COMMONWEALTH of VIRGINIA

Office of the Governor

Mark R. Warner
Governor

May 31, 2005

To the General Assembly of Virginia:

I am pleased to transmit the semi-annual report of the Office of the Inspector General for the Department of Mental Health, Mental Retardation, and Substance Abuse Services. This report summarizes the activities of this important office.

As Virginia continues to progress in improving care for persons with behavioral health care needs, the Office of the Inspector General plays a vital role. The independence and professionalism of this office continue to contribute to our joint efforts to provide world -class quality of care.

I trust that you will find this report informative and helpful. I look forward to continuing to work with the General Assembly in our ongoing reform of behavioral healthcare in the Commonwealth.

Sincerely,

Mark R. Warner

Mark R. Warner

MRW/wlm

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COMMONWEALTH of VIRGINIA

Office of the Inspector General

James W. Stewart, III
Inspector General
for
Mental Health, Mental Retardation &
Substance Abuse Services

May 31, 2005

To the General Assembly of Virginia:

The Office of the Inspector General (OIG) for Mental Health, Mental Retardation and Substance Abuse Services is pleased to submit this semi-annual report of activities for the period ending on March 31, 2005. This report is issued in accordance with the provisions of VA Code §37.1-256.1, which specifies that the Office report on significant activities and recommendations of the OIG during each six-month reporting period.

The mission of the OIG is to serve as a catalyst for improving the quality, effectiveness and efficiency of services for people and their families whose lives are affected by mental illness, mental retardation, and substance abuse disorders. The primary goal of the OIG during this period has been to complete the first systemic reviews of the five Mental Retardation Training Centers and the nine Mental Health Hospitals operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). In designing these two major projects every effort was made to seek input from a broad range of stakeholders. It is my belief that this inclusiveness has contributed to findings and recommendations that will be more meaningful to the Governor, the members of the General Assembly, and most importantly to the consumers and families who benefit from the system of services.

I am pleased to provide this summary of the activities of the Office of the Inspector General for your review.

Sincerely,

James W. Stewart, III
Inspector General

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

Semi - Annual Report
October 1, 2004 – March 31, 2005

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FOREWORD

The Office of the Inspector General (OIG) for Mental Health, Mental Retardation and Substance Abuse Services is pleased to submit this semi-annual report of activities for the period ending on March 31, 2005. 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.

During the past six months, the OIG completed a report of the first systemic inspection of the state Mental Retardation Training Centers and conducted the first systemic inspection of the state Mental Health Hospitals. A summary of these efforts is provided in this report.

The semi-annual report outlines the accomplishments of the OIG from October 1, 2004 through March 31, 2005. Information regarding the inspections that have been conducted at state facilities is included as well as summaries of other significant monitoring and review activities. It is through these activities that the OIG *"serves as a catalyst for improving the effectiveness, efficiency and the quality of services"* provided by the publicly funded mental health, mental retardation and substance abuse services system.

HIGHLIGHT OF ACTIVITIES

- **Ten unannounced inspections** were conducted at state facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS).

  Nine Primary Inspections were conducted at the following facilities:

  - Southern Virginia Mental Health Institute
  - Commonwealth Center for Children and Adolescents
  - Catawba Hospital
  - Western State Hospital
  - Piedmont Geriatric Hospital
  - Northern Virginia Mental Health Hospital
  - Central State Hospital
  - Eastern State Hospital
  - Southwestern Virginia Mental Health Institute

  One Secondary Review was conducted at:

  - Central State Hospital

  This report was not completed in time for the release of this semi-annual report and will be included in the next semi-annual report.

- **Twelve inspection reports were completed and released to the public.** All the reports completed can be found on the OIG website at www.oig.virginia.gov. Completed reports included:

  - Southside Virginia Training Center #102-04
  - Southeastern Virginia Training Center #103-04
  - Central Virginia Training Center #104-04
  - Southwestern Virginia Training Center #105-04
  - Northern Virginia Training Center #106-04
  - Systemic Review of the Training Centers #107-04
  - Southern Virginia Mental Health Institute #108-04
  - Commonwealth Center for Children and Adolescents #109-05
  - Catawba Hospital #110-05
  - Western State Hospital #111-05
  - Piedmont Geriatric Hospital #112-05
  - Northern Virginia Mental Health Institute #113-05

Reports for the following inspections that were conducted during this semiannual period have not been completed and will be placed on the OIG website as soon as they are released:

- Central State Hospital #114-05
- Eastern State Hospital #115-05
- Southwestern Virginia Mental Health Institute #116-05
- Systemic Review of the Mental Health Hospitals #117-05
- Central State Hospital Secondary #118-05

- The Office **reviewed approximately 590 critical incidents** during this six-month period. Additional information was requested for 82 of these incidents.

- The Office reviewed monthly quantitative data that was received from the sixteen DMHMRSAS operated facilities. **Six follow-up inquiries were completed** regarding this data.

- A formal **review of 4 DMHMRSAS Departmental Instructions and Regulations** was completed.

- A formal review was completed of the following DMHMRSAS regulation, 12 VAC 35-210-10 et seq., Regulations to Govern Temporary Leave from State Mental Health and State Mental Retardation Facilities

- The **Inspector General made 9 presentations** regarding the work of the Office and other topics at various conferences, statewide and local organization.

- Staff **participated in a number of statewide committees** and other activities related to the mental health, mental retardation and substance abuse service system.

- Staff **attended 11 conferences or training events** regarding issues relevant to the work of the Office.

- The Office of the Inspector General responded to **33 concerns, complaints and inquiries** from citizens, consumers and employees regarding a variety of issues during this reporting period.

- The Office of the Inspector General **reviewed the autopsy reports of 82 deaths** that occurred at DMHMRSAS facilities between January 8, 2004 – December 17, 2004.

VISION, MISSION, VALUES AND GOALS

The Office of Inspector General was created to provide an independent system of accountability to the Governor, elected officials, consumers and other stakeholders, regarding the quality of the services provided by the sixteen (16) DMHMRSAS operated facilities and the licensed providers in Virginia, as defined in § 37.1-179, including the licensed mental health treatment units in state correctional facilities.

During the past six months, the Office of the Inspector General reviewed and revised vision, mission and values that guide the work of the office.

Vision

Virginians who are affected by mental illness, mental retardation, and substance use disorders, and their families, will receive high quality, consumer focused services.

