Joint Commission
Gold Seal of Approval™

QUALITY AND COMPLIANCE EXTERNAL REVIEW REPORT

for the

Oregon State Hospital

and

Oregon Department of Human Services

Produced by: **Liberty Healthcare Corporation**
401 E. City Avenue, Suite 820
Bala Cynwyd, PA 19004

Contact: **Ken Carabello, M.S.W.**
Director of Regional Operations
800-331-7122

DRAFT REPORT – FOR INTERNAL DISCUSSION ONLY

Table of Contents

I. Executive Summary

1. Overview

Background: Oregon State Hospital has invested great energy and vigor in striving to improve, but the results to date have been disappointing. It is paradoxical that the very efforts to improve the hospital have contributed to the current confusion because changes have been implemented on so many fronts and with such rapidity. The sheer volume of change at OSH would overwhelm any organization, but we believe that the essential problem has been the lack of adequate planning and coordination of these improvement efforts. To date, the hospital has received many ideas and recommendations for improvement from entities such as the DOJ, the Governor's Special Master, the Geller/McLaughlin consultants, the Department of Human Services, the Hospital Advisory Board, the OIT and more, and the State has directed generous resources to achieve a lasting solution at OSH. Many of the best recommendations have already been implemented, or are under development (e.g., electronic medical record, treatment mall) and other ideas are worthwhile.

A framework for organized change: Having completed our on-site review and analysis, the Liberty Review Team believes that the challenge at OSH is how to prioritize and organize the planned changes and how to establish clear authority and accountability in the leadership entities that will marshal the needed resources and actively direct and monitor the implementation. Many of our recommendations will echo those of other experts, but we hope to contribute a fresh and practical framework for better organizing the change process. We will present many recommendations, both detailed and general, but we also hope to provide a structure that can help prioritize and organize the recommended changes and, ultimately, guide the establishment of an enduring and effective hospital organization that delivers high quality care to the people of Oregon.

Convergence of change factors: Historically, the current level of disorganization and frustration at OSH has resulted from a complex convergence of factors and changes. One major factor has been the monumental strain of building and moving into the new hospital. Another has been the scrutiny of the US DOJ. The recent changeover from a Unit Director model to a Unit Nurse Manager model presents another profound and fundamental change at OSH. The hospital has historically operated as independent units with the Unit Director functioning somewhat differently unit to unit. Another problem has been the dilution of authority and decision-making caused by a proliferation of committees that perform uncoordinated and sometimes redundant functions. An ineffectual system for performance

monitoring and disciplinary action has hindered the hospital's ability to remove poor performing personnel. Moreover, the crucial function of Quality Improvement (QI) in daily operations has been rendered impotent through a combination of factors.

2. Summary of Key Findings

Key domains for improvement: In light of these and other complex challenges at OSH, the Liberty Review Team has endeavored to formulate and simplify its recommendations for improvement at OSH by presenting them within each of the following seven domains:

1) *Staff Compliance vs. Quality Improvement*: Historically, each of the 22 treatment units at OSH had functioned as an independent operation with distinct variations in roles and practices. Despite the recent change from a Unit Director to a Unit Nurse Manager model, however, the hospital units continue to struggle to establish standardization of best practices. The Liberty Review team believes that this struggle is rooted in a fundamental confusion between staff compliance and quality improvement. Stated most simply, the hospital is attempting to use QI to enforce compliance. But the current departmental and committee structures under the Quality Council are so disorganized and diffuse that neither compliance nor quality improvement is being served effectively. Quality Improvement activities cannot take the place of an effective performance management system. Without a functioning supervisory structure that holds staff accountable and a meaningful process to appraise employee performance, compliance will not improve at OSH. By adding new committees and task forces and increasing quality monitoring activities within each of them, the hospital has endeavored to establish compliance and accountability. But leadership by multiple committees is diffuse and ineffective and supervisors need both performance data and clear lines of authority to manage personnel. Compliance is a supervisor's responsibility not the QI Department's responsibility.

2) *Need for stronger front-line engagement by Cabinet and leadership*: The Hospital's leadership team – specifically the Cabinet, Clinical Discipline Chiefs and Nurse Program Managers – need to establish a much stronger presence inside the treatment units by making daily engagement with the clinical and direct care staff. Specifically, the clinical leadership needs to regularly visit the units to directly observe operations in order to effectively monitor and reinforce standardized roles and procedures across units. In turn, unit staff needs to see the visible presence of clinical leadership to be assured of their concern and oversight. In particular, the Unit Nurse Managers currently feel unsupported and overwhelmed in their new expanded role in which they are assuming some of the job responsibilities from the former Unit Director role. The Nurse Program Managers should be frequently interacting with the Unit Nurse Managers and clinical personnel on every unit. The use of email as the primary mode of communication and

policy enforcement exacerbates the perceived disconnection between hospital leadership and unit staff. The absence of visible leadership has created the perception that unit-based staff must be self-sufficient in managing operations and delivering patient care within their own units. This perceived leadership vacuum fuels the tendency for each unit to "do things its own way" and resist efforts to standardize practices.

3) *Need for clear and decisive authority*: Combined with the actual and perceived absence of hospital leadership on the units, the lines of authority for decision-making are confused and unclear. Staff at all levels are hampered by uncertainty about who is in charge and who is making decisions with regard to different functions. Accountability is vague. For example, clinical supervisors have looked to HR to manage under-performing clinicians, while HR accurately regards such supervisory intervention to be beyond their scope of practice. Although recent directives have established the mechanism of having clinicians supervise clinicians within their own discipline, there is still need to clarify mechanisms for cross-disciplinary supervision and lines of authority. For example, security personnel are given primary authority to manage volatile situations within the units, which reflects a correctional/control approach rather than a hospital/therapeutic response to challenging behavior. This model for handling disruptive behavior greatly raises the liability and risk of injury. There should be no question that OSH is a treatment facility. It is imperative that a lead clinician must guide the decision-making in managing aggression and conflict on the units. Security staff should not take any independent action in the resolution of behavior problems within the therapeutic interior of the program. They should be working under the direction of senior clinical staff at the scene of the incident.

4) *Proliferation of committees and diffusion of leadership authority*: In its earnest initiatives to correct problems and improve health delivery as quickly as possible, the hospital has initiated multiple committees and workgroups to take action. Unfortunately, the proliferation of committees at OSH has contributed to the disorganization. With approximately 28 standing committees, nine MAHPS committees and eight transition workgroups, it is nearly impossible to communicate and coordinate efforts. Committees and teams are working in isolation and ignorance of each other's goals and interventions and there is serious confusion about which entities hold the authority to resolve issues and are accountable for results. Hospital managers and professionals at OSH universally complain about having to attend too many meetings, which translates into a massive drain on clinical staff resources and detracts from the primary mission of patient care. The excessive reliance on committees gives the appearance of greater inclusion of input from all participants, but has paralyzed decision-making and action. There is a need to greatly simplify and streamline the committees and workgroups, such as consolidating clinically-focused committees, disbanding committees performing duplicate functions and time-limiting the work of performance improvement teams and working groups. Some functions do not require their own Committee and can be consolidated.

5) *Health Information Group and Quality Management is disorganized and ineffective*: Unlike any other hospital of its kind, OSH has four major departments that are primarily carrying out the functions of a hospital quality management department – Strategic Planning, Quality Improvement, Risk Management and Planning Analysis and Research. Compared to most public sector psychiatric hospitals, OSH would be considered richly staffed in terms of quality management resources. But the Quality Management function is disorganized and has been marginalized at OSH. There are no hospital-wide QI performance measures that reflect the mission and priorities of the organization. Extensive data is collected at the unit level, but it is not applied in a meaningful way. Staff are not taught to appreciate the purpose and value of QI and are ignorant of, and largely excluded from, participating in current QI activities. QI has been cut from orientation training. The HIG departments, particularly the Strategic Planning Unit, QI Department and Planning Analysis and Research (PAR), are disconnected from each other and the hospital as a whole. The PAR Department operates in a silo, often taking on projects that are driven by individual requests instead of those generated by clinical leadership.

6) *Rectify causes of excessive 1:1 which drives excessive overtime*: The ordering of 1:1, 2:1 and 3:1 observation has been the primary cause of costly mandatory overtime at OSH. Intensive observations are too frequently ordered because staff are afraid to manage aggressive patients rather than for reasonable clinical/treatment purposes. Unit staff request 1:1 because they do not feel safe with certain patients. Or, they will request a 2:1 because they fear that doing a 1:1 could result in an investigation or reprimand if the patient makes an unsubstantiated complaint against the staff. The multiple factors leading to this pervasive apprehension need to be addressed. The policy and practice of heightened observation must be critically examined to bring more order to the units, decrease the demand for mandatory overtime and free up the Unit Nurse Managers to more adequately address patient care issues. The excessive demand for overtime has had profound consequences for staff morale at OSH and has led to abuse of the overtime system.

7) *Perception that management cannot dismiss poor performers*: There is prevalent thinking that managers can do little to discipline or remove problem employees. Clinical managers have looked to HR to handle personnel issues, while HR declines such responsibility because it is a management issue. At the same time, undue fear of union issues and the lack of management knowledge concerning the personnel system have reinforced the conviction that it is exceedingly difficult to remove problematic employees. Reluctant to act, managers retreat into helplessness and tolerate continued poor performance from problem employees whose behavior hurts team cohesion and morale.

II. Review Team and Methodology

1. Members of the On-site Review Team

The Liberty's on-site Review Team consisted of the following professionals, who conducted a five-day on-site review during the week of July 12, 2010.

- **Ken Carabello, M.S.W.** served as the Liberty's on-site Review Team Leader. Mr. Carabello is the Director of Operations for the west coast for Liberty Healthcare Corporation. Ken is an experienced clinician/administrator, who has managed delivery of hospital-based clinical and staffing services as well as community-based forensic mental health programs. He is the immediate Past President of the Forensic Mental Health Association of California.

- **Todd Graybill, M.P.H., MSW** has extensive hospital management and "turnaround" experience. He currently serves as a senior executive consultant to the State mental health director in Indiana. He has managed two Indiana state hospitals, including its forensic facility. He has had an array of hospital management responsibilities in the public and private sector.

- **Patricia L. Christian, Ph.D., M.S.N.** has an extensive public hospital management track record as a CEO. Her clinical and management experience includes new hospital construction, patient relocations, reduction of seclusion and restraint, and certification and accreditation. She is currently in the Division of Health Services Regulation in North Carolina, where she served as CEO at various state hospitals from 1993-2008. She is a CMS surveyor and has taught nursing at the graduate level for nearly a decade.

- **Cheryl Ouimet, M.S.W.** is the Clinical Improvement and Compliance Consultant for the Division of Health and Human Services State Operated Healthcare Facilities in North Carolina. She has extensive experience as an expert in USDOJ situations and has held top leadership responsibilities for quality improvement in two large public hospitals for nearly a decade.

