crafts and an exercise program led by a recreational therapist. A fifth activity was conducted by the occupational therapist with the goal to learn better communication skills with an emphasis on goal setting and task completion. In addition, OIG staff was informed of the assignment of a Recreational Therapist to the adolescent unit. This person in conjunction with the evening staff nurse plans and executes structured recreational activities including a designated gym time. Nursing staff noted that with the increased evening activities there had been a decrease in the usage of PRN medications.

Not only has the facility expanded program offerings, efforts have been made to enhance rehabilitation staff skills in the key areas of the Boston Model through a quality management initiative. This initiative was established to incorporate previously learned skills by the rehabilitation staff into four quality component procedures. These include a review of staff skills in orienting, coaching, applying activity content and varying contextual support. The results of this performance improvement initiative demonstrated an enhancement of staff skills in all areas. It is the facility's goal to expand rehabilitation skills through trainings regarding the Boston Model to all the nursing staff. This will help the principles of the recovery model to generalize to unit management.

Recommendation: Continue efforts to broaden the principles of recovery within this facility.

DMHMRSAS Response: The Rehabilitation Department at SWVMHI continues to enhance and monitor the Psychiatric Rehabilitation (recovery enhancing) programs through an ongoing Quality Management program. Indicators this year continue to track Quality of Programs, Effectiveness of Programs and Patient/Staff Satisfaction with programs.

Employees are supported in becoming competent in the application of skills and technologies of rehabilitation service delivery through training and technical assistance. Specific Quality Management Indicators are as follows:

- Indicator #1 - Ensures, through supervision and coaching, that supervisors regularly observe and document the quality of practitioner's skills during the service delivery session.
- Indicator #2 - Documentation reviews to ensure standards of Treatment Planning, progress note documentation and that patient is progressing toward established objectives within designated time frames.
- Indicator #3 - gives patients and staff a survey tool by which they can express opinions specific to Rehabilitation programming.

Additionally, the Rehabilitation Department of SWVMHI continues to work closely with each Unit Director and Treatment Team in reviewing the menu of services, changing the components to meet patient needs. Recent additions to the provision of services include:

- **Individualized programming for the geriatric population**
- **Short-term fast tracked skill program for patients in the Admissions Unit**
- **Recovery readiness program for patients in the Admissions Unit**
- **Afternoon enrichment sessions for Extended stay patients**
- **Weekly LEAP (Leadership, Empowerment, and Advocacy Program) Consumers from the local Clubhouses assist SWVMHI patients gain skills and knowledge that will support re-entry to desired communities.**

OIG Comment (November 2003) - Interviews, reviews of programming schedules, direct observation and record reviews demonstrated that persons receiving care and treatment at SWVMHI have access to a variety of programming opportunities designed to enhance their skills for successful community living. This finding was determined to be INACTIVE at the time of the POC response.

OTHER FINDINGS

FINDING 4.1: Record reviews revealed that "safety net "crisis plans were not consistently developed for patients at the time of discharge.

Background: Five discharge records were reviewed. Of the five, three individuals were admitted to the facility on temporary detention orders. This requires a hearing to occur within 48 hours to determine if commitment to the facility continues to be warranted due to the person's level of dangerousness to himself or others or inability to substantially care for himself in the community. These individuals were discharged as a result of their commitment hearing. For example, one of the three individuals' profile was consistent with a high risk category of persons that successfully commit suicide. The facility did establish appropriate follow-up community appointments, but the earliest one was scheduled for six days after his discharge. There was not an indication in the record that staff had developed and discussed a crisis plan with this patient. This patient, because of no prior involvement in the mental health community, may represent a population that typically does not follow through with formalized treatment recommendations but may use natural support systems in times of trouble.

The discharge instruction forms used by the facility and community providers contains a section for the development of a written plan for crisis intervention but not one of them was completed in the five records reviewed. Any assessment at the time of discharge for the patient's ongoing level of risk needs to include availability of both professional and natural community supports. (Natural community supports include family, neighbors, social groups, faith communities, etc.) Helping the patient think through strategies for dealing with re-emerging feelings that were associated with the crisis (often suicidal plan or attempt) and are likely to recur upon discharge. Articulating this formally with the patient increases the likelihood that the person will use these supports constructively.

It makes good risk management sense for the facility to document in the hospital chart, this level of crisis planning with the patient at the time of discharge.

Recommendation: Develop and document crisis intervention plans as a routine part of the clinical discharge process.

DMHMRSAS Response: Discharge planning, including crisis planning is under the joint purview of the facility and the Community Service Board responsible for the client, SWVMHI has educated and reminded facility and CSB staff regarding the importance of including a crisis plan for all clients being discharged. The CSB After Hours Crisis number, is designated as the routine crisis plan by the Discharge Protocols for Community Services Boards and Mental Health Facilities and is included in all cases. Pursuant to Section 5.2 of the DMHMRSAS Discharge Protocols, "when specialized crisis plans are recommended, Facility Staff shall notify the CSB that a specialized crisis plan needs to be developed as part of the final discharge plan".
The facility will notify all CSBs in the region of this finding on the part of the OIG seeking to ensure responsiveness to the need for a crisis plan.

OIG Comment (November 2003) *– Interviews with staff and discharge record reviews indicated that the facility has made progress on working with the community services*

boards on developing and providing information to the patients regarding a plan of action following discharge in the event that a psychiatric emergency occurs. All of the records reviewed had a number for patients to call. Interviews with patients indicated that they would "probably not call a stranger" if the circumstances that resulted in their hospitalization occurs following discharge and before their appointments in the community. Most respondents indicated that they would notify a friend or pastor if they were feeling suicidal or homicidal. Helping the patient think through strategies for dealing with re-emerging feelings that were associated with the crisis (often suicidal plan or attempt) and are likely to recur upon discharge is an important discharge function. Articulating this formally with the patient increases the likelihood that the person will use these supports constructively. As the facility is not the designated party for completing this task, this Office will discuss resolution of this issue with Central Office staff. It will remain actively monitored by this Office.