Mission

It is the mission of the Office of the Inspector General to serve as a catalyst for improving the quality, effectiveness, and efficiency of services for people whose lives are affected by mental illness, mental retardation, and substance use disorders.

Values to Guide the Work of the OIG

Consumer Focused and Inclusive
Quality Processes and Services
Integrity
Mutual Support and Teamwork
Respect
Creativity

Goals of the Office

Goal #1: Conduct oversight activities that monitor the quality of services provided in the mental health, mental retardation and substance abuse service delivery system and identify needed improvements.

Strategic Objective:

- Expand oversight activities of the OIG to include community providers by July 1, 2006

Goal #2: Influence actions that (1) improve organizational and service effectiveness, and (2) resolve public concerns and management challenges in the mental health, mental retardation and substance abuse service delivery system

Strategic Objective:

- Design and implement system(s) for assessing organizational effectiveness of facilities by July 1, 2006

Goal #3: Continuously improve the OIG systems for inspecting, monitoring and reviewing the quality of mental health, mental retardation and substance abuse services provided by state facilities and licensed programs.

Strategic Objectives:

- Redesign and implement the process for inspecting state facilities to enable more effective system-wide assessment and the formulation of recommendations that will improve care across all facilities by July 1, 2005.
- Improve the skills of OIG staff through targeted training of staff who have primary responsibility for conducting inspections by July 1, 2006

ACTIVITIES OF THE OFFICE

A. INSPECTIONS

The OIG conducted eleven unannounced inspections during this reporting period. This included ten primary inspections and one secondary inspection. The OIG performs at least one unannounced inspection annually at each of the DMHMHSAS operated facilities.

PRIMARY INSPECTIONS

The purpose of a primary inspection is to evaluate a broad array of components of the quality of care delivered by the facility and to make recommendations regarding performance improvement. Primary inspections are defined as routine comprehensive reviews of quality indicators such as the provision of active treatment within the context of the total environment of care. This includes, but is not limited to, the availability of adequate staff, the assurance of human rights and the adequacy of residents' access to medical care. The Office conducted primary inspections at Southern Virginia Mental Health Institute in Danville; Commonwealth Center for Children and Adolescents in Staunton; Catawba Hospital in Catawba; Western State Hospital in Staunton; Piedmont Geriatric Hospital in Burkeville; Northern Virginia Mental Health Institute in Falls Church; Central State Hospital in Petersburg; Eastern State Hospital in Williamsburg; and Southwestern Virginia Mental Health Institute in Marion.

SYSTEMIC REVIEW OF STATE MENTAL HEALTH HOSPITALS

During this semi-annual reporting period, the Office of the Inspector General conducted the first systemic review of the mental health hospitals operated by DMHMRSAS. These Hospitals provide services for children, adolescents and adults who have a primary diagnosis of mental illness or a dual diagnosis that includes mental illness. This review included a primary inspection of each of the nine hospitals. Each inspection was based on a series of nineteen Statements of Quality that were developed by the Office of the Inspector General with input from a broad array of stakeholders. These included the mental health facility directors, consumers, DMHMRSAS central office administrative staff, DMHMRSAS Office of Mental Health Services staff and directors of mental health services for community services boards (CSB). The report of the systemic review of the mental health facilities was not complete in time for inclusion in this semi-annual report.

The Statements of Quality on which the systemic review was based are as follows:

<u>Facility Management</u>

1. The facility has a mission statement and identified organizational values that are understood by staff.
2. The facility has a strategic plan.

3. The mission and strategic plan have been reviewed and are linked to the recently adopted DMHMRSAS Vision Statement.
4. There are systems in place to monitor the effectiveness and efficiency of the facility.
5. There are systems in place to assure that there is a sufficient number of qualified staff.
6. There are mechanisms for direct care staff and clinical staff to participate in decision-making and planning activities.
7. Facility leadership has a plan for creating an environment of care that values employees, assures that treatment of consumers is consistent with organizational values, and supports recovery principles for consumers.

Access

1. There are systems in place to assure that those admitted to the facility are appropriate.
2. The facility works collaboratively with CSB's to assure access to appropriate services when admissions to the facility are inappropriate or not possible due to census.

Service Provision

1. There are systems in place to assure that the patient receives those services that are linked to his/her identified barriers to discharge.
2. There are processes in place that support evidence-based practices.
3. The facility assures that service provision is grounded in the principles of recovery, self-determination and empowerment.
4. There are systems in place to measure the perceptions of consumers, families, direct care staff, clinical staff and administrative staff regarding the quality of the provision of care and services.

Discharge

1. There are systems in place for effective utilization review and management.
2. There are systems in place to assure that effective communication occurs between the patient, facility and community liaisons regarding discharge readiness in order to assure a smooth transition of the patient into the community and to prevent re-hospitalization.

Environment of Care

1. The physical environment is suitable to meet the individualized residential and treatment needs of the consumers and is well maintained.
2. There are systems in place to assure that the environment of care is safe and that consumers are protected.

Quality and Accountability

1. There are systems in place to assure that the services provided from the time of admission to discharge are quality services.

2. The facility has an accurate understanding of all of the stakeholders' perceptions regarding the services provided by the facility.

SECONDARY INSPECTION

A secondary inspection is conducted in response to a specific concern or complaint received by the OIG. Secondary inspections often involve confidential information regarding consumers or employees. As a result, these reports are not released to the OIG website. One secondary inspection was completed at Central State Hospital during this reporting period.

B. REPORTS

The OIG completed ten reports during this six- month period. Reports are generated as a tool for performance improvement and provide the Governor, General Assembly and DMHMRSAS with findings and recommendations regarding observations related to 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 by the OIG until successful resolution has occurred. A report is not considered complete until a plan of correction has been approved and the full report forwarded to and approved by the Office of the Governor. These reports can be found on the OIG website at www.oig.virginia.gov

The following reports were completed on inspections that occurred during the previous semiannual period and released to the OIG website during this semiannual period:

Southside Virginia Training Center	#102-04
Southeastern Virginia Training Center	#103-04
Central Virginia Training Center	#104-04
Southwestern Virginia Training Center	#105-04
Northern Virginia Training Center	#106-04
Systemic Review of the Training Centers	#107-04

The following reports were completed on inspections that occurred during this semiannual period and have been released to the OIG website:

Southern Virginia Mental Health Institute	#108-04
Commonwealth Center for Children and Adolescents	#109-05
Catawba Hospital	#110-05
Western State Hospital	#111-05
Piedmont Geriatric Hospital	#112-05
Northern Virginia Mental Health Institute	#113-05

Reports for the following inspections that were conducted during this semiannual period have not been completed and will be placed on the OIG website as soon as they are released:

Central State Hospital	#114-05
Eastern State Hospital	#115-05
Southwestern Virginia Mental Health Institute	#116-05
Systemic Review of the Mental Health Hospitals	#117-05
Central State Hospital Secondary	#118-05

C. DATA MONITORING

Critical Incident Reports

Documentation of critical incidents as defined by Virginia Code *§ 2.1-817* is forwarded routinely to the OIG for review and monitoring. Approximately 590 critical incident (CI) reports were reviewed during this semiannual period. The OIG conducted an additional level of scrutiny and follow up for 82 of the CI's that were reviewed. The information gathered from the additional inquiries was used to identify potential problems within state facilities and to track trends in areas of concern.