- **Jerry Jennings, Ph.D.** is Liberty Healthcare's Vice President of Clinical Services. Dr. Jennings has a broad range of clinical and administrative experience in behavioral health and has published thirty articles and books in the field. He co-authored a highly successful forensic treatment model that is recognized as a best practice by the APA. This program successfully transitioned high risk forensic patients from inpatient to residential to community restoration with nearly zero recidivism. Dr. Jennings visited the campus one day and primarily assisted the

Review Team in synthesizing and analyzing its findings and recommendations for this report.

In addition, Liberty's Review Team conducted an extensive discussion with the following two clinicians who have been acting as clinical experts at OSH for several years:

- **Jeffery Geller, M.D., M.H.P.** is a nationally recognized psychiatrist who has been a consultant to OSH for several years. His familiarity with the hospital enabled the Liberty Review Team to accelerate its learning curve and integrate its observations and recommendations with those of the State's other consultants and current priorities.

- **Kris McLoughlin, D.N.P., A.P.R.N., BC, CADC-II** is a nationally recognized psychiatric nurse who serves as an expert consultant to OSH. . She holds a Doctor of Nursing Practice with specializations in psychiatric mental health nursing and substance abuse treatment. Her contributions are well known to the hospital and the State of Oregon mental health executive team.

2. Methodology

Dates of on-site review: Liberty's Team Leader conducted an initial on-site visit to Oregon State Hospital on June 29-30 to meet the hospital management team and set the groundwork for the on-site review. Liberty's designated Review Team then conducted its on-site review at the Salem campus from July 12 through July 15, 2010. Todd Graybill also reviewed the Portland campus on July 14, 2010.

On-site interviews and observations: The on-site team conducted extensive interviews with dozens of administrators, clinicians, employees and patients. These included scheduled and unscheduled interviews, team meetings, committee meetings, tours of every treatment mall and clinical unit, and even a "surprise" visit to the forensic units in the late night hours. The Review Team endeavored to speak with every key clinical and leadership position or team at OSH, but also make a point of talking with mid-level managers, employees and patients. In total, the Liberty Review Team directly observed over 25 units and met with and/or interviewed over 300 people. A schedule summary is included in Attachment D which shows the range and scope of the on-site unit tours, meetings, interviews and observation activities.

Review of documents: The Review Team requested a comprehensive list of policies, reports and materials for review in advance of the on-site visit and also requested and reviewed other documents over the course of the week. Some of the documents reviewed by the team are listed in Attachment D.

Consolidation of findings and report: During the week of the on-site review, the Liberty Review Team met together each evening to share observations and discuss issues and themes. Based on the progress of each day's on-site review and the evening team discussions, the team flexibly shifted their focus to best maximize their time and efforts in assessing, interviewing and pursuing clarifying information. In the weeks after the on-site review, the Review Team worked closely to complete the report of its findings and recommendations. An initial draft of the report was shared with the two OSH consultant experts for their critical feedback, including suggested modifications or additional recommendations.

Note regarding the Team Review of the Portland facility: Liberty's findings and recommendations reflect a predominant emphasis on the Salem campus of OSH. It is the opinion of the leadership and these reviewers that the Portland campus is better staffed and operates more effectively. As a comparative index of effectiveness between facilities, the average length of stay at Portland is approximately 250 days shorter (165 days without outliers) than Salem. Since the greatest challenges exist at the Salem facility, the Liberty Review Team focused the vast majority of its time and attention on the Salem campus. All told, the Liberty team spent approximately 12 hours dedicated to review of the Portland campus. The review process included visits to four representative units at the Portland facility. During the onsite visit, interviews and small group meetings were held with physicians, nurse supervisors, direct care staff and a number of patients. The most notable negatives observed at the Portland facility were deficient numbers of secretaries and Social Workers and some concerns about the low educational caliber of direct care staff (i.e., few college graduates). The team did not view these issues at the Portland campus as being as critical as the pervasive difficulties at Salem. Additionally, the team was impressed with the leadership of the Portland Campus, its clear lines of authority and the consistent, clear communication which is present within the Portland organization.

III. Recommendations by Key Domains

1. Staff Compliance vs. Quality Management

Summary: Historically, each of the 22 treatment units at OSH had functioned as an independent operation with distinct variations in roles and practices. The recent change from a Unit Director model to a Unit Nurse Manager model, the introduction of a new role at the Unit level (Treatment Care Plan Specialist), and the proposed addition of a Unit Shift Supervisor on each unit makes it an especially important time to move toward greater standardization, beginning with a clear, shared mission, values and philosophy of care. Nevertheless, although OSH fully recognizes the crucial importance of establishing standardized best practices, it continues to struggle with this overarching goal. There are

several factors that hinder progress, but the Review Team believes the most important factor may be a fundamental confusion between compliance and quality improvement. Stated most simply, the hospital is attempting to use QI to enforce compliance. But the current departmental and committee structures under the Quality Council are so disorganized and diffuse that neither compliance nor quality improvement is being served effectively. Quality Improvement activities cannot take the place of an effective performance management system. Without a functioning supervisory structure that holds staff accountable and a meaningful process to appraise employee performance, compliance will not improve at OSH. By adding new committees and task forces and increasing quality monitoring activities within each of them, the hospital has endeavored to establish compliance and accountability. While both current organizational and committee structure is less disorganized and diffuse than before; nonetheless; neither Staff Compliance, nor Quality Management are being served well under the present system.

At present, OSH managers have little understanding or appreciation of the deficiencies in their current supervisory structures and performance management systems. Consequently, there is a tendency to blame an ineffective QI program as the major factor contributing to the staff's poor compliance with policies and procedures. Compliance is a supervisor's responsibility not the QI Department's responsibility. As a case in point, OSH is implementing a comprehensive auditing process that is designed to capture discipline-specific documentation (MD, Nurse, Social Worker, Psychology) and compliance with standards (S&R documentation, TO/VO Authentication within 48 hours. etc.). But the process does not require the auditor to list the specific practitioners who are involved in the patient's care, so there is no way that clinical supervisors can follow up to address performance problems. Additionally, the numbers of audits being conducted to address compliance with standards are too few in number to obtain an accurate picture of whether standards are being met. The auditing process by itself cannot achieve compliance.

Presently, OSH is also floundering under capable, yet reluctant and disorganized leadership. The Liberty Review Team believes that the expected hiring of a high energy, competent superintendent will provide much more stability and direction to the organization. The new Superintendent will be the final authority for enforcing compliance through standardized operations across units. This will entail revision of the organizational structure to simplify lines of command and communication and strengthening the executive leadership team for greater accountability for improvement.

Recommendations:

C 1.1. – *Clarify OSH mission and values*: The new OSH Superintendent with a smaller Executive Team reconstituted from the current Cabinet should clarify and define a new Mission, Vision and Values for the hospital and then communicate them to the staff.

C 1.2. – *Focus on key standardized policies*: There is need for a systematic and prioritized plan for revisiting particular crucial policies/practices to support standardization of best practices and compliance across the multiple units. At a minimum, the Liberty Review Team recommends the following policies/practices be reviewed.

- Given the volume of aggressive episodes (patient to patient and patient to staff) at OSH, most facilities that employ psychologists would place strong emphasis on team-based, positive behavioral management methods to prevent disruptions and aggression and maintain safe, therapeutic environments for the patients and staff. We recommend that OSH move in that direction as quickly as possible.

- Revise policies and practice so that clinicians always supervise security personnel when responding to disruptive and aggressive behavior episodes and that interdisciplinary team-work is involved in planning, responding to and evaluating behavior incidents. Each episode involving the direct participation of security personnel should be reviewed by Risk Management. Revise all applicable policies and practice (i.e., nursing, clinical, security, behavior, etc.) to remedy competing or conflicting policies.

- Review/revise the Seclusion/Restraint policy and practice in order to protect patient rights and to be current with standard practice. The current policy allows for a step-down from restraints to seclusion. A patient who is calm and can be removed from restraints cannot then be placed in seclusion unless the behavior warrants.

- Review/revise the Behavior Precautions policy. This policy requires that a staff member could be responsible for maintaining visual contact with up to 4 patients on "Visual Precautions." Since it would be impossible to keep tract of multiple patients unless everyone moved as a group, the assigned staff member could not be compliant with this policy. The Liberty Review Team also recommends that consideration be given to reviewing the policy and practice of rotating staff on an hourly basis when they are assigned a 1 to 1 patient. This is not the common practice in other facilities (staff are relieved, but not on an hourly rotating basis) and could actually be counter-therapeutic for patients who are already destabilized and must now adjust to multiple staff changes during a shift. Given the current number of patients on 1:1, the current practice of moving staff from one 1:1 assignment to another fails to accomplish the rest break that the policy is intended to provide.

C 1.3. – Identify current and potential areas of variance: The Nurse Program Managers, especially on the Forensic Units, must become more involved in the day-to-day operations of the units they supervise. If this scope of supervision is too great, then additional Nurse Program Managers should be hired. Without this type of oversight, there is little chance that standardization across units can be accomplished at OSH. Given the implementation of the new Unit Nurse Manager role, the upcoming Unit Shift Supervisor role and the unfolding of the Treatment Care Plan Specialist role, it is critical that each position understands the functions of the others within the milieu setting. In view of the long-standing tradition of

semi-autonomous units at OSH, we believe that the goal of standardization of best practices across unit will not occur without intensive, first-hand, continuous intervention and education of staff.

C 1.4. – Clarification of lines of command within new unit leadership structure: The Unit Nurse Managers, primarily on the Forensic Units, are experiencing a high level of frustration and anxiety regarding their new roles. At the time of the review, they were uncertain which duties, previously within the Unit Director's job description, would be added to the Unit Nurse Manager job description. The job description of the Treatment Care Plan Specialist states that this person will "lead Quality Assurance projects related to the IDT (Interdisciplinary Team) as delegated by the nurse manager or Associate Director of Clinical Services." There is no direct reporting line from the nurse manager to the TCP Specialist so delegation of work from the Unit Nurse Manager could create conflicts. In addition, the Unit Shift Supervisors are not in place, leaving months when the Unit Nurse Manager will be expected to assume the duties previously done by the Unit Director (except for those dealing with treatment planning and patient grievances). This is a critical time when many Unit Nurse Managers are voicing being overwhelmed and fearful of negative patient outcomes and must be given face-to-face supervisory support. With the implementation of the full model (Unit Nurse Manager and Unit Shift Supervisor), it is critical that both job descriptions are operationalized the same unit to unit. The presence of the Program Nurse Managers at the unit level will allow them to identify variances from standardized procedure, provide consultation and problem-solving with unit leadership, develop a plan to bring practice within policy, and deliver targeted training to staff as needed to address variances.

