REPORT OF THE
OFFICE OF THE INSPECTOR GENERAL
FOR THE DEPARTMENT OF MENTAL HEALTH, MENTAL
RETARDATION AND SUBSTANCE ABUSE SERVICES

# Semi-Annual Report

(October 1, 2001 - March 31, 2002)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

# HOUSE DOCUMENT NO. 38

COMMONWEALTH OF VIRGINIA
RICHMOND
2002

# COMMONWEALTH *of* VIRGINIA

*Office of the Governor*

Anita S. Everett, M.D.
Inspector General
to the Department of Mental Health, Mental Retardation
and
Substance Abuse Services

May 31, 2002

To the General Assembly of Virginia:

I am pleased to submit for your review this semi annual report for the period October 1, 2001 – March 31, 2002. This report reflects the activities of the Office of the Inspector General over this six-month reporting period.. In addition to the summary of activities of the Office, included are the actual findings and recommendation from the new reports completed within this time frame. Additionally, Chapter 3 includes all recommendations made by the OIG that have not been resolved as of December 2001.

This office has been instrumental in stimulating a number of changes that have increased the quality of care within the facilities operated by the Commonwealth of Virginia for those with serious mental illness and mental retardation. One in five Virginia citizens is directly affected by Mental Illness. We are proud to be of service to this often disenfranchised and unheard group of very vulnerable citizens. It is a profound function of government to provide for those who truly are incapable of caring for themselves. As you will see from this report, the Office of the Inspector General is critical in providing accountability regarding access to quality care for these citizens and their families.

Sincerely,

Anita Everett, M.D.
Inspector General

P.O. Box 1475 • Richmond, Virginia 23218 • (804) 692-0276 • FAX (804) 786-3400 • TTY (804) 786-7765

# COMMONWEALTH *of* VIRGINIA

*Office of the Governor*

Mark R. Warner
Governor

May 31, 2002

To the General Assembly of Virginia:

I am pleased to transmit the semi-annual report of the Inspector General for the six-month period ending March 31, 2002. This report includes a summary of the activities of the Inspector General's Office, as well as outstanding recommendations for each facility.

I am committed to building on the progress that our state has already made in improving the quality of care in our mental health and mental retardation facilities. While it is important to focus resources on community-based care, we must not do so at the expense of our fellow Virginians who require institutional care.

I commend the Inspector General for her thoughtful, independent reviews of facilities. Her office is a valuable complement to the newly created Virginia Office of Protection and Advocacy in promoting the rights, dignity, and well being of some of our most vulnerable citizens. Accordingly, I am pleased to transmit this report.

I look forward to working with the Inspector General, the Virginia Office of Protection and Advocacy, the General Assembly, the advocacy community, and all interested parties in continuing to move forward to build a mental health and mental retardation system of care that we can all be proud of.

Sincerely,

Mark R. Warner

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# COMMONWEALTH *of* VIRGINIA

*Office of the Governor*

Anita S. Everett, M.D.
Inspector General
to the Department of Mental Health, Mental Retardation
and
Substance Abuse Services

May 1, 2002

Dear Governor Warner,

I am pleased to submit for your review this semi annual report. This report reflects the activities of the Office of the Inspector General over the last six-month period ending March 31, 2002. In addition to the summary of activities of the Office, included are the actual findings and recommendation from the new reports completed within this time frame. Additionally, Chapter 3 includes all recommendations made by the OIG that have not been resolved as of December 2001.

As you are aware, it is my duty to directly report to you situations, which are felt to represent imminent danger to institutionalized persons, or situations, which in my opinion represent serious concern and are not being addressed in a timely and appropriate fashion. This six-month period has been one of transition in state government leadership. There has been no imminent situation within the facility population that has required immediate report to you, however there are a number of ongoing gaps in care, which may need to be brought to your attention. The Department of Mental Health, Mental Retardation and Substance Abuse Services is fortunate with the dedicated leadership put into place by your administration.

This office has been instrumental in stimulating a number of changes that have increased the quality of care within the facilities operated by the Commonwealth of Virginia for those with serious mental illness and mental retardation. We are proud to be of service to this often disenfranchised and unheard group of very vulnerable citizens. It is a profound function of government to provide for those who truly are incapable of caring for themselves. As you will see from this report, the Office of the Inspector General is critical in providing accountability regarding access to quality care for these citizens and their families. One in five Virginia citizens is directly affected by Mental Illness.