Quantitative Data

In order to track potential areas of risk within the facilities on a routine basis between periodic inspections, the OIG receives monthly statistical data from each of the 16 DMHMRSAS operated facilities. Over time the tracking of this information has enabled the development to trends within each facility. Areas that are monitored through this in this way include, but are not limited to, facility census, seclusion and restraint use, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect. During this six-month reporting period, the office identified 4 areas of concern from this data and initiated requests for clarification. All of the responses provided by the facilities were satisfactory.

The OIG has initiated meetings with DMHMRSAS Human Resources, Fiscal, and Facility Operations personnel to review this data to determine if changes in the data elements that are required will enable more effective monitoring of the facilities.

D. 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 patients; or a review of policies, procedures, memoranda, medical records, meeting minutes, or other documents.

CVTC submitted a follow-up plan for all outstanding findings during this reporting period. The OIG is currently tracking 88 findings that have not been resolved as of March 31, 2005.

E. REVIEW OF DEPARTMENT INSTRUCTIONS AND REGULATIONS

During this semi-annual reporting period, the OIG reviewed and made comments on the following Departmental Instructions and Regulations:

- DI 211, Use of Seclusion and Behavioral Restraint in DMHMRSAS Hospitals
- DI 305, Blood borne Pathogen Exposure Control Plan and 306 TB Control Plan
- DI 509, Employee Educational Assistance and Leave Draft Proposed Regulations
- 12 VAC 35-210-10 et seq. Regulations to Govern Temporary Leave from State Mental Health and State Mental Retardation Facilities

F. PRESENTATIONS AND CONFERENCES

Inspector General Stewart made presentations regarding the work of the office or served as the guest speaker for the following:

- A local church group regarding the development of the MH/MR/SA service system and the work of the OIG
- Staff of the House Appropriations Health and Human Services Subcommittee
- Staff representative from the VCU Medical College Department of Psychiatry.
- Grand Rounds at both Western State Hospital and Commonwealth Center for Children and Adolescents
- Governor's Conference, *Envision the Possibilities: Self-Determination, Empowerment and Recovery.*
- Legislative conference of the Virginia Association of Community Service Boards (VACSB)
- Moderator for the *Richmond Behavioral Health Authority, Henrico Area MH and MR Board, and Chesterfield Community Services Board: Joint Launch Event for Network of Care.*
- NAMI – CVA
- State Facility Nursing Executives

Staff of the OIG participated in the following conferences and trainings events:

- NAMI-VA's 20th Annual Convention
- Virginia Executive Institute
- Fall Conference of the Association of Inspectors General
- National Inspector General Certification Institute
- Governor's Conference, *Envision the Possibilities: Self-Determination, Empowerment and Recovery*

- Leading Educating and Developing (LEAD) course
- Governor's Conference and Network Symposium: Beyond Psychology

G. MEETINGS

The OIG participated in a variety of forums and on various committees that address issues relevant to mental health, mental retardation and substance abuse issues and to state government:

- Virginia Association of Community Services Boards
- Joint meeting of the CSB executive directors and the facility directors
- Integrated Strategic Plan Leadership Meeting
- County Behavioral Health Institute (CBHI) Board of Director's
- DMHMRSAS Central Office workgroup on investigation methods
- Code Commission Meetings
- DMHMRSAS System Leadership Council
- DMHMRSAS Restructuring Advisory Committee
- Human Rights Regulations Revision Advisory Group

H. INTERFACING WITH OTHER AGENCIES

The OIG staff met with the following agencies and organizations for the purpose of planning specific OIG projects:

- Consumer and family groups
- Community Services Boards
- MR Training Center and MH Hospital staff
- DMHMRSAS leadership and operations staff
- Staff of the General Assembly

I. COMPLAINTS, CONCERNS AND INQUIRIES

The Office of the Inspector General responded to 33 concerns, complaints and inquiries from citizens, consumers and employees regarding a variety of issues during this reporting period. Of these contacts, 9 were complaints or requests for information regarding community programs, 11 were complaints regarding facilities operated by DMHMRSAS, 13 were requests for information or assistance.

ADDENDUM A

COMPLETED FACILITY REPORTS
October 1, 2004 – March 31, 2005

SYSTEMIC REVIEW OF THE TRAINING CENTERS

A systemic review of the five Training Centers operated by DMHMRSAS was conducted during the last semiannual reporting period. This consisted of a primary inspection of each of the following facilities:

Southside Virginia Training Center / August 19-20, 2004
Southeastern Virginia Training Center / September 2-3, 2004
Central Virginia Training Center / September 8-9, 2004
Southwestern Virginia Training Center / October 8-9, 2004
Northern Virginia Training Center / October 13-14, 2004

Because the written reports for these inspections were not completed in time to be included in the last semiannual report, they were distributed during the October 2004 to March 2005 reporting period. The recommendations and DMHMRSAS responses for the five inspections and the systemic report are provided below.

SYSTEMIC REVIEW OF TRAINING CENTERS
OIG REPORT #107-04

Recommendation #1: It is recommended that each training center review it's mission statement and make any needed changes to assure consistency with the system-wide vision statement adopted recently by DMHMRSAS. Once this is done, each facility should review its strategic objectives and initiatives to assure that these are consistent with the system vision statement and revised facility mission statement.

Recommendation #2: It is recommended that each facility develop a clearly stated set of values or principles that are consistent with the system vision statement. The purpose of these values or principles will be to guide how services are delivered to residents and how the facility will relate to the broader system of care. Once these statements are established, each facility should take the necessary steps to assure that the actions of staff at all levels and the culture of the facility reflect the value or principle statements.