C 1.5. – Temporary expert support for Superintendent: Given the magnitude and complexity of work to be accomplished, it could be very helpful to provide a time-limited support executive (or two) to directly assist the Superintendent on a daily basis during this critical period of reorganization and consolidation. The executive support executive would be an objective party without operational demands or responsibilities, who would be ready to advise and guide on the many demands immediately facing the new Superintendent.

C 1.6. – Facilitate "buy-in: Once an important and fundamental policy decision has been made, it is crucial to communicate the change to everyone –at all levels of the organization and in all capacities – by gaining their "buy-in" as the foundation for subsequent implementation and operations decisions. The leadership needs to publicize the top hospital-wide quality goals for OSH (such as decreasing seclusion/restraint, assaults; serious injuries from falls) so that staff at every level, from management to direct care, are fully informed, involved and gain buy–in. This should be followed up with continuing efforts that publicize progress being made toward the goal, including employee recognition and rewards, so that staff can take pride in progress and gain confidence in their leaders.

C 1.7. Streamline credentialing process: The credentialing process for the MAPHS Bylaws should be streamlined. In most hospitals, the bylaws only require medical staff to credential

physicians and physician extenders. But OSH has developed an almost unworkable system for credentialing all clinicians that renders the credentialing system too big to function efficiently or effectively. Instead it is strongly recommended that the Chiefs of the other Clinical Department take responsibility for conducting primary source verification (PSV) of their respective staffs. The Clinical Chiefs should then be held accountable for licensure, training and performance of their staff rather than shifting this function to another committee under the medical staff structure.

C 1.7.a. Redeploy administrative support for credentialing: Given the time-consuming and detail-driven work involved in primary source credentialing, it is possible to utilize well-trained clerical personnel to perform many "paperwork" functions for the credentialing clinicians. The Chief Medical Officer reported that he has four administrative staff, but has requested an additional position to perform credentialing duties, however, this position has been frozen. The complement of four staff assigned to the CMO's would seem to be more than adequate resources and OSH should consider redeploying one or more of the current administrative staff to perform credentialing activities.

C 1.7.b. – Clinical chiefs should revamp job descriptions: The hospital has moved in the right direction by now having clinical chiefs (rather than Unit Directors) perform performance appraisals of clinical staff by respective disciplines. This helps to clarify reporting lines to hold staff accountable for their performance, but job descriptions for staff with supervisory responsibility have not been updated to include their role and responsibility for supervising staff. Developing and rewriting job descriptions is the responsibility of department heads and the clinical chiefs within them. The HR Department should only function as technical advisors to staff in crafting the job descriptions.

C 1.8. – Improve auditing of clinicians performance: The comprehensive "10-day" auditing process that is being implemented at OSH is trying to meet the needs of both QI and Staff Compliance, but is failing to satisfy either. The auditing tool is designed to capture both discipline-specific documentation (MD, Nurse, Social Worker, Psychology) and compliance with standards (S&R documentation, TO/VO Authentication within 48 hours). But the process fails to identify the specific practitioners so that clinical supervisors can follow up to address performance problems and the sample size is too small to collect reliable data. We recommend creating a separate audit form that focuses on indicators that address practitioner performance and identifies the individual practitioner so that clinical supervisors can follow up with specific individuals to address performance issues.

C 1.9. – Direct audit results to Clinical Chiefs: At present, the results of the 10-day audits are not being used to evaluate staff performance. The results are submitted to the Medical Records Committee, but no action is taken and compliance rates are poor with no measurable improvement over time. We recommend changing the audit methodology to identify specific practitioners with poor performance and giving those results to the designated clinical chiefs (instead of or in addition to the MR Committee) so that the data

can be used to measure and monitor performance improvement. If indicated, the data adds objectivity to personnel decisions to remove poor performers.

C 1.10. – Performance management/appraisals: OSH needs to develop a strong peer review process in each clinical department that reinforces that clinical performance is the responsibility of the clinical discipline chiefs and that compliance with policies and practices are addressed through the clinical supervisory chain of command. A qualified expert should be used to provide training to all clinical chiefs on establishing strong peer review systems, understanding the distinction between peer review and quality improvement, and using data to assist staff to improve their job performance.

2. Leadership

Need for strong front-line engagement by Cabinet and clinical leadership

Summary: The Hospital's leadership team – specifically the Cabinet, Clinical Discipline Chiefs and Nurse Program Managers – need to establish a much stronger presence inside the treatment units and treatment malls by making daily engagement with the clinical and direct care staff. Specifically, members of the clinical leadership need to regularly visit the units to directly observe operations in order to effectively monitor and reinforce standardized roles and procedures across units. In turn, unit staff needs to see the visible presence of clinical leadership to be assured of their concern and oversight. In particular, as stated before, Unit Nurse Managers currently feel unsupported and overwhelmed in their new expanded role in which they are assuming some of the job responsibilities from the former Unit Director role. The Nurse Program Managers should be frequently interacting with the Unit Nurse Managers and clinical personnel on every unit. The use of email as the primary mode of communication and policy enforcement exacerbates the perceived disconnection between hospital leadership and unit staff. The absence of visible leadership has created the perception that unit-based staff must be self-sufficient in managing operations and delivering patient care within their own units. This perceived leadership vacuum fuels the tendency for each unit to "do things its own way" and resist efforts to standardize practices.

Additionally, leadership needs to examine issues/problems and make a decision. An example is the issue of census on the geriatric units. The geriatric units run at two thirds capacity. While hospital leadership has discussed the low census, and various options for remedy; no decision has been made.

Recommendations:

L 2.1. – Strong presence of leadership on units: All Cabinet members and/or Clinical Chiefs should visit all hospital units and treatment areas on a regular (weekly) basis with an eye on

strengthening standardized practices. Engagement and interaction with clinical staff, direct care staff and consumers is vital and their input needs to be welcomed. Leadership needs to do direct observation of unit activities and staff performing usual duties to identify salient challenges or problems and to be in touch unit life and progress. Leadership needs to be highly visible to staff and patients alike in order to demonstrate concern and active oversight by the leadership.

L 2.2. – Cabinet should conduct visits all shifts on all units: The Review Team recommends that each member of the Cabinet should personally conduct "rounds" on all off-shifts and weekends. During this critical time of transition at OSH, each Cabinet member should "round" once a month either on the swing shift after 5PM, night shift or weekends. This can be accomplished by creating a quarterly schedule and adding a clerical monitoring function to confirm that all shifts on all units are being visited. The purpose of the rounding is to talk with the staff, listen to their concerns, observe the delivery of patient care and formally report back to the Cabinet at the next meeting. This will not only provide valuable information to the Cabinet regarding the "pulse of the organization," but will also help staff feel more involved and connected. It is also an opportunity for top leadership to dispel rumors, discuss policies/practice and answer questions.

L 2.3. – Strong presence of Nurse Program Managers on units: Nurse Program Managers should be present on their assigned units a minimum of twice a week. This presence should be for a substantial amount of time (1-2 hours) and should not be used for regularly scheduled meetings. Rather the purpose of unit visits is to directly interact with staff, ascertain that staff has what is needed to take care of patients in a safe and therapeutic manner, talk with patients about their care, randomly review nursing progress notes, assist the Unit Nurse Manager in his/her job as needed and provide consultation/education. Being on the units with some degree of frequency will also allow the Nurse Program Managers to observe the interaction between patients and staff and potentially role model such behaviors as de-escalating patient conflicts, engaging a withdrawn patient in conversation, etc. These expectations should be included in the Nurse Program Manager's Performance Evaluation Plan. This expectation should be tempered by the fact that there are presently 3 RN Program Managers for 14 forensic units.

L 2.4. – Importance of face-to-face rather than e-mail communication: It is important to stop the over-reliance on E-mail as the primary means of communication between leadership and unit managers and for the dissemination of important policy changes. Nor is it effective to provide hard copies of policies for those who do not use the computer. Important policy changes naturally elicit questions and concerns. There needs to be face-to-face time between leadership and unit-level supervisors and between supervisors and line staff for discussion, questions, clarification and follow-up reinforcement for compliance, all of which helps to build teamwork.

L 2.5. – Mechanism for Superintendent engagement: It will be crucial for the Superintendent to be a highly visible leader with a first-hand awareness of facility operations and issues throughout the hospital. The Liberty Review Team recommends that the new Superintendent establish times when he/she can meet with Direct Care and Support Staff. The HR Department could randomly select a group of 10-12 employees (e.g., nursing, physicians, dietary, housekeeping, physical plant, etc) to meet monthly (or more often) with the Superintendent. The purpose is to enable staff to candidly discuss what they think is working well at the hospital and what is not working. It is important that the Superintendent is alone with staff and is not accompanied by other hospital executives. His/her commitment to taking time out of a busy schedule to meet with staff in a small group will give the clear message that their ideas and input are valuable. The small group meetings also generate very good ideas for improvement. HR will need to be careful to avoid mixing employees who supervise others with those who do not. The supervisory group can also be randomly chosen and the groups can alternate from meeting to meeting. The use of personal invitation cards adds to the perception that the staff person is important and valued by the hospital.

3. Decisive Authority

Need for clear and decisive authority

Summary: Combined with the actual and perceived absence of hospital leadership on the units, the lines of authority for decision-making are confused and unclear. Staff at all levels appear hampered by uncertainty about who is in charge and who is making decisions with regard to different functions. Accountability is vague. For example, clinical supervisors believe that HR prevents them from disciplining under-performing employees and look to HR to tell them what to do. HR believes that the managers know what to do but want HR to make the decisions regarding discipline, which is not a HR but a management function. Although recent directives have established the mechanism of having clinicians supervise clinicians within their own discipline, there is still need for clarification on cross-disciplinary supervision and lines of authority. For example, security personnel are given full authority to manage volatile situations within the units, which reflects a correctional/control approach rather than a therapeutic response to challenging behavior. This model for handling disruptive behavior greatly raises the liability and risk of injury. There should be no question that OSH is a treatment facility. It is imperative that senior clinical staff must guide the decision-making in these situations. Security staff should not take any independent action in the resolution of behavior problems within the therapeutic interior of the program. They should be working under the direction of RN supervision at the scene of the incident.

There is a serious lack of cohesive teamwork between the Clinical Departments and the Health Information Group (HIG). The perception of the clinical group is that a lot of data is collected, but that little is done with it. They complain of not getting feedback information

and analysis in a form that can be readily and directly applied to practice. The quality group, in turn, complains that the clinical group discounts or disregards the findings and feedback by "explaining away" the findings as artifacts and attacking the data as faulty and unreliable. Neither group has the authority to make decisions or enforce compliance.