Sincerely,

Anita Everett, M.D.
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# CHAPTER 1 - ACCOMPLISHMENTS

The Office of Inspector General (OIG) was created to increase accountability in the public funded mental health, mental retardation and substance abuse service system in Virginia. The OIG mission is to challenge the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to provide quality care that is consistent with contemporary best practices. The Office of Inspector General works to compliment the usual regulatory processes such as licensure, JCAHO and the Center for Medicare and Medicaid Services (formerly HCFA, Health Care Financing Administration). The goal of the Office of Inspector General is to promote public services that are safe, effective, patient centered, timely, efficient and equitable. Ultimately this will result in Virginia being less vulnerable to scrutiny by external entities such as the Department of Justice.

This report outlines the work of the Office during the semi-annual reporting period October 1, 2001 - March 31, 2002. (House Document No. 16 (2002) outlines the work during the semi-annual reporting period April 1, 2001 - September 30, 2001.)

## A. INSPECTIONS

The OIG routinely conducts unannounced inspections at each of the fifteen state facilities operated Mental Health and Mental Retardation facilities annually. Subsequent inspection reports contain findings and recommendations for performance improvement. Each finding and recommendation made in an inspection report is responded to by the facility and DMHMRSAS through a plan of correction.

During this reporting period the OIG has completed 10 new inspections.

A **Primary Inspection** is announced and includes evaluation of eight areas that are consistent with areas of concern raised by the Department of Justice. These eight areas include: Treatment with Dignity and Respect, Use of Restraint and Seclusion, Access to Medical Care, Access to Rehabilitative Psychiatric Treatment, Condition and Maintenance of the Facility, Relationship with Institutions of Higher Education, Performance improvement Projects actively underway, and Administrative Challenges. One primary inspection was conducted in this six-month reporting period at: Southwestern Virginia Mental Health Institute in Marion.

A **Secondary Inspection** is an inspection that occurs in response to an alleged problem at a facility. These may be announced or unannounced. A secondary inspection may consist of an independent review of the incident and subsequent management, or may include a review of the management or peer review performed by the facility. One secondary inspection was conducted within this six-month reporting period at: Central State Hospital in Petersburg.

A **Snapshot Inspection** is an unannounced inspection wherein three essential areas are addressed. These are the core features that a person institutionalized within a state hospital has a right to under the Federal Civil Rights for Institutionalized Persons Act. These are:

1. Participation in *active rehabilitative treatment* designed to facilitate community reentry;
2. Access to *adequate numbers of staff* who are appropriately qualified to provide this treatment;
3. A facility environment that is attended to in terms *safety* and general housekeeping.

Eight snapshot inspections were conducted within this six-month reporting period. One each at the following facilities:

Commonwealth Center for Children and Adolescents in Staunton;
Eastern State Hospital in Williamsburg;
Northern Virginia Mental Health Institute in Fairfax;
Northern Virginia Training Center in Falls Church;
Piedmont Geriatric Hospital in Burkeville;
Southeastern Virginia training Center in Chesapeake;
Southwestern Virginia Training Center in Hillsville and
Western State Hospital in Staunton.

## B. REPORTS

An inspection report accompanies each Inspection. The inspection report contains observations in sets of information that includes for each issue of significance: a finding, background, and corresponding recommendation. This report is then presented to the Governor's Office and to the Commissioner of DMHMRSAS. A Plan of Correction (POC) is developed within two weeks that includes a response to each recommendation within the OIG Inspection Report. The plan of correction is reviewed by the OIG and is either accepted or returned to DMHMRSAS for revision. Upon acceptance of the POC, the report is considered to be a complete report package.

During this semi-annual reporting period there were 12 completed report packages. (Note there were two more completed report packages than inspections completed due to the normal time lag in preparing the report and negotiating a plan of correction.) These included: two primary inspection report packages, Northern Virginia Training Center and Southwestern Virginia Mental Health Institute; one secondary inspection report package at Central State Hospital; and nine snapshot inspection report packages, Commonwealth Center for Children and Adolescents; Eastern State Hospital (2); Northern Virginia Mental Health Institute; Northern Virginia Training Center; Piedmont Geriatric Hospital; Southeastern Virginia Training Center; Southwestern Virginia Training Center and Western State Hospital.

The findings and recommendations from inspection reports completed during this semi-annual reporting period are located in Chapter Two of this report.