> *DMHMRSAS Response: Because of the inter-relatedness of these two recommendations, DMHMRSAS responses to OIG recommendations 1 and 2 are combined. The Assistant Commissioner for Facility Management will assure that each MR facility has received copies of the Department's mission, vision, and values statements. Each training center will review their vision and mission*

statements for consistency with those of the DMHMRSAS. A meeting will be called with the training center Directors and other representatives to review each MR facility's mission statements, strategic objectives and initiatives, guiding values and principles, and staff training methods. The goals of this initiative are threefold:

1.) *to ensure that facility mission statements are consistent with the system's vision and mission statements;*
2.) *to ensure the facility has a clearly stated set of values and principles that are consistent with the system vision and that will guide both service delivery to consumers and facility relationships with external partners in the service system;*
3.) *and to identify actions necessary to assure that each facility's culture and staff behaviors reflect those values and principles*

Recommendation #3: It is recommended that DMHMRSAS establish a statewide policy that clarifies the role of the training centers in providing emergency services to consumers with mental retardation who demonstrate severe behavior management problems and consumers who are dually diagnosed with mental retardation and mental illness. This policy should state clearly what conditions are appropriate for emergency admission, which are not and when it is appropriate for an individual with either of these conditions to be admitted to a state mental health hospital.

DMHMRSAS Response: The Department has initiated a comprehensive effort within the regions (Regional Partnerships) to develop strategic directions and an integrated strategic plan for both MH and MR services. For MR, the Regional Partnerships will address: a.) changes in utilization of training center and community ICF/MR beds; and the community services and supports that must be created or expanded to meet need by the end of each of the next three biennia (FY 06-08, FY 08-10, and FY10-12). Each region will consider required state facility capital infrastructure costs in deciding the specific types, amounts, and location of services as well as current healthcare markets and projected population and demographic changes. The MR Special Populations Workgroup has been charged with developing a methodology to assist each Regional Partnership as it examines future need for ICF/MR beds and other MR services needed. Clarification of the role of state training centers and the populations that they will serve will be an important part of the Regional Partnership discussions and planning.

Addressing the needs of consumers with mental retardation who demonstrate severe behavior management problems and those who are dually diagnosed with mental retardation and mental illness (MR/MI) has been a concern of the Department. At the regional level, training center staff, psychiatric facility staff, and Community Service Board (CSB) staff have been engaged in a collaborative effort to determine the most appropriate services and placement for this population. This is done both on a case-by-case basis as well as on a regional planning level.

The Division of Facility Management, in collaboration with the Office of Mental Retardation, and the Regional Partnership representatives will review recommendations made by the MR Special Populations Work Group and work with the Facility Directors and CSBs to examine regional need for, and access to, facility emergency services by this population and others. This will include identification of barriers to access as well as outcomes of requests during FY 2004 and the first half of FY 05; and will include development of action steps as indicated. Target date for completion is May 30, 2005.

The State Board for DMHMRSAS has promulgated two policies pertaining to services to consumers with dual diagnosis: Policy 1015(SYS) 86-22, Facility and Community Services Board Services to Persons who have Co-occurring Mental illness, Mental Retardation, and/or Substance Abuse (MICA, Mentally Ill Chemical Abusers, SA/MH, MH/MR, SA/MR or MH/MR/SA); and Policy 1017(SYS) 86-31, Facility and Community Services Board Services to Persons with Mental Retardation and Mental Illness). Copies of these policies are attached for OIG review. These policies were last updated in 1993 and 1992, respectively.

State Board Policy 1015 posits the responsibilities of State facilities and CSBs "for ensuring, within available resources, that persons who have co-occurring mental illness, mental retardation and/or substance abuse disorders receive the services they require and to charge the Department with policy implementation" (page2). This policy emphases the provision of appropriate, comprehensive assessments, pre-screening and services throughout the system of care; provision of integrated, coordinated care that meets individual needs; and encourages development of programs for persons with multiple impairments.

State Board Policy 1017 posits facility and CSB responsibility specifically to ensure that individuals with mental retardation and mental illness receive necessary services. This policy states:
"… If pre-screening and evaluation indicate that a mentally retarded individual requires inpatient hospitalization for acute stabilization of a mental disorder which cannot be provided in any less restrictive setting, such inpatient hospitalization is provided by the State hospital system. … Training Centers will be responsible for coordinating services for the less intensive mental health needs of their residents with mental illness if their disorder does not require inpatient psychiatric hospitalization" (page 2).

These policies are due to be reviewed and updated. Revisions to reflect more person-centered language and to better address current practices are indicated. Because of recent turnover from new appointments, the State Board has not been able to address review as yet. To facilitate a timely update, a collaborative review of these policies first will be conducted internally by the DMHMRSAS program Offices (Mental Health, Mental Retardation, Substance Abuse Services), Operations/QA, and Planning and Development as well as by the MH and MR

Facility Directors, or designees. The Associate Commissioner for Facility Management will convene and coordinate this review. Recommendations for revisions will be developed and forwarded to the State Board by September 1, 2005.

Recommendations #4: It is recommended that DMHMRSAS conduct a study to determine the appropriate staffing ratio for direct care workers and professional clinical and rehabilitation positions in the training centers before efforts are made to significantly alter staffing patterns. This study should take into account the changes in population served and census that have occurred in the facilities over the past decade since the Department of Justice (DOJ) settlement agreement with NVTC was established.

DMHMRSAS Response: The Department has been monitoring staffing needs of all training centers during formulation of the NVTC/Department of Justice (DOJ) settlement agreement as well as on an on-going basis since that Agreement. Unlike NVTC, the other Training Centers did not receive sufficient funding to meet the staffing ratios in the agreement. DMHMRSAS annually has submitted a request to the Department of Planning and Budget and /or the General Assembly for funding positions for direct care workers, professional clinical staff and rehabilitation staff. In making these requests, comparisons were made between current staffing levels and those established in the NVTC/DOJ settlement agreement. Exploration of national staffing models for state training centers has been conducted. However, no standard ratios were found; and the NVTC/DOJ ratios were adopted.