The Forensics Service, in particular, is a huge service and the scope of work is intensive. There are currently three Nurse Program Managers divided among the 14 wards of the Forensics Service, which are now directed by the newly implemented Unit Nurse Manager role. This strain is exacerbated by the fact that the new Unit Shift Supervisor positions, which will report to the Unit Nurse Managers and assume some of the current job duties, have yet to be implemented.

Recommendations:

A 3.1. – Reduce Cabinet size for effectiveness: The 14-member Cabinet is simply too large and unwieldy to be an effective executive decision-making team for a psychiatric hospital. We recommend reducing the Cabinet to a tight executive team of 5-7 managers, such as the Superintendent, Clinical Director, Medical Director, Chief Financial Officer, Chief Nursing Officer, HR Director and Quality Management Director.

A 3.2. – Streamline the number of Committees for effectiveness: As described in detail in the next section, the Liberty Review Team recommends a major restructuring and consolidation of committees, subcommittees and performance improvement teams that will reduce the number of committees, simplify lines of authority and accountability, and free professional staff to focus more on the delivery of care.

A 3.3. – Enhance support for Unit Nurse Managers: The Unit Nurse Managers are confused, anxious and overwhelmed by the changeover of administrative/clinical structure at the unit level. They need greater support to take full authority in their new role. In addition, the Unit Shift Supervisors must be given the support and training needed to fulfill their role in dealing with work performance issues. The Unit Nurse Managers are still learning the scope and range of their authority and most need stronger personnel management skills to apply their authority. There is a lack of interaction between the MHTs and RNs on many of the Forensic units. On some of the units there is conflict between the RNs and the MHTs about who is in charge. This conflict must be addressed in order for the units to stabilize and patients to receive the best care possible. OSH needs to enhance support for the Unit Nurse Managers by:

> A 3.3.a – Strong presence of Program Nurse Managers on units: The Nurse Program Managers must provide strong and frequent on-site support to the Unit Nurse Managers by mentoring them for leadership, directly observing the work load and challenges on the units, and facilitating support from HR in managing personnel problems. It is imperative that the Program Nurse Manager have a strong working

knowledge of the Union contract and HR rules/regulations regarding employee disciplinary actions. The Program Nurse Manager should be facilitating the movement of actions through the HR Department. A frequent presence on the unit will allow the Program Nurse Manager, the Unit Nurse Manager and eventually the Shift Supervisor to clarify expected duties and responsibilities and to potentially modify the job or systems accordingly. The issue of MHT/RN control of the unit must be addressed at all levels of the organization (Cabinet to MHTs). Once the problem is clearly identified, a determination must be made as to whether the problem is specific to a unit or systemic requiring a more formalized action plan. The Program Nurse Manager should also support the Unit Nurse Manager in working with individual MHTs. It is important that the role of the MHT is respected within the organization.

A 3.3.b. – Personnel management skills training: The HR Department does offer a two-day course for new supervising managers but given the pervasive manager view that HR prevents them from taking corrective action with problem employees, the Team questions the overall value of this course in dealing with performance issues. OSH needs to establish annual refresher training for Unit Nurse Managers and Program Nurse Managers (and possibly the Clinical Chiefs) in performance management techniques for managing problematic employees. This training will also need to include strategies geared toward helping employees to improve in their performance and become successful.

A 3.3.c. – Designated personnel management support consultant: The HR Department should designate a HR expert in performance management, job performance appraisal and disciplinary actions to provide intensive consultative support to the Program Nurse Managers and the Unit Nurse Managers. (This should include the Unit Shift Supervisors when they are hired since they will be evaluating work performance and completing the work appraisals for nursing staff on their shift). Given that HR is minimally staffed and have a couple of positions frozen, this recommendation may necessitate the hiring of an additional HR position that could be dedicated to assisting nursing managers and shift supervisors.

A 3.3.d. – Designated labor relations consultant: OSH should consider hiring a full-time labor relations expert to serve as a liaison between hospital management, HR and the unions to provide on-going advice, support and problem-solving as needed. This position can help navigate and mitigate the perceived intimidation and learned helplessness of managers and supervisors in handling problematic union employees for fear of conflict.

A 3.4. – Personnel skills for other clinical supervisors: In addition to the Unit Nurse Managers, all other clinical supervisors need support and training to work within the system to deal with staff performance issues in a timely and effective manner. There is a pervasive

belief among clinical managers that they can do little to discipline and remove problem employees and that this is the domain of HR. HR is very clear that supervision is a management responsibility, not an HR function. HR expects the clinical supervisors to discipline their own staff. The Liberty Review team recommends both the addition of refresher training and the establishment of a designated personnel management position or "hot line" to provide immediate consultative assistance to supervisors in responding to complex personnel issues.

A 3.5. – Clarify authority structure of new unit supervision model: OSH is in the process of introducing a new model of unit supervision that calls for shared responsibility between the Unit Nurse Manager, Treatment Care Plan Specialist and the Unit Shift Supervisor. This model is untested and the Liberty Review Team has concerns that this "co-leadership" model could be another way that authority will become diffused and potentially undermine decisive leadership at the unit level.

> A 3.5.a. – Put Unit Nurse Manager in clear command: We recommend that the Nurse Manager should be the position with clear unit director authority. The Unit Shift Supervisor will be directly reporting to the Unit Nurse Manager, but the Treatment Care Plan Specialist reports to the Associate Director of Clinical Services. There could also be some conflict or role delineation issues/questions between the Unit Nurse Manager and the new Treatment Care Plan Specialist positions because some of these individuals had previously held the authority of Unit Directors. There is also some risk of confusion between the Unit Nurse Manager and the Unit Shift Supervisor roles because the Unit Shift Supervisor has the responsibility for evaluating the staff on his/her assigned shift.

A 3.6. – Strengthen inter-shift linkages: Although the treatment malls have been a resounding success at OSH, the new model has created a new challenge to be addressed. Given that staff is now frequently "off unit" to supervise/escort patients to and from the treatment malls, there is a need for a stronger mechanism for inter-shift reporting/transfer of information, especially on the Forensic Units where some units send patients to two different malls. Shift reports are critical to the continuity of patient care and safety. At present, the Unit Nurse Managers feel that they can accomplish little more than read the shift report and they are unable to share specific patient information with the on-coming shift. This important concern was frequently voiced during the Unit visits and in the meetings with the Nurse Executive Committee, Program Nurse Managers and Unit Nurse Managers. The Liberty Review Team recommends that nursing should work with Dr. McLoughlin, the Nursing Consultant for CRIPA issues, to determine how to resolve this dilemma.

A 3.7. – Clinical staffing schedules need to meet organization's needs: The use of four-day work week schedules for some psychiatrists and psychologists has had some negative impact on the fulfillment of clinical functions, participation in interdisciplinary team planning and continuity of care. Specifically, about half of the Psychologists and many of the

psychiatrists work four 10-hour days per week. The needs of the hospital must supersede the needs of the individual clinicians. The Review Team recommends a critical reexamination of the scheduling practices.

A 3.8. – Need to enforce documentation: It is notable that the OSH policy calling for the standardization of documentation around progress notes is still not in effect as of 7/15/10. Lack of documentation was highlighted as a major issue at OSH shortly after the patient death in October 2009. Auditing and identification of deficiencies may be a quality function, but enforcement of a fundamental policy is the responsibility of the clinical leadership. The clinical leadership must promptly address this compliance issue.

4. Diffusion

Proliferation of committees and diffusion of leadership authority

Summary: In its earnest initiatives to correct problems and improve health delivery as quickly as possible, the hospital has initiated multiple committees and workgroups to take action. Unfortunately, this proliferation of committees has contributed to the disorganization. With approximately 28 standing committees, nine MAHPS committees and eight transition workgroups, it is nearly impossible to communicate and coordinate efforts. Committees and teams are working in isolation and ignorance of each other's goals and interventions and there is serious confusion about which entities hold the authority to resolve issues and are accountable for results. Personnel universally complain of attending too many meetings, which translates into a massive drain on clinical staff resources that detract from the primary mission of patient care. The excessive reliance on committees gives the appearance of greater inclusion of input from all participants, but has paralyzed decision-making and action. There is a need to greatly simplify and streamline the committees and workgroups, such as consolidating clinically-focused committees, disbanding committees performing duplicate functions and time-limiting the work of performance improvement teams and working groups. Some functions do not require their own committee and can be consolidated. For example, the EBP Committee could be disbanded and include an EBP representative on relevant clinical and QI committees, and the Patient Rights Committee (which meets infrequently and seems to have a rather vague charge) could be eliminated with the Patient Grievance Committee elevated in the organization with reporting directly to the Superintendant.

One of the 2010 goals of the Quality Council is to "support, monitor, and evaluate all OSH Committee activities". The Liberty Review Team questions the utility of this goal, which is an artifact of a cumbersome system. OSH has had to create an entire infrastructure, supported by QI staff, to track its committee activities. The process is labor intensive and ineffective. On the contrary, if the committee system can be consolidated and streamlined as we recommend, it will eliminate the need to have this added infrastructure to monitor the uncoordinated work of multiple committees.

Recommendations:

D 4.1 – Consolidation of goals between and across committees: Although each of the various committees has important goals for the year, these goals are not known or understood by other committees or by pertinent clinical and operational personnel. The success of many goals is dependent on staff working together. For example, the Patient Safety Committee has set goals to reduce the use of restraints by 20%, seclusion by 10% and serious injuries from falls by 10%. We recommend using these paramount goals as hospital-wide goals that nearly everyone, at every level of the organization, is aware of and invested in achieving.

D 4.2. – Consolidate clinical committees: Consolidate the committees that primarily address clinical operations and combine functions under a Clinical Services structure. Specifically, at least four of the subcommittees currently under the Care of Patients Committee (Core Curriculum, Treatment Care Planning Advisory Group, Treatment Mall Planning, Recovery Work Groups, and possibly BSP and START as well) should be realigned under and/or the functions incorporated in to a Clinical Services Committee chaired by the CMO, CNO and the Clinical Director.

D 4.3. – Eliminate committees with duplicate functions: The Liberty Review Team recommends disbanding committees that appear to serve duplicate functions and/or combining affiliated functions that can be assumed by other committees.

> D 4.3.a. Eliminate the Patient Rights Committee: The Patient Rights Committee has many of the same functions as the Patient Council or Patient Grievance Committee.
>
> D 4.3.b. Eliminate the Patient Care Consults: This is a “one-person” committee that primarily focuses on challenging clinical cases that can be assigned to a clinician reviewer based on the nature of the case.
>
> D 4.3.c. Disband EBP Committee: The EBP Committee could be disbanded in favor of including an EBP representative on relevant clinical and QI committees. An EBP expert could also serve as a consultant to clinical services and QI committees

D 4.4. – Apply time-limits to consolidate PITs: There are many subcommittees under Care of Patient and Patient Safety Committees within the QI Program structure. These are reported as standing subcommittees rather than Performance Improvement Teams (PITs); PITs are short-term, focused work-groups that tackle a specific assignment, present recommendations to the Quality Council and then disband. OSH has tried to abstain from initiating any new PITs because there is so much transitional work-group activity occurring on campus at the present time. Nonetheless, OSH has added layers of subcommittees

under the Quality Council Committees which should be re-evaluated as PITs or assumed under the direction of clinical leadership.