## C. SPECIAL PROJECTS

Special Projects are projects identified by the OIG as issues that have an impact on the facility system and/or are of national significance. The purpose of many special projects is to benchmark aspects of the public mental health, mental retardation and substance abuse system in Virginia with contemporary national trends. Eight projects have been either continued or initiated during this semi-annual reporting period. Among the special projects are the following:

**Mortality Study** – This study, which was released to the OIG website in December 2001, reviewed the charts of each of the 127 deaths of patients admitted to a state facility that occurred during the thirteen-month period from October 1, 1998 to October 31, 1999. This study found considerable inconsistencies within state facilities in the post mortem review of the circumstances and management of deaths. Additionally, despite the fact that there were a number of unexpected deaths, very few autopsies or external peer reviews were conducted. The life expectancy of individuals residing within our training centers may be above average compared to available national data. The majority of deaths occurred in one of the three geriatric psychiatric treatment facilities. The majority of these deaths were associated with known serious medical conditions.

As a result of this study, several policies were created and amended within DMHMRSAS that provided for the consistent review of deaths with an emphasis on looking for opportunities to apply what is learned from the reviews to ongoing management of other patients and residents, reporting of unexplained injury or death, and reporting deaths to the Medical Examiner.

A second Mortality Study has been initiated as of January 2002. This study will focus on all deaths in the facilities occurring between November 1, 2000 – October 31, 2001. The purpose of this study is to review the clinical circumstances of each of these deaths. A retrospective chart review will be completed on the 85 patients who died while admitted to a Virginia mental health or mental retardation facility during the twelve-month study period. It is anticipated that this study will be completed by September 30, 2002.

**Chief Medical Examiner Legislation** – The "Mortality Study" conducted by the OIG, provided information, which resulted in collaboration between the OIG, DMHMRSAS and the Chief Medical Examiner regarding legislation. This legislation calls for a referral of all deaths to the state medical examiner. This legislation was passed by the General Assembly and signed by the Governor to be effective, July 1, 2002.

**Discharge Study** – The Southeastern Rural Mental Health Research Center (SRMHRC) at the University of Virginia under the auspices of the OIG conducted a study of patients discharged from public inpatient psychiatric facilities in Virginia. The study was designed to examine the discharge placement process and outcomes.

**Psychiatrists in Underserved Areas** - This program's goal is to encourage newly trained psychiatrists to pursue practice in a rural area in Virginia. This program is administered by the Psychiatrists in Underserved Areas Committee (PUAC), whose members include

the Inspector General, representatives from the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Virginia Department of Health (VDH). The program provides for one Faculty Fellow at each of the Psychiatry programs in Virginia, plus awardees from each program that receives financial benefits from the program in exchange for professional services within an underserved area. Four psychiatrists have been placed in practice in rural areas in Virginia as of July 1, 2002 as a result of this program.

**American Association of Community Psychiatrists (AACP) Spring 2003 meeting –** The Inspector General will be hosting the Winter 2003 conference of this national organization in Charlottesville, Virginia. Planning is underway with the University of Virginia Continuing Medical Education Office to organize this event. The Inspector General is a member of the AACP Board of Directors and has been able to represent the work that Virginia has done within its Mental Health delivery system at these semi-annual conferences. It is the intent to bring together clinicians from across Virginia to this forum designed to bring to Virginia several effective models for state of the art recovery oriented mental health services.

**Training Center Resource Inequity** – In 2001, the OIG concluded a review of staffing patterns within training centers as it relates to quality of care. This review was conducted on-site at all five training centers. The data demonstrated that the residents in several training centers were at risk due to inadequate access to appropriate staffing. Emergency funding was made available and maintained within the State Budget to alleviate these at risk conditions.

**Central State Hospital Forensics Building Conjoint Project** - During 2001, the OIG received 87 critical incident reports from CSH. Forty-seven of those reported involved the forensic units in Building 39. Allegations of violence either towards self or others were prevalent in the reports associated with this unit, including 29 reports of allegations of sexual and other physical assaults and 13 self-injurious behaviors. Six reported incidents occurred in the bathroom, 2 in the bedroom and 9 in other public areas and 25 in unknown locations. The purpose of this conjoint project was to conduct a review of the environmental and personnel factors on the forensic services particularly in Building 39 that relate to the management of physical safety on these units.