To more fully address staffing needs at the training centers, the DMHMRSAS has been collaborating with the facilities as well as our Office of Human Resource Development. Two current initiatives focus on Relief Factor and patient acuity. Examination is underway of the amount of Relief Factor needed to ensure appropriate coverage for direct care services. Relief factor is a numerical value used to calculate the number of persons needed to cover a position 24 hours, seven days a week. Determination of the relief factor involves calculation of many variables that impact coverage (e.g., all types of leave, training time, workman's compensation, among others).

A related initiative is examination of standardized, validated methods for determining consumer acuity of needs, which is a fundamental indicator for determining staffing levels. At this time, the Department is examining adoption of the Supports Intensity Scale (SIS), which is an assessment tool developed exclusively to help identify and measure the support needs of adults with mental retardation. The SIS was developed by, and is available through, the American Association on Mental Retardation (AAMR). Staff training by AAMR recommended trainers would be necessary to ensure reliability. The data gleaned would provide an indication of consumer clinical acuity that then could be used to determine staffing needs at each facility relative to population change.

Recommendation #5: It is recommended that SEVTC take immediate steps to drastically decrease or eliminate the use of isolated time-out. It is further recommended that DMHMRSAS conduct a study to determine whether or not the use of isolated time-out can be discontinued in all training centers.

> *DMHMRSAS Response: The DMHMRSAS has over the past several years been committed to the successful reduction of seclusion and restraint. Relative to the findings related to the SEVTC, the Assistant Commissioner for Facility Management will convene a meeting with representatives of the Office of Facility Operations/ QA, the Office of Health and Quality Care, the Office of Risk and Liability Affairs, and MR Facility Directors and their representatives to examine best practice alternatives to the use of isolated time out and undertake an analysis of alternatives used in other facilities. A series of recommendations to the MR centers will result. Target completion date is October 2005.*

Recommendation #6: It is recommended that DMHMRSAS take steps to enable more consistent reporting of critical incidents so that the variable staffing pattern for medical personnel among the five training center no longer causes inconsistent reporting.

> *DMHMRSAS Response: The Director of the Office of Risk and Liability Affairs and the Director of Facility Operations will be meeting in March 2005 with Risk Managers from all state facilities to examine this recommendation. The Code of Virginia related to reporting of critical incidents (Section 51.5-39.12) requires the reporting to the Virginia Office of Protection and Advocacy (VOPA) of a critical incident defined as death or a serious bodily injury requiring medical treatment. Agreement with VOPA has defined medical treatment to be that treatment provide by a physician or an extender.*
>
> One of the MR Training Centers, CVTC, as indicated in the OIG report, continues to be an outlier in physician handling of critical incidents. CVTC is the only MR facility, which is a certified as a skilled nursing facility thus having physician capability around the clock to handle such cases. Thus, they do not have to maintain prn or standing orders. The Department will be re-visiting once again the reporting requirements and operational definitions of " serious bodily injury" and "medical treatment". CVTC will also be examining internal policies and practices regarding critical incident reporting as part of its participation with the above referenced group with the intent of altering policy. Final recommendations and actions will be forthcoming by August 1,2005.

Recommendation #7: It is recommended that DMHMRSAS continue to advocate for an increase in the number of Mental Retardation Medicaid Waiver slots that are dedicated to training center discharges in order to enable residents who have been determined clinically ready for discharge and who wish to live in the community to be discharged. It is further recommended that DMHMRSAS continue to advocate for additional Mental

Retardation Medicaid Waiver slots for the community in order to address community need and to prevent unnecessary admissions to the training centers.

> *DMHMRSAS Response: As the Inspector General's report has noted, DMHMRSAS is committed to promoting choice and the highest possible level of participation in work, relationships, and all aspects of community living for consumers. The Department has vigorously advocated, and will continue to advocate, for additional Medicaid Waiver slots dedicated to training center consumers who are determined clinically ready for discharge and who wish to live in the community, and for additional slots for communities to address community need and to prevent unnecessary admissions to the training centers.*

Recommendation #8: It is recommended that DMHMRSAS conduct specific system-wide comprehensive planning that will clarify the population to be served, the types of services to be delivered, the projected census, and the type of physical plants needed for the training center system in the future before decisions regarding significant capital improvement projects are made. This planning process should include broad stakeholder involvement.

> *DMHMRSAS Response: As reported in our response to recommendation #3, the MR Special Populations Workgroup has been charged with developing a methodology to assist the Department's comprehensive planning for the MR population. Included in this workgroup are parent, advocate, private provider, state facility and CSB representation. More recently, a representative of the Department's Office of Architecture and Engineering has been added to the workgroup. The methodology, when applied in the regions, should provide data that identifies projected census, population(s) to be served, and services at the Training Centers. Concurrently, a review of physical plant design development is being undertaken. Since form follows function, the plant design process also will require identification of the specific populations to be served. The result of this work will be integrated into the Capitol Improvement submissions, which will be due to the Governor in June 2005.*

Recommendation #9: It is recommended that each training center develop a process for routinely seeking evaluative comments from consumers, families and community providers regarding the quality of services provided by the facility, the effectiveness of the facility's relationship with the broader provider service system, and general satisfaction with services.

> *DMHMRSAS Response: The Department recognizes the importance of feedback from family members, consumers and community providers in the continuous quality improvement efforts for MR facilities. Thus, the Office of Mental Retardation will collaborate with the Office of Facility Operations/QA in convening a group of facility representatives, advocates, family members and providers. The purpose of this group will be to develop instruments that provide facilities and the Department with a broad range of information and feedback*

concerning service quality and effectiveness. As part of this process, each facility will identify current mechanisms in place for receiving feedback, and will determine revised or new methods to enhance feedback opportunities that are most useful to its region and its stakeholders. It is anticipated that testing of these instruments could occur in September 2005.

SOUTHSIDE VIRGINIA TRAINING CENTER
OIG REPORT #102-04

There were no findings or recommendations associated with this report.

SOUTHEASTERN VIRGINIA TRAINING CENTER
OIG REPORT #103-04

Finding 1: The majority of staff interviewed, including administrative, clinical and direct care staff, indicated that the facility did not have a formalized mission statement.

Recommendation: It is recommended that SEVTC develops a mission statement with broad-based staff participation and assure that the mission statement is consistent with the system-wide DMHMRSAS Vision Statement.

DMHMRSAS Response: SEVTC's leadership staff will work the initiative undertaken within the Department's Division of Facility Management as noted within our response to the systems recommendations to assure their mission, vision and values are consistent with that of the Department. They will collaborate with the other MR Facility Directors to identify training and actions needed to assure the facility culture reflects the mission, vision and values of the Department. The target date for this initiative is June 30,2005.