D 4.5. – Re-classify long-term subcommittees as short-term PITs: The Review Team recommends that the following subcommittees should be re-classified as short-term (e.g., 2-4 months) focused, time-limited Performance Improvement Teams that report recommendations back to the QI or Clinical Services Group and are then disbanded: Seclusion & Restraint, Diversity, Metabolic Syndrome, Self-Harm and HAP. Additionally, we recommend that these committees should come to QC with specific reasons to justify their existence.

See Organization chart in Attachment E for recommended restructuring of committees.***

5. HIG and the Role of Quality Management

Quality Management is disorganized and ineffective

Summary: The Liberty Review Team has organized its observations and recommendations for this domain into two major categories: restructuring the Health Information Group and developing a more meaningful Quality Improvement plan.

Recognizing the importance of the Electronic Medical Record (EMR) project on the future of the Quality Management Program, our team met with individuals with key roles in the development, training and implementation of the EMR product. Despite the magnitude of this project, occurring in concert with construction of a new facility, it is evident that a great deal of very thoughtful and methodical planning has gone into the project. While the true effectiveness of the transition to an EMR will become evident post-implementation, we were quite impressed with the attention to detail in all aspects of the project. It is our expectation that the move to the EMR will not only support, but enhance, the quality management effort at OSH.

1) Restructuring the HIG Departments at OSH to regain effectiveness:

Unlike any other hospital of its kind, OSH has four major departments that are primarily carrying out the functions of a hospital quality management department – Strategic Planning, Quality Improvement, Risk Management and Planning, Analysis and Research. Compared to most public sector psychiatric hospitals, OSH would be considered richly staffed in terms of quality management resources. But the Quality Management functions are not organized to best serve the organization or to support the hospital's QI and Risk Management functions. The HIG departments are disconnected from each other and the hospital as a whole. Similarly, the Planning, Analysis and Research Department operates in a silo, often

taking on projects that are driven by individual requests instead of those generated by hospital or clinical leadership.

Strong QI and RM Departments play an essential role in a public psychiatric hospital, particularly at facilities that have been involved with US DOJ and are addressing CRIPA compliance issues. We believe that the first step in restoring QM to its appropriate position at OSH should be a major consolidation and simplification of its multiple QM-related departments and entities within the Health Information Group (HIG). We will begin with a functional analysis of the current QM operations as follows:

Currently, the Health Information Group is organized into six departments under the oversight of the Director of Strategic Planning. These are the Strategic Planning Unit, Medical Records, Technology Services Management, Planning, Analysis and Research (PAR), Quality Improvement (QI) and Risk management (RM). Four of the six perform QM functions.

The role of the PAR Department is to assist OSH administrative and clinical leadership with improved decision making that is clinically-led and data-informed. In practice, however, the PAR Department operates independently, making unilateral decisions on what quality projects to pursue rather than working in collaboration with hospital leadership in setting priorities for analysis and research.

The hospital also has a separate Strategic Planning Unit. Strategic planning is a hospital leadership function and it is unusual to have a separate department with resources under one Cabinet member. A Quality Management Director in a public psychiatric hospital often facilitates and assists leadership with strategic planning activities, however, strategic planning is the responsibility of the Superintendent and his/her Cabinet.

The actual role of the QI Department, meanwhile, has been diminished to an administrative support role, focusing on tasks such as developing agendas, scheduling rooms for meetings, tracking committee minutes, and sitting on multiple hospital committees. Traditionally, QI should be actively auditing and monitoring key processes that maintain patient safety and quality of care and is a position to alert the leadership of incidents and negative trends at the earliest point of identification so that the leadership can evaluate and implement corrective actions or improvement as needed. QI's role appears to have migrated to the PAR Department and its marginalized role is reflected in its relocation to a "marginalized" location over the State Vehicle Maintenance Shop, cut off from the administrative and clinical leadership.

Finally, there is additional confusion regarding the role of the CRIPA Manager and nine positions that were funded to OSH as part of Special Session HB 5556 in February 2008 for "developing a mechanism for organized, strategic data collection and analysis" evolved into the current HIG structure. The relationship between this entity and the other QM functions

is ill-defined, which translates into more confusion about who is truly in authority and directing the QM process, who is accountable to whom and for what processes.

Thus, as it currently stands, the QM departments at OSH are not organized to best serve the hospital. Although there may have been good reasons for creating and structuring the various quality-related departments and committees over the years, there is no reason to retain the current structure today. The Liberty Review Team recommends a major consolidation and simplification of the QM organizational structure. We recommend disbanding the Strategic Planning Unit and PAR as separate departments in the HIG structure and realigning these resources under the existing QI and Risk Management Departments.

Recommendations for restructuring HIG:

QM 5.1. – More appropriate job title: We recommend changing the title of Director of Strategic Planning to a title that highlights the QI and RM roles that are essential components of a public psychiatric hospital. Consider the title Director of Quality Management.

QM 5.2. – Realign the resources of the HIG Departments Our specific recommendation would be to realign resources in the Health Information Group to establish cohesive, integrated QM departments and operations.
See Organization chart in Attachment F for recommended restructuring of HIG.***

> QM 5.2a – Shift resources in the HIG to cover staff vacancies. There are three vacancies in the QI Department and the Director of Strategic Planning has asked for two additional positions for Risk Management. The HIG is well staffed and additional positions are not required if current resources are redeployed to assist with performing important QI and RM functions.
>
> QM 5.2b – Redeploy PAR staff: Re-assign some PAR positions (6-7) under the QI or RM departments and/or reassign some PAR positions (2-3) to Clinical Leadership (CMO, CNO, Clinical Director) to help develop strong peer review systems and provide support for Clinical QI initiatives. Incumbents in the current PAR positions would be evaluated for appropriateness, as positions are re-assigned.

QM 5.3. – Create Joint Commission PPR Position: OSH should create a new Accreditation Manager position in the QI Department who will be responsible for the annual Joint Commission Periodic Performance Review (PPR). Currently, the QI Director is spending nearly one third of his time completing this function, which undercuts time needed for planning and managing the immediate day-to-day quality process at OSH.

QM 5.4. – Reduce committee administrative duties performed by QI staff: Streamlining the number of committees will eliminate labor intensive and ineffective infrastructure, which is administratively supported by QI staff who now coordinate (scheduling rooms) and track committee activities (fact sheets, committee minutes, etc).

QM 5.5. – Relocate the QI Department closer to hospital administration: To be successful, the QI department must work closely and be well aligned with hospital and clinical leadership. Close physical proximity to each other on campus (in the same building) will help to strengthen and facilitate these collaborative working relationships. Counteract the perception that QI is not really important by physically relocating the QI Department from its current location (over the garage) to administration.

QM 5.6 – Clarify Role of the CRIPA Manager with QI & RM Departments: Recognizing that OSH cannot dictate the role and purpose of the CRIPA Manager, it remains vitally important that restructuring of QM is completed with participation and input from staff who have been coordinating CIP activities so that there is full agreement and understanding of how the new streamlined function will continue to cover all required areas of responsibility.

QM 5.7. – Training on CRIPA: Include an overview of the CRIPA Statute and how it is applied and evaluated in a state psychiatric hospital in the orientation for new employees in the Quality Improvement and Risk Management departments

2) Developing a more meaningful QI plan for OSH:

Any public sector psychiatric hospital should have a Quality Improvement (QI) Plan that is based on hospital-wide goals and specifies the performance measures that will be evaluating the most important processes over the year. The OSH QI Plan is silent about who and how the facility will implement its QI priorities and initiatives in 2010. Currently, OSH has no hospital-wide goals for quality nor is there a comprehensive list of QI performance measures to help prioritize the organization's activities and guide the use of staff resources for these activities. At the same time, OSH has a Continuous Improvement Plan (CIP) that appears to command greater attention and help determine the quality improvement priorities for the hospital. Moreover, the various committees have their own "internal" QI goals that may or may not coincide with CIP priorities. There also seems to be no designated authority responsible for tracking the implementation of the CIP priorities.

During multiple interviews with a variety of clinical and direct care staff on the units and in the treatment malls, no one could answer the question, "What are the two most important hospital goals or quality improvement initiatives that OSH is working on this year?" Many staff said they didn't know, some cited the DMH core values, some flipped their ID badge over and recited the National Patient Safety Goals, and others made a guess that it was "ensuring the safety and security of the patients?"

In short, OSH has no overarching "quality plan" that guides staff and no clear mechanisms to ensure that goals/priorities are being met or achieved. The call for greater accountability was a predominant theme at OSH. "We don't hold each other accountable for getting things done. " We believe that it has not been possible to establish true accountability at OSH because of the disorganized structure and diffusion of authority. There are too many quality-related processes under too many entities without clear lines of command and without a systematic hospital-wide plan that prioritizes goals and activities.

Recommendations for improving the QI Plan:

QM 5.8 – Hospital-wide quality goals: The Quality Council, chaired by the Superintendent, must establish hospital-wide quality goals that are prioritized by OSH Leadership. Once goals are established, the QI Plan should be revised and revitalized and made to complement the Continuous Improvement Plan (CIP).

QM 5.9 – Better use of QM data at unit level: Quality data are collected at the unit level (e.g., falls, assaults, seclusion/restraint, staff/patient injuries, medication variances, etc.) but the unit staff does not see this coming back in any meaningful way that could alter outcomes of care. The complex committee structure does not make for timely responses to aggregated data. For instance, falls data is collected at the unit level, then sent to PAR who aggregates the data for the Falls Committee and the Patient Safety Committee, both of which then report to the Quality Council with their recommendations. In addition to the delay and inefficiencies of this multi-step process, it is questionable that the Quality Council can realistically share the results and recommendations in a meaningful way with the unit staff at the unit level. Certain recommendations and data, such as Highly Aggressive Patient (HAP) data, must be timely and delivered to staff at the unit level so that they can fully "own" the process and be able to effectively monitor their progress (or lack of) on their unit.

QM 5.10. – Improve the current Risk Management – Incident Response system: The process for managing incidents could be strengthened in three ways:

> QM 5.10.a. – Maintain the CIRP: The Level 3 incident investigations are well done. There is a good representation of hospital and clinical leadership on the Critical Incident Review Panel (CIRP) who ask thoughtful questions and request follow-up and closure on corrective actions taken in response to the investigative findings. CIRP is chaired by the Superintendent and is a very worthwhile committee that should be maintained in any restructuring of OSH committees.
>
> QM 5.10.b. – Clarify Level 2 incidents for investigation: OSH has a good electronic incident reporting system, and the RM Department staff is diligent in reviewing shift reports and other information sources to ensure incidents are being reported. But the RM incident report grid needs to be revised to clarify what incidents are

categorized as Level 2 incidents and require an investigation at the unit level. Previously, Level 2 investigations were performed by Unit Directors. With the change to Unit Nurse Managers, it is important to clarify who will now conduct the investigations.