Eric Roskes, MD and Lyle Forehand, MD, from Springfield State Psychiatric Hospital in Maryland, served as consultants during this project. Dr. Roskes has extensive experience in working with forensic patients both in inpatient and outpatient public mental health settings in Maryland. He has served as State Medical Director for psychiatric services for the Maryland Department of Corrections. Dr. Forehand is in his final year of training in his psychiatric residency program at the University of Maryland.

This project was completed at nominal expense to the OIG. Both consultants provided their expertise in exchange for the opportunity to have the staff from Springfield learn about the Central State Hospital psychosocial rehabilitation treatment mall. The hospital in Maryland is planning to initiate a similar project.

**CSB/Family Education and Illness Management Project** – This project is designed to assess the current status of the availability of formalized education offered to families about severe and persistent mental illness. Additionally we will assess the offering of formalized illness management education to persons with severe and persistent mental illnesses. These two areas have been demonstrated in multiple studies to be a vital component in the best practice of management of those with serious and persistent mental illness in a community setting. Once completed, this study could lead to information that would reshape practice such that existing natural supports such as family members could be appropriately included in community care. The OIG has contracted with Anita Heisterman MSN, FNP, CNS, RN of the University of Virginia School of Nursing. The expected completion date for this study is September 30, 2002.

## D. DATA MONITORING

### Critical Incident Reports

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

Since the beginning of this official monitoring the OIG has reviewed and monitored **1,458** critical incident reports. Three hundred and sixty eight critical incidents were reviewed within this semi-annual reporting period. This information is used to identify potential clinical problems with treatment of individuals within DMHMRSAS facilities and to track trends in facilities. The information is integrated into the inspections and schedule of the OIG.

### Quantitative Data

Quantitative facility data has been received each month from DMHMRSAS, beginning in January 2002. The basic information requested includes: facility census data; facility human rights data; facility seclusion and restraint data; facility death data; facility personnel data, facility staff injury data, and facility overtime data. The personnel data addresses position vacancies, new hires and separation from service.

A database has been established to track the monthly Quantitative facility data. This allows OIG to monitor trends within individual facilities at a reasonable interval as well as throughout the facility system. An example as to how this information might be utilized would be to follow changes in use of seclusion and restraint rates. If a particular facility has an increase in these rates, an inquiry or inspection will be conducted to establish the cause of these changes.

## E. FOLLOW-UP MONITORING

Two hundred and eleven of the 418 recommendations made by the OIG reports as of September 30, 2001 had been successfully acted upon and completed. Compliance with the accepted Plan of Correction (POC) is monitored through periodic onsite follow up visits as well as through progress reports that are submitted to OIG by DMHMRSAS from all the facilities at six-month intervals. This semi-annual report period incorporates the second set of 6-month reports submitted by DMHMRSAS. The first review period closed 211 out of 418 active findings and recommendations.

During this reporting period, 10 new on-site follow-up inspections have been conducted. This included follow up on **38** reports that included **151** active findings and recommendations. Follow-up site visits are the mechanism by which the OIG verifies on-site the progress of a facility toward the compliance with the POC. Follow-up inspections in general are unannounced in order to gain a realistic perspective of the facility's progress. At a follow-up inspection, any active recommendations from previous Inspection reports are reviewed. Evidence is required from at least two sources in order to recommend that the finding become inactive. The sources may include interviews with staff, patients, review of procedures, memoranda, medical records, meeting minutes, or other administrative and/or clinical documents.

## F. REVIEW OF DEPARTMENT INSTRUCTIONS AND REGULATIONS

Virginia Code § 2.1-817 requires that the OIG: *review, comment and make recommendations, as appropriate, about any reports prepared by the Department of Mental Health, Mental Retardation and Substance Abuse Services and the critical-incident data collected by the Department of Mental Health, Mental Retardation and Substance Abuse Services in accordance with regulations promulgated under § 37.1-84.1 to identify issues related to quality of care, seclusion and restraint, medication usage, abuse and neglect, staff recruitment and training, and other systemic issues.*

*To monitor and participate in the promulgation of regulations by the State Mental Health, Mental Retardation and Substance Abuse Services Board.*

During this semi-annual reporting period a formal review has been completed of three DMHMRSAS sets of regulations and five DMHMRSAS Departmental Instructions. These included the following Departmental Instructions (DI's):

DI 107, Medical Assessment, Consultation and referrals;
DI 302, Medicare and Medicaid Compliance;
DI 709, Approval of Automated Systems Development;
DI 201, Abuse and Neglect Investigations;
DI 521, Return to Work/Worker's Compensation Management Program

The following Regulations were formally reviewed within this reporting period:

Regulations for Licensing of Mental Health, Mental Retardation and Substance Abuse Services;
Regulations for Respite and Emergency Care Admissions to Mental Retardation Facilities;
Regulations to assure the Rights of Individuals receiving services from providers of mental health, mental retardation and substance abuse services.