Finding 2: SEVTC used isolated time-out 529 times during 2004. The maximum number of times any of the other 4 training centers used this most restrictive technique during the same period was 15 times. One of the other four training centers has been able to eliminate the use of use of isolated time-out and has banned the use of the technique.

Recommendation: It is recommended that SEVTC take immediate steps to drastically decrease or eliminate the use of isolated time-out.

DMHMRSAS Response: (See DMHMRSAS response to this recommendation within systems recommendations) The Department would also like to point out that three individuals accounted for a majority of the ITO occurrences in 2004. Program data for two of those individuals shows significant progress later in the year. In fact, during the last quarter of 2004, these two individuals had a combined total of just ten occurrences. The team at SEVTC continues to work with the third individual. Center interdisciplinary teams will review all residents with programs that include isolated time-out with a goal of decreasing use of this procedure during 2005.

In addition, SEVTC will participate in an initiative undertaken by the Central Office of Health and Quality Care (OHQC), which in part will determine the reasons why SEVTC is an outlier relative to the use of isolated time out and will examine best practices in addressing challenging behaviors. A series of recommendations will be forthcoming from the work with the OHQC by October 2005. SEVTC is being encouraged to obtain case consultation and technical assistance through the OHQC regarding cases with the highest use of Isolated Time out. These efforts will be on going through 2005.

Finding 3: There was evidence that Building 28, in particular, and the grounds, in general were not well maintained during the time of the facility inspection.

Recommendation: It is recommended that SEVTC develop a specific mechanism for tracking the condition and maintenance of Building 28 as this residential unit has been and continues to be the site with numerous environment of care issues.

DMHMRSAS Response: The Buildings and Grounds Department at SEVTC, which includes Maintenance and Housekeeping, makes routine rounds to assure that cottages and grounds are maintained appropriately. Quarterly surveys are done of staff for their input on services. The Safety Program also includes Building 28 on a rotating basis with the others in Safety Rounds looking for dangers to residents and staff. Each of these programs will focus closer attention on Building 28 and make more routine rounds of both inside and outside the building effective February 14, 2005. A Quality Management pinpoint at SEVTC will be added to the current QM Plan to monitor these activities. Works orders will be immediately generated from these rounds for any item that is broken, dirty, or a safety hazard.

Finding 4: Despite the fact that each shift did have on duty the number of staff that are called for in the facility's established staffing ratio, staff deployment during certain activities observed by the OIG was not sufficient to create a treatment environment that engaged residents in training/treatment programs and met the individualized training needs of the residents in a consistent manner.

Recommendation: It is recommended that SEVTC review staffing patterns and deployment of staff to assure that the complement available allows for the active treatment of residents at all times.

DMHMRSAS Response: The SEVTC Program Director and Quality Manager will evaluate staff competencies to assure active treatment is occurring in cottages. Where skill sets are deficient related to the provision of active treatment the Program Director will meet with the Training Director to identify a training plan to assure a time frame for staff to obtain training. These activities will be completed by June 30, 2005. The facility will also gradually reduce the resident census by a minimum of 8 beds in order to improve staffing ratios as agreed

earlier in this year. As recommended, SEVTC will continuously review deployment of staff to assure individualized resident needs relative to supervision and treatment planning and will be able to demonstrate staff redeployment based upon need at any given time.

Finding 5: Space for vocational programming and other non-residential unit training activities is not adequate.

Recommendation: It is recommended that DMHMRSAS place the highest priority on adding additional facility space for vocational programming and other non-residential unit training activities.

DMHMRSAS Response: SEVTC's residents and staff would benefit from additional space tailored for vocational training and employment to include industrial/production workspace, materials delivery and storage space, and facilities for recycling. Significant improvements of this nature are difficult given current fiscal limitations. SEVTC will seek ways of improving the utility of space currently available. This internal review will be completed by June 30th, 2005. Additionally, the Department's 2005 Capital Budget submission includes funds for renovation and construction of three new residential buildings. Within that project space will be allocated for vocational programming. The Capital submission will be forwarded to the Governor by June of 2005.

CENTRAL VIRGINIA TRAINING CENTER
OIG REPORT #104-04

Finding 1: The majority of staff interviewed indicated that the facility did not have a formalized mission statement.

Recommendation: It is recommended that CVTC develops a mission statement with broad-based staff participation and assure that the mission statement is consistent with the system-wide DMHMRSAS Vision Statement.

DMHMRSAS Response: CVTC has begun the strategic planning process initiated by the Facility Director with all Departments and levels of staff to gain input and agreement on what CVTC's mission, vision and value statement should look like. This process began in December 2004 and drafts are presently being formulated.

In addition, the facility will work with the initiative undertaken within the Department's division of Facility Management as noted within our response to the systems recommendation. (See Systems Recommendations 1 and 2.) They will collaborate with the other Mental Retardation Facility Directors to identify training and actions needed to assure the facilit8y culture reflects the mission and vision of the Department. Target date for completion of this initiative is June 30, 2005

Finding 2: A majority of the residents at CVTC have been diagnosed with mental retardation, unspecified.

Recommendation: It is recommended that the facility review the current diagnosis of its residents to determine if a level of functioning and severity of mental retardation can be determined.

DMHMRSAS Response: CVTC has begun a process of reevaluation of the mental retardation diagnoses documented in the medical records. This is done through the ID Team process with the psychologist, psychiatrist and other IDTeam members input into the evaluations, thus this will take a full IHP cycle to complete all individuals who live at CVTC. An estimated target date of completion would be October 2005.

SOUTHWESTERN VIRGINIA TRAINING CENTER
OIG REPORT #105-04

Finding 1: Space for vocational programming and other non-residential unit activities is not adequate.

Recommendation: It is recommended that DMHMRSAS place the highest priority on adding additional facility space for vocational programming and other non-residential unit activities.

DMHMRSAS Response: The Department recognizes that SWVTC's residents would benefit from additional space tailored for vocational programming. Improvements of this nature are difficult given current fiscal limitations. However, the Department's 2005 Capital Proposed Budget includes funds for renovation and construction of residential buildings that will accommodate vocational programming space.

NORTHERN VIRGINIA TRAINING CENTER
OIG REPORT #106-04

There were no findings or recommendations associated with this report.