QM 5.10.c. – Thorough reviews of Level 4 incidents and staff accountability: Although the QI staff leads the Root Cause Analysis (RCA) process in addressing Level 4 Sentinel events, there is little collaboration between QI and hospital leadership to conduct a thorough, comprehensive RCA or to enforce and hold staff accountable for implementing action plans. It is important to conduct a thorough comprehensive RCA that drills down to credibly identify areas in need of improvement. There must be collaboration between QI and clinical and hospital leadership in asking tough questions about what went wrong and making sure that appropriate corrections are implemented. With the general diffusion of authority at OSH and the marginalization of the QI Department, the Department has become weak and unassertive in determining that corrective actions have been implemented by other hospital staff in timely fashion to address problems revealed in the RCA process.

QM 5.11 – Restructure the comprehensive audit process and increase quantity of audits: Due to vacancies in the QI Department, managers from across the facility have been enlisted or "volunteered" to assist with the 10 day comprehensive audits. The audit tool is lengthy, very time consuming to complete and tries to capture staff's compliance with policies (documentation) and evaluate compliance with Joint Commission standards and CMS regulations. The audit tool needs to be down-sized with practitioner compliance indicators separated from deficiency driven standards indicators (verbal orders). A new, more manageable compliance tool could be developed and used by clinical leadership to evaluate practitioner specific performance (See also Recommendation C 1.8- Improving audits of clinician's performance). The numbers of QI audits being conducted are too few to obtain a reliable picture of whether standards are being met to address deficiencies cited by accreditation agencies. The numbers of QI audits need to be increased to collect meaningful data. OSH should consider the sampling guidelines provided by the Joint Commission to assist with determining adequate numbers of audits to reliably measure compliance with standards. If HIG resources are re-aligned as suggested in recommendations QM 5.2, the QI Department would be able to increase the number of audits and expand the indicators that should be monitored to evaluate compliance with JC, CMS and CRIPA requirements.

QM 5.12 – Reinstitute QM training: The QI module has been removed from the 40 hours of hospital orientation for new employees. This is particularly unfortunate as OSH is moving toward implementing more sophisticated quality improvement approaches (LEAN & RPI) and staff has not even been introduced to the most basic concepts of quality improvement and how quality improvement activities are structured and occur at the hospital. Reinstitute

the QI training module in hospital orientation for all employees. Moreover, it should be bolstered by explicitly demonstrating that the leadership is fully behind the revitalized quality initiatives.

QM 5.13. – Improve the patient grievance process: Dissatisfaction with the current grievance system is widespread at OSH. Patients have little to no faith in the grievance process. Staff has been lax in reviewing, investigating and providing a reply to patients about complaints within the set time requirements. All too often complaints simply "drop into a black hole" by being lost, destroyed or ignored entirely. There have also been complaints that individuals have suffered retaliation for filing complaints. The grievance process needs to be carefully reviewed and overhauled. In addition to reorganizing committees per recommendation D 4.3.a. Eliminate the Patient Rights Committee, there is a need for systematic training, accountability and communication. First, many employees do not understand the grievance process and need specific training. Second, response times must be enforced and a system that ensures 100% of grievances receives an adequate response. To hear nothing is very demoralizing and devaluing for patients. The grievance policy and procedure should be reviewed and revised for maximal efficiency and accountability and should report directly to the Superintendent. Hospital leadership must clearly designate staff to maintain a grievance log to track the type of grievances, the timeliness of response, etc. and once a reliable system is in place, leadership can more easily identify trends that reflect underlying unit issues. At that point, emphasis should be on addressing milieu issues in an effort to improve the patient treatment experience, rather than solely responding to grievances.

6. Prime Causes of Overtime

Rectify causes of excessive 1:1 which drives excessive overtime

Summary: The ordering of 1:1, 2:1 and 3:1 observation has been the primary cause of costly mandatory overtime at OSH. Intensive observations are too frequently ordered because staff are afraid to manage aggressive patients rather than for reasonable clinical/treatment purposes. Unit staff request 1:1 because they do not feel safe with certain patients, or simply want more staff on the unit. Or, they will request a 2:1 because they fear that doing a 1:1 could result in an investigation or reprimand if the patient makes an unsubstantiated complaint against the staff. Noise, confusion and congestion also increase when multiple patients have additional staff assigned to them. The combined chaos and intensity of activity directly undercuts the maintenance of a calm, orderly, and respectful therapeutic environment and paradoxically leads to increased agitation and aggression and the potential for increased use of seclusion/restraint, PRN medications, and intensive observations. Four main factors appear to drive the pervasive sense of staff apprehension and disorder:

(1) Teamwork is weak at the unit level. Direct care staff is not fully integrated into the treatment teams and therefore have little opportunity to give input into day-to-day assessment of patient functioning, treatment plans, behavior management issues, unit operations, safety and security, scheduling and much more. There should be strong opportunities for staff development for the direct care staff so that they can continue to strengthen and expand their skills and competencies and gain pride from their increased effectiveness. At the same time, cooperation between and among disciplines is variable. The Treatment Care Planning process is emblematic of the lack of coordination and/or communication within the hospital units. There are disconnects between the hospital leadership, clinical leadership, treatment teams, direct care and security. There is only a weak sense of a unified team that shares responsibility for unit security, therapeutic environment, behavior management and responding to challenging behavior.

(2) The policy and practice of heightened observation must be critically examined to bring more order to the units, decrease the demand for mandatory overtime and free up the Unit Nurse Managers to more adequately address patient care issues. The excessive demands for overtime have had profound consequences for staff morale at OSH and have led to abuse of the overtime system. It has also exacerbated conflicts between the Unit Nurse Managers and the MHTs especially on those units where clinical leadership is weak and the direct care staff is more accustomed to directing patient interventions.

(3) The methodology for preventing, managing and responding to aggression, self-injury, and other challenging behavior at OSH, especially on the forensic units, is variable, under-resourced and ineffective. There are far too many “take downs” and the staff are more aggressive than is necessary in applying restraints. The hospital must commit to a single approach that supports its goal of reducing seclusion/restraint and injuries to nil level. There needs to be a very strong leadership from psychology staff with expertise in positive behavior management techniques, including an increase in the number of behavior specialists throughout the hospital for designing individualized behavior plans, training staff, monitoring implementation and training and directly supporting staff across disciplines. Above all, the methodology should be team-based, with all unit staff involved in managing difficult behavior and directed by clinical personnel, not abdicated to security and/or direct care paraprofessionals.

(4) HR must continue to rapidly fill new positions and existing vacancies. Although additional staff will not solve the issue of placing large numbers of patients on heightened observations, it will reduce the number of times any one person is required to work overtime.

Recommendations:

OT 6.1. – Strengthen the team-based application of positive behavior management: The proactive use of positive behavioral management by a coordinated team must be accentuated, strengthened and unified at OSH. Clinicians must be more involved in decision-making, implementation, monitoring and follow-up of behavioral interventions. Successful prevention and management of aggression requires an approach that is fundamentally team-based in its values and application. There are several ways to bolster this crucial function:

OT 6.1.b. – Improve behavior management training for MHTs: Improved training, and on-going refresher training for direct care staff. Provide greater investment in staff development by strengthening and expanding skills and competencies so they are more confident (less afraid) in preventing and deescalating difficult behavior.

OT 6.1.c. – Mentoring new direct care staff: Mentoring for new line staff to reinforce and role-model procedures and methods. Although overtime does not significantly impact the RN staff, mentoring of new RNs is certainly critical, especially at this time when more RNs are being hired. There is the feeling among at least some of the current new RNs that the orientation process is lacking in skill development needed to feel comfortable in working with an aggressive population. Feedback from new RNs and MHTs to Nursing Education is critical to reassessing the orientation period.

OT 6.1.d. – Bolster teamwork and methodology for handling aggression: OSH needs to bolster both its teamwork and methodology for managing aggressive/disruptive patients so that staff has the appropriate skills and confidence and team support to deescalate and handle conflictive situations. This is crucial so that it will not be necessary to order so many 1:1, 2:1 and 3:1 intensive observations and should greatly reduce the frequency of restraint/seclusion intervention. This is especially important because large numbers of new MHTs are currently being hired. This is the prime time to provide them with the skills needed to prevent and deescalate aggressive patient behavior. If the practice of freely placing patients on 1:1, 2:1 and 3:1 is not adequately addressed, the new direct care staff will think that this is always needed for safety, thereby making them feel unsafe when this practice is more thoughtfully and clinically followed. OSH needs to forestall new staff becoming acclimated to the status quo.

OT 6.1.e. – Direct care belongs on treatment teams: Direct care supervisory personnel should be included in treatment team meetings and QI activities. They are crucial members of the team, who provide the eyes and ears on the units and have the most involvement with the patients, and their “buy-in” is essential. It is unclear to what degree MHTs and MHT supervisors are involved in treatment planning in general, and behavioral planning in particular.

OT 6.2. – Revise policy for use of intensive observations: The policy and practice of placing a patient on heightened observation should be critically examined in order to bring more order to the unit, decrease the mandatory overtime and potentially free up the Unit Nurse Manager to more adequately address patient care issues. In order to make an impact in this problem area, it will require the buy-in of physicians, RNs and MHTs (and potentially other direct care staff). Moreover, psychology should have a much stronger role (see below).

OT 6.3. – Strengthen role of psychology in guiding behavior management: Teamwork is absolutely crucial to prevention, de-escalation and management of aggressive and challenging behavior and psychology is crucial to behavior management methods. This will require a lot of focused attention and training with much stronger participation of psychology in managing challenging behavior. Presently the minimum core "treatment team" appears to require only a psychiatrist and a nurse. While other disciplines are encouraged to participate, actual level of involvement varies by unit. Treatment planning meetings need to emphasize a fully integrated interdisciplinary team approach that includes active involvement of interdisciplinary clinicians and direct care personnel. The Liberty Review Team recommends a much strong role for psychology staff to support the comprehensive application of positive behavior management across the units. This calls for a reexamination of how psychology staff is being utilized at OSH. Under the previous Unit Director model, psychologists were assigned to separate units. Currently, OSH is trying a new centralized model in which psychology staff are assigned to any unit as need arises. A priority for OSH is to develop a means to ensure the comprehensive application of a solid behavior support plan. We feel this is integral to addressing the issues necessitating excessive use of 1:1 coverage, and milieu management issues.