## G. PRESENTATIONS AND CONFERENCES

The essential function of this office is to provide an enduring challenge to the quality of clinical care in the facility system in Virginia. In order to incorporate contemporary clinical ideas, the OIG actively participates in statewide and nationally recognized meetings and conferences. These meetings provide valuable information and opportunities for exchange of ideas and exposure to successful programs developed in other state systems and countries.

During this reporting period staff from the Office of the Inspector General participated in a number of state and national groups and meetings associated with the mental health mental retardation and substance abuse community. Presentations were made at a number of these meetings. These include:

MCV Grand Rounds-Dr. Everett presenting: Suicide Prevention as a Public Health Initiative
Mental health in the Millennium conference (Dr. Everett was Key Note speaker)
American Psychiatric Association: Institute on Psychiatric Services (Dr. Everett Presented)
Rural Mental Health Association Conferences at Virginia Tech (Dr. Everett was key-note speaker)
Virginia association of Community Service Boards, Physicians Institute conference (Provided opening remarks)
Conference on Implementing Evidence Medicine in Mental Health at Catawba Hospital
Department on Aging Conference
National Conference on Consumer Employment, Washington D.C.
Mental Health Quality Council
American Association of Community Psychiatrists National Conference
Virginia Statewide Facility Nursing Board Meeting
DMHMRSAS Board Meetings
DMHMRSAS Stakeholders Meeting on Rationing Psychiatric Medications

## H. LEGISLATION

The OIG officially tracked and were involved in the following pieces of legislation during this six-month reporting period.

**HB 8:** This legislation, which was patroned by Delegate Hamilton, has two components. It removes the requirement that regular OIG reports must first be sent to the Office of the Attorney General for an opinion regarding any individual breech of confidentiality or breech of peer review. This legislation also dictates for the required semi-annual reports, that the Governor's office shall not provide "preliminary clearances" prior to release to the General Assembly. Additionally a mandate to conduct at a minimum a snapshot inspection at each facility with comments regarding staffing, condition of the facility and access to active treatment became codified.

This bill was passed by the General Assembly and signed by the Governor.

**HB 9:** This legislation reestablishes the Department for the Rights of Virginian's with Disabilities into an independent Agency, the Virginia Office for Protection and Advocacy.

This bill was passed by the General Assembly and signed by the Governor.

**HB 396:** This legislation requires that all deaths that occur at DMHMRSAS facilities be reported to the State Medical Examiner. The Medical Examiner will then determine if an autopsy is to be performed.

This bill was passed by the General Assembly and signed by the Governor.

**HB 995:** This bill enables the DMHMRSAS Commissioner to engage in DMHMRSAS System restructuring.

This bill was passed by the General Assembly and signed by the Governor.

**HB 1228**: This bill sets up a clear role for a substituted decision maker in the discharge of mentally incompetent persons from state operated Training Centers (Institutions for the Mentally Retarded)

This bill was passed by the General Assembly and signed by the Governor.

## I. WEBSITE

The Office of the Inspector General was designed to increase accountability and integrity in the quality of clinical services as delivered by the public funded mental health, mental retardation and substance abuse services in Virginia. We have endeavored to design an inspection process that is objective, professional, independent, fair and forthright. Promotion of accountability to

consumers as well as the general public (who ultimately pays for these services) was the impetus of the OIG website. This was designed at the outset of the office and revisions were completed in June 2001. Since June 30, 2001 the site has been visited 1,489 times. The website currently has 49 inspection reports posted for public review. The website can be accessed at www.oig.state.va.us.

## J. MEETINGS

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

Our current goals are to participate regularly in:

- DMHMRSAS Facility Directors' Meeting;
- DMHMRSAS Facility Medical Directors' Meeting;
- American Association of Community Psychiatrists conferences and regional meetings;
- Virginia Association of Community Psychiatrists;
- American Psychiatric Association
- DMHMRSAS facility sponsored clinical conferences
- Psychiatric Society