SYSTEMIC REVIEW OF THE MENTAL HEALTH HOSPITALS

During this reporting period, the OIG conducted a systemic review of the nine DMHMRSAS operated Mental Health Facilities. This review included a primary inspection of each mental health hospital and institute. Six of the nine individual facility reports had been completed by time this semiannual report was prepared. Findings, recommendations and DMHMRSAS responses for these six inspections are provided below. The remaining three reports and the systemic report will be completed in the coming months.

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE OIG REPORT #108-04

Finding #1: The majority of consumers who were interviewed by OIG staff during the inspection reported that they do not feel safe in the facility environment. The explanations provided by these consumers included:

- Negative interactions between staff and consumers
- Negative or disruptive behaviors of other consumers
- Threats which are described as racial in nature

On several occasions during the inspection, members of the OIG team observed or were told about specific incidents that were representative of all three of these explanations. In addition, the majority of direct care staff who were interviewed by the OIG team had difficulty defining the values that govern the work of the facility and how staff is to relate to consumers.

> Recommendation: It is recommended that SVMHI assess its organizational culture with the assistance of outside experts to determine why consumers do not feel safe and what steps will be required to correct this problem. Once this assessment is complete, the facility should develop an action plan to implement the identified steps. This plan should also include clarification of the organizational values or principles that guide how the staff is to relate to consumers, establish a training program for both new and existing staff related to these values, and establish an ongoing system for monitoring the extent to which staff's actions are consistent with these values.
>
> *DMHMRSAS Response: As part of an on-going process to identify concerns of consumers served at SVMHI, the Executive Director has been holding monthly meetings with consumers; and the Administrator-on-call has regularly made "walk-through" rounds on all shifts (including weekends and holidays). In addition to continuing these activities, SVMHI will establish a special team to hold individual interviews with patients to explore in-depth patients' felt personal safety and to identify incidents involving staff and/or peers that threatened their*

sense of safety. The team will be comprised of the facility's Human Rights Advocate, at least one consumer from the SVMHI Members Advisory Group (which has one patient representative from each unit), and a member of the Local Human Rights Committee. This team will report their findings to the SVMHI Executive Director and to the state Director of the Office of Human Rights by July 1, 2005. Based on these findings, the facility Administrative Team will develop and implement corrective actions, as indicated.

Within the next week, SVMHI also will assign the Administrator-on-Call to: 1.) observe staff-to-patient and patient-to-patient interactions; and 2.) speak with staff about the OIG findings as well as explore any incidents about which they are aware that affect patient feelings of safety. These activities will be used as opportunities for impromptu education sessions about facility values, recovery principles, and potential interventions. The Administrator-on-Call will report weekly the findings and issues to the facility Executive Director and members of the Administrative Team at the regularly scheduled Administrative Team meeting by July 1, 2005.

The results of these processes will then help determine milieu and organizational dynamics that may be contributing to consumers' perceived lack of safety. SVMHI is, and has been, committed to ensuring a treatment environment that is safe and free of physical/verbal harm for consumers; and to ensuring that staff interactions and interventions are congruent with the Vision and the Mission of both this facility and the DMHMRSAS. As indicated, SVMHI Administrative Team will take appropriate actions, including reporting any Human Rights violations and investigating any suspected patient abuse or neglect. The Administrative Team, as indicated, will obtain assistance from external experts to develop a plan for improving staff understanding of organizational values, for better equipping them with skills to interact with our consumers within the framework of our values, and for developing a methodology to monitor outcomes of any corrective actions.

Finding #2: Consumer engagement and participation in the psychosocial rehabilitation programming (PSR) sessions observed was very limited. The OIG observed three different PSR groups. One group was cancelled because no consumers showed up. In the second group, 5 of the 10 consumers assigned to the group left in the middle of the session. The third session began late due to a change in staff leadership. As a result, the majority of consumers in all 3 groups failed to experience active treatment and/or skill development.

Recommendation: It is recommended that the facility develop a workgroup that involves consumers, clinical staff and direct care staff to review active treatment programming in the facility and develop strategies for improving the effectiveness of the PSR program.

DMHMRSAS Response: SVMHI concurs with the OIG recommendation. As noted in the OIG report, SVMHI staff had recognized a need to improve PSR

groups and improve consumer participation in them: and a group of clinical staff and direct care staff, under the leadership of our Trainer and Instructor III, visited sister psychiatric facilities to identify "best practices" in PSR. Based on those visits and the needs of our consumers, a PSR Committee was formed to restructure the PSR program. The PSR Committee currently is comprised of: representatives from unit nurses, Activity Therapists, Social Workers, and Psychologists; the PSR Coordinator. Consumer involvement will be added from the Member Advisory Group to the PSR Committee as the planning for restructuring the PSR program begins. The PSR Committee will regularly review attendance data and will identify key PSR components and processes needed for improvement. The Committee will report its recommendations to the Administrative Team through the PSR Chairman, who is a standing member of the Team, by July 1, 2005.

COMMONWEALTH CENTER FOR CHILDREN AND ADOLESCENTS OIG REPORT #109-05

Finding #1: Over the past several years, there have been significant changes in the facility's utilization patterns:

- The number of admissions annually increased 8.6% over 10 years from 441 (FY 95) to 479 (FY 04).
- The average length of stay (ALOS) decreased 33% over 10 years from 41.2 (FY 95) to 27.6 (FY 04).
- In 2004, the facility was able to prevent state hospitalization of 50% of the requests for admission (503 of 1002 requests) because applicant's had private insurance, applicants did not meet acute hospitalization criteria, or bed space could be located in the community.

As a result:

- The annual average daily census (ADC) dropped 24.4% over 10 years from 45 (FY 95) to 34 (FY 04).
- The ADC dropped 27% over the past 5 years from 37 (FY 01) to 27 (first 9 months of FY 05).
- With an average ADC of 33.8 over the past 5 years, the facility has operated at 70.4% of it's 48 bed capacity from FY 01 through the first nine months of FY 05.
- The number of days in which the census exceeded 75% of capacity dropped from 43.8% in FY 03 to 9.15% in the first nine months of FY 05.
- The current staffing ratios when calculated against the ADC of 33.8 over the past 5 years reveal the following:

	Current Complement	Staff to Consumer
Psychiatrist	4	1 to 8.5
Psychologist	5	1 to 6.76
Social Worker	10	1 to 3.38
Activity Therapist	4	1 to 8.5
Nurse Manager	3	1 to 11.4

- The cost per bed day as reported by the facility is $1,019. This is the highest daily cost of all 16 facilities operated directly by DMHMRSAS.