OT 6.4. – Remove incentives for abuse of overtime: If the MHTs do not sign up for voluntary overtime, they are able to volunteer the day of the overtime and have it count as mandatory overtime. This actually was part of an agreement between the Union and administration. The advantage is that their name goes to the bottom of the mandatory list, which makes it likely that they can stay on their usual unit. Those who voluntarily sign up ahead of time for overtime are likely to be assigned to another unit. Although the facility may be unable to modify this agreement, attention should be given to collecting data on mandatory overtime. Since there is currently a disincentive to voluntarily sign up for overtime, more MHTs are waiting until the day the overtime in needed, volunteering for the mandatory overtime, having their name go to the bottom of the mandatory list and being allowed to stay on their home unit. The facility should consider counting this time as voluntary instead of mandatory when reporting out the data. During the Liberty review, some staff voiced that it was demoralizing to see other staff "gaming" the system to get overtime, holiday pay, etc.

OT 6.5. – Balancing security and treatment: The relationship between security and clinical and nursing needs to be improved with greater cooperation and communication. Given the

failure of clinical leadership to take charge and direct the response to emergency situations and challenging behavior, security has been given control and tends to utilize a heavy handed approach. It is not enough to provide some training on behavior management. First there needs to be a clearly conceptualized approach that balances treatment and security and is applied the same way across all hospital and forensic units alike. (A sample model is presented in Attachment B). Second, mechanisms must be put into place for continuous refresher training – with security and direct care and treatment personnel together – and meetings where all three can interact and develop teamwork.

7. Improving Personnel Management

Perception that management cannot dismiss poor performers

Summary: There is prevalent thinking that managers can do little to discipline or remove problem employees. Clinical managers have looked to HR to handle personnel issues, while HR declines such responsibility because it is a management issue. At the same time, undue fear of union issues and the lack of management knowledge concerning the personnel system have reinforced the conviction that it is exceedingly difficult to remove problematic employees. Reluctant to act, managers retreat into helplessness and tolerate continued poor performance from problem employees whose behavior hurts team cohesion and morale. The common perception is that the HR process is too cumbersome to manage and remove "bad" employees and that it cannot recruit, hire and train new staff quickly enough to ameliorate the chronic desperate need for direct care staff that has been continually strained by the high rates of mandatory overtime.

Although the hospital is striving to hire more RNs and direct care staff as quickly as possible, some units remain understaffed with just one RN and 2-5 MHTs being assigned to serve 40-44 forensic patients. This is creating a "perfect storm" for negative outcomes. It would be extremely difficult, if not impossible, for the RN to supervise the MHTs to ensure compliance with policies and standards of care and to be responsible for the assessment and care of so many patients.

Recommendations:

HR 7.1. – Selecting for compassionate attitudes: The hiring and retention process must include an appreciation for identifying candidates who demonstrate the inherent qualities of compassion, tolerance, patience, respect and empathy. Although training can increase awareness and skills, some personality traits and attitudes/values such as these are not skills to be taught.

HR 7.2. – Career development program for MHTs: Given the fact that direct care staff (MHTs) comprises the largest contingent of employees at OSH, it might be wise to develop

a special subprogram within HR that could focus on hiring. This could include targeting recruiting and incentives; better presentation of MHT jobs as genuine careers with an emphasis on expanding competencies and career advancement; better training programs to provide the initial skill sets; formalized mentoring program to support new staff; employee recognition programs; and streamlining operational procedures for accelerating recruiting, interviewing, credentialing, hiring, orienting, mentoring and evaluating new employees.

HR 7.3. – Mentoring for new staff: Hospital needs to implement a mentoring model wherein new staff are paired with a seasoned competent staff member for one to two months (or more if needed) for role modeling, skills development, confidence, etc. This is also described in Recommendation OT6.1.c with respect to new direct care staff.

HR 7.4. – Employee recognition program: OSH has many dedicated, committed staff; yet they have been beaten down by all the negative exposure. There should be employee recognition programming in which the hospital can recognize and celebrate successes. Staff needs to hear praise for good performance and learn to take pride in their important work.

HR 7.5. – Forums that value feedback from staff and patients: Feedback from staff and patients is often ignored or discounted at OSH. The hospital should have forums where patients and line staff can provide input to leadership and be engaged in policy discussions. They currently feel unvalued and unheard. One possible forum is described in Recommendation L2.5. "Mechanism for Superintendent engagement."

HR 7.6. – Pressing need to fill Social Work vacancies: The Social Work Department has primary responsibility for discharge planning, which is vitally important to a recovery-oriented public psychiatric hospital. With 15 reported vacancies, this function is being under-served, which has the potential for increasing the rate of hospital readmissions and other negative outcomes, including mortality. There is a critical need to bolster recruiting for Social Workers at OSH.

8. Additional Observations

This section consists of additional observations that may be of use to Oregon State Hospital.

Recommendations:

QUESTIONS ABOUT THE ADEQUACY OF CARE

X 1.1 – MISC: Although OSH has a medical clinic, there are limited medical services provided on the units. There is no medical OD on-site after hours to respond to medical

issues. The unit staff calls the psychiatrist OD who triages and calls the medical OD for guidance. Evaluate adequacy of medical coverage on all units.

X 1.2 – MISC: The Review Team had questions as to the adequacy of OT and PT services. Evaluate OT or PT services at hospital

X 1.3 – MISC: Reportedly, on certain units, durable medical equipment is outdated. Evaluate adequacy of the same.

THERAPEUTIC ENVIRONMENT

X 1.4 – MISC: There are limited, if any, planned structured leisure or recreational activities offered to patients on evenings and weekends on any of the units at the Salem campus. We recommend an evaluation of whether these activities should be increased.

X 1.5 – MISC: There are numerous hanging hazards on the units (ex: grab bars in bathrooms, plumbing fixtures exposed, etc.) and no supervision or routine checks of these areas by staff to monitor patient safety. We recommend a review of this observation.

X 1.6 – MISC: Staff reported that most patients on 50G and 50F are not attending the treatment mall. Review and address treatment mall attendance and effectiveness for all units.

X 1.7 – MISC: Develop specific ISP objectives for individuals returned to OSH after a failed community placement that focus on providing supports for the specific problem/issue the individual experienced while in the community setting.

X 1.8 – MISC: After traumatic event on unit (medical emergency, physical restraint, etc.) staff often debrief. Patients say they need the same opportunity, since the situation is very upsetting for them and the milieu.

Attachment A. Organizational Structure of Current QM/Leadership Bodies at OSH

- Superintendent's Cabinet
  - (Institutional Review Board)
    - I. Clinical Executive
    - II. Nursing Executive Council
    - III. Medical & Allied Health Professional Staff (MAHPS)
      - Bylaws
      - Credentialing
      - Ethics
      - Medical Dept. CQI
      - Medical Records
      - Morbidity and Mortality
      - Pharmacy and Therapeutics
      - Utilization Review
      - Infection Control/Employee Health
    - IV. Quality Council
      - Research Committee
      - Consumer Council
      - Education & Development Advisory Committee
      - Patient Rights
        - Patient Grievance
      - Environment of Care
        - Emergency Preparedness
        - Hospital Safety
      - Care of Patients
        - Evidence-Based Practice
        - *Patient Care consults
        - Treatment Care Planning Advisory Group
        - Treatment Mall Planning
        - Core Curriculum
        - Recovery Workgroup
          - Valuing Diversity
          - Metabolic Syndrome
          - START
          - BSP
      - Patient Safety
        - Critical Incident Review Panel (recommended by DOJ & CIP)
        - Falls Committee (required by Joint Commission)
        - *Highly Aggressive Patients (PI team)
        - *Self-harm (PI team)
        - Seclusion/Restraint

*Working Well

Attachment B.

MANAGEMENT STRATEGIES FOR IMPROVING THE DELIVERY OF MENTAL HEALTH SERVICES IN SECURE SETTINGS

by Anthony T. Cimino, Liberty Healthcare Corporation

Problems and Barriers	Solutions
Environmental Issues	
1. Spatial intrusion. High density of population leads to lack of privacy and intensified environmental (e.g., noise) and social friction, which can lead to violence.	❑ Security is focused on maintaining a highly secure perimeter, allowing treatment to occur in the interior. ❑ Easy-to-understand behavior modification system consisting of levels requiring increasing levels of clearly defined appropriate behavior and active participation in treatment. Compliance at each level is rewarded with greater variety of activities, chances for more privacy, and chances to contract for individual privileges. Noncompliance results in loss of gained privileges. ❑ Sufficient and appropriate space to run a varied activity program and allow for controlled stimulation. ❑ Sufficient space for smaller groups and some individual privacy. ❑ Patients gain some control over environment by having ability to earn privileges and greater mobility. ❑ Patients have real input into program planning and problem resolution via Community Meeting and natural daily interactions with staff. ❑ Behavior modification program provides structure, stability and predictability.
2. Monotony and boredom. Drab and low levels of stimulus change combined with high absolute levels of stimulation cause boredom that can lead to violence and disruptive behavior.	
3. Lack of control and predictability. Individual cannot control environmental changes and changes are unpredictable, resulting in behavior breakdown.	
Staffing and Organizational Issues	
4. Differing goals of security and treatment staff. Security and treatment staff are separate with differing goals. Security usually has greatest influence.	❑ Security staff focused on perimeter security and has minimal responsibility for interior. When they do respond to interior emergency, they are under direction of clinical staff. ❑ Interior security is responsibility of *all* treatment staff. ❑ All treatment staff are expected to respond in an emergency situation. Practiced teamwork facilitates rapid staff notification and arrival in emergency situations. ❑ Policies and procedures are simplified and call for close patient supervision (frequent patient counts, control of contraband). All staff, without exception, must clear metal detector and submit to package inspections. ❑ Reduce security/treatment split by making both staffs accountable to same administrator who is a clinician versed in both. Administrator must take broad view of both to integrate them as one seamless program, which leads to more creativity. ❑ Establish clear admission policy to reduce inappropriate referrals from jails and mental health departments. When case is discharged for being inappropriate, program gives clear rationale and realistic recommendations for follow-up care.
5. Non-cooperation between security & mental health personnel. Usually a poor to nonexistent level of cooperation between security and mental health departments, preventing them from working together effectively.	
6. Managing violent patients. It is difficult to manage violent and aggressive patients with effective therapeutic means that do not rely on coercive force.	❑ All treatment staff trained in same techniques of non-aggressive behavior management and physical management of violent patients. Team approach is emphasized and bolstered with training and frequent relationship-building interactions/communication.