Two of the major factors that have enabled this significant decrease in the utilization of CCCA include effective diversion to community alternatives and successful utilization management by the facility.

Recommendation: It is recommended that DMHMRSAS and CCCA conduct a study with the involvement of a broad range of stakeholders to determine:

- The appropriate capacity for CCCA in order to serve the needs of the most seriously emotionally disturbed children and adolescents in the Commonwealth who cannot be served in less restrictive settings.
- The appropriate staffing complement to support this capacity.
- The financial resources required to operate the facility at this capacity
- What portion, if any, of the resources currently deployed to CCCA could be more effectively utilized to address the needs of seriously emotionally disturbed children and adolescents with the goal of providing services closer to home in less restrictive and less costly settings.

DMHMRSAS Response: The Department is aware of the difficult position that CCCA is in with regard to cost effective service and being the only freestanding treatment facility for children and adolescents and the only state facility for children under the age of twelve. The Department and CCCA will work together with stakeholders to discuss the appropriate size, staffing, resources and function of CCCA as a portion of restructuring and under the broader legislative mandate regarding the study of an integrated system for services for seriously emotionally disturbed youth under House Bill 330-H. I hope that you will be willing to be part of the discussion of the future of CCCA as we begin to explore its niche in the broader service continuum.

CATAWBA HOSPITAL
OIG REPORT #110-05

The OIG has no facility specific recommendations for Catawba Hospital as a result of this inspection.

WESTERN STATE HOSPITAL
OIG REPORT #111-05

The OIG has no facility specific recommendations for Western State Hospital as a result of this inspection.

PIEDMONT GERIATRIC HOSPITAL
OIG REPORT #112-05

Finding #1: Observations revealed that psychosocial rehabilitation programming (PSR) was not occurring as scheduled with a number of cancellations. Consumer engagement and participation in the PSR sessions was very limited and in some groups was not occurring.

> Recommendation: It is recommended that the facility develop a workgroup that involves consumers, clinical staff and direct care staff to review active treatment programming in the facility and develop strategies for improving the effectiveness of the PSR program. A mechanism should be developed to monitor consistency between the planned program and the services that are actually delivered.
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> *DMHMRSAS Response: The Department will be monitoring the plan of correction for increasing the active treatment participation of the consumers at PGH which includes the following:*
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> - *Rehabilitation Staff of the facility will assume overall responsibility for the psychosocial program scheduling and program activities on each Unit by June 1, 2005.*
> - *Rehabilitation Staff will continue to train direct care and nursing staff on appropriate group and individual activities.*
> - *Direct care/nursing staff will continue to implement psychosocial group activities, which will be developed by clinical staff.*
> - *The Clinical Leadership Team will develop a monitoring system by June 1, 2005 to ensure that the unit program teams meet on a monthly basis to review or modify program concerns.*
> - *The Clinical Leadership team will ensure, through a quarterly monitoring process, that there is consistency between planned scheduled programs and the actual service delivery. The Rehabilitation Director, Recreation Supervisor, and Clinical Nurse Specialists will review posted program schedules with rehab staff monthly, and monitor programs on a monthly basis to ensure that mandated standards are consistently met.*

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
OIG REPORT #113-05

Finding #1: Consumer engagement and participation in the psychosocial rehabilitation programming (PSR) sessions observed was very limited. Attendance at scheduled sessions was also limited. The OIG observed five different PSR groups. One group that was scheduled for 8 participants had only 1 consumer in attendance. Only two consumers were present for another group, but none had shown up the previous week. The facilitators for one group did not show up so the consumers who were present were

dismissed. Another facilitator reported that by the end of a programming cycle or term a number of consumers have either dropped out or have been discharged.

Recommendation: It is recommended that the facility develop a workgroup that involves consumers, clinical staff and direct care staff to review active treatment programming in the facility and develop strategies for improving the effectiveness of the PSR program. A mechanism should be developed to monitor participation and consistency between the planned program and the services that are actually delivered.

DMHMRSAS Response: The Plan to increase active treatment is as follows:

- *The NVMHI Treatment Mall Council, which is comprised of staff representatives from all disciplines and consumers, has been meeting since March 2005 to determine better ways to address active treatment needs for a changing patient population. As a result of feedback obtained through patient focus groups, planning priorities were identified: enhance opportunities for patients to select their programs, adjust program offerings, and provide more depth of content in key areas.*
- *The Council will be proposing program modifications that are based on different levels of readiness for change and participation in treatment, inclusive of the patient's clinical status. The Council and PSR Director will present their recommendations to the facility Clinical Leadership during the third week of May for final approval. Implementation of approved actions will begin in early June 2005.*
- *While monitoring mechanisms have been in place at the individual level, a systemic mechanism will be developed to monitor groups/programs. The Psycho-social Rehabilitation (PSR) Director will conduct "walk-throughs" on a regular basis to enhance monitoring of patient participation in programming; and will monitor the consistency between planned programming and what was actually delivered. The PSR Director will forward weekly reports to facility Clinical Leadership to facilitate prompt adjustments when needed.*

Finding #2: A majority of the consumers who were interviewed (6/8) reported not feeling safe within the facility. This was based on their perception of the frequency of aggressive acts and the lack of male staff members.

Recommendation: It is recommended that the facility conduct a review of consumers' perceptions regarding safety within the environment. Based on the findings from this review, the facility should develop and implement a plan to improve the safety of the environment so that consumers do feel safe.

DMHMRSAS Response: A critical factor in moving toward consumer empowerment and self-determination is the need for consumer feeling of safety in the environment. The plan to increase patient comfort relative to safety is as follows:

- *In order to better understand patients' perception of personal safety, over the next four weeks the Chief Nurse Executive will dialogue with nursing staff to increase sensitivity to patients' sense of safety. Dialogue will include the expectation that nursing staff will assess individuals and groups for the need for supportive interventions to promote feelings of safety when unsettling events occur in the milieu.*
- *The Director of Psychology, in collaboration with the Behavior Team, will develop an array of resources for patients and staff to utilize to support individuals in the management of stress, anxiety and agitation that could result in unsafe behaviors. Dissemination of materials is planned by the end of June 2005.*
- NVMHI will conduct a comprehensive patient satisfaction survey, which includes questions on consumers' perceptions regarding safety, by the end of June 2005. Based on the findings, additional actions, as indicated, will be developed and implemented.