Attachment C. Summary of On-Site Meetings and Review Activities

Date	Meeting / Committee / Unit Tour / Interviews	Total OSH Participants
7/12	Meeting with OSH expert consultants	2
	Opening Conference with OSH Cabinet	15
	Meeting Clinical Services Leadership (3 clinicians)	3
	Meeting with Strategic Planning Dir., QI Dir., QI Assoc Dir. & Asst. Risk Manager	4
	Meeting with Chief Nursing Officer/Director of Nursing	2
	Meeting with Superintendant	1
	Meeting with CFO	1
	Meeting with 5 Program Nurse Managers from Forensics, Gero & Portland	5
	Meeting with Interim Superintendent	1
	Meeting with 20 Supervisory Nurse Managers	20
	Meeting with Director of Social Work/Discharge Planner	2
	Meeting with Director of Security	1
	Meeting with Director of PAR	1
	Meeting with Consumer Group	9
7/13	Nurse Executive and Leadership Council (18 people)	18
	Meeting with Electronic Med Record (5 staff)	5
	Meeting with PSRB liaison	1
	Meeting with Friends of Forensics (family members)	9
	Meeting with Unit Director of Gero Services	1
	Meeting with Interim Director/ Recovery Services	1
	Attended Quality Council meeting	20
	Attended Medical Staff Meeting (30 physicians)	30
	Meeting with Clinical Disciplines: Directors of Social Work, Psychology, Rehab, Vocational Rehab & Clinical Director	5
	Meeting with Unit Program Directors	5
	Attended Critical Incident Review Panel meeting	15
	Meeting with QI Director and Assoc QI Director	2
	Tour of 34D with MHT1and Internist	2
7/14	Tour of 40 Treatment Mall and meeting with Program Director and RN	2
	Interview with patient on 40-Mall who lives in the Cottages	1
	Interview with Supervising RN in Cottage	1
	Tour of 50E unit with Supervising RN	1
	Tour of 35A unit & Transitional Treatment Mall, interviewed staff & patients	20
	Tour of Geriatric Units 34C and 34D, interviewed RNs & MHTs	6
	Tour of Medium Security Units 50J & 50I, interviewed unit staff and patients	20
	Tour of Geriatric Learning Center, interviewed staff and patient	2
	Tour of Forensic Treatment Mall (Bldg 50), interviewed staff	5
	Night shift surprise tour of two units, meeting with nurses & MHTs	7
	Tour of Unit 50H, meeting with 11 clinicians	11
	Portland - Tour Unit P6A, meeting with Unit Nurse Mgr, MD & interviewed 2 patients	4
	Portland - Tour Unit P1A, meeting with Unit Nurse Mgr & interviewed patient	2
	Portland - Tour Unit P5A, meeting with 1 MD, 3 MHTs & interviewed 2 patients	6
	Portland - Tour Unit P1B, meeting with 1 nurse, 2 MHTs	3

7/15	Tour of Maximum Security Units 48B & 48C, interviewed unit staff	10
	Tour 50C, meeting with 3 clinical staff & interviewed patient	4
	Tour 34A, meeting with 5 clinical staff & interviewed 2 patients	7
	Tour 50H, meeting with 6 unit staff	6
	Tour 35B, meeting with 3 unit staff	3
	Meeting with Chief Medical Officer and President of Medical Staff	2
	Tour of 50G unit	5
	Meeting with HR Director	1
	Tour of 50D unit with RN and Psychiatrist	2
	Meeting with Exec Director of NAMI Oregon	1
	Tour of 50F unit and meeting with 6 employees	6
Totals: 4 days on-site; toured 26 units; met with and interviewed over 300 people		**313**

Attachment D. List of Documents Reviewed

Organizational documents:

- Hospital Mission Statement
- Organizational Charts
- Program Descriptions
- Description of Strategic Planning Departments
- Committee Resource Handbook list/description
- Job descriptions of front-line supervisors
- Job description of TCPS
- List of Cabinet members
- List of key Medical and Clinical staff
- Quality Improvement Plan
- Continuous Improvement Plan
- Continuous Improvement Plan Priorities
- MAHPS Bylaws
- PAR data reports
- Instructions and audit tool for 10 day comprehensive chart reviews
- Union Contract

Reports:

- Un-redacted Perez Investigation Report by OIT
- Oregon OIT Report
- Hospital Plan in response to OIT Report
- OSH Annual Budget
- Annual/Monthly Budgets and Financial Reports
- Quarterly Governing Body Reports
- USDOJ reports (11/06 & 1/8/08)
- USDOJ letter to State Attorney General in request for documents
- Training curriculum/competency assessments
- Special Master's Final Report
- Joint Commission Survey Report (2/09)
- Most recent CMS Report (2/08)

Monitoring logs:

- Abuse/Neglect/Exploitation cases (past 3 months)
- Deaths in hospital or within 14 days of discharge (past 12 months)
- Incident log for the last 30 days (by patient)
- Seclusion/Restraint log (last 30 days) by patient

Key forms:

- Incident Report Grid
- Patient Satisfaction Questionnaire
- QI Dept Orientation Checklist

Policies:

- Abuse/Neglect/Exploitation reporting and investigation
- Abuse/Neglect/Exploitation documentation (draft policy)
- Assessment Timeline Guide
- Behavioral Precautions
- Constant Behavior Precautions Policy
- Consumer Council Policy
- Documentation
- Emergency Alarm System
- Employee Response to Violent Situations
- Falls Prevention
- Incident Reporting
- Sentinel Event
- Medication Administration
- Medical Emergency Response
- Mortality Review
- Nursing Assessment
- Pain Management
- Patient Assignments
- Patient Education
- Patient Grievance
- Physical care (intake & output, vital signs, weights, wounds)
- Physician Notification Parameters
- Positive behavior support principles & positive interventions to prevent/deescalate crises
- Provision of a therapeutic milieu
- PSRB Guidelines
- Seclusion/Restraint
- Security Dept. General Work Expectations
- Special Precautions (Suicide, Assault, Elopement, etc)
- Special Observations (1:1, 2:1, 3:1)
- START
- Training in Preventing/Managing Aggression
- Time and Attendance
- Unauthorized Leave Policy
- Verbal Orders

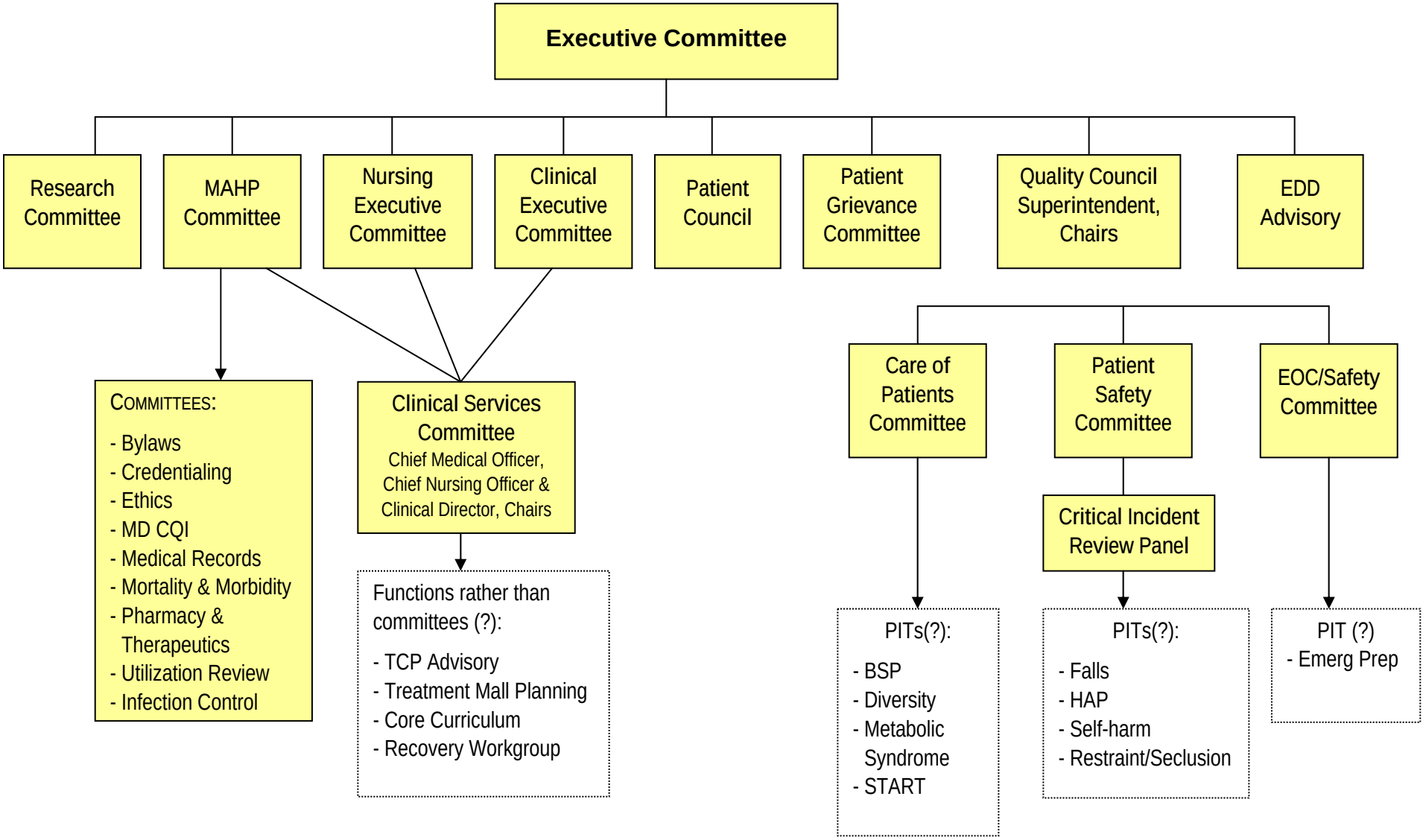
Committee Minutes:

- Care of Patients Committee minutes
  - Critical Incident Review Panel Minutes
  - Committee Fact Sheets
- Clinical Executive Committee minutes
- Superintendent's Cabinet meeting minutes (past 12 months)
- Death Review Committee (past 12 months)
- P&T Committee (last 3 months)
- Quality Council minutes (last 12 months)
- EOC Committee (last 6 months)
- Medical Staff Committee minutes
- Patient Safety Committee minutes (last 6 months)
- Seclusion Restraint subcommittee minutes
- TPAG Committee (last 6 months)
- Nurse Executive &Leadership Council

Nursing specific documentation:

- Shift reports (past month)
- Staffing by ward/shift (past 2 weeks)
- Current vacancies
- Turnover data
- Staffing ratios,
- Medical Treatment Plans,
- QI plan, data and reports,
- Nursing competencies specific to particular populations.
- Staffing Proposal
- Nursing hours per patient day
- Nursing Leadership Management Series
- Staffing Patterns by unit and shift
- Curriculum for medication administration
- Role comparisons for new Unit structure

Attachment E. Organization Chart – Recommended Committee Restructuring



Attachment F. Health Information Group (HIG) – Organization Chart Recommended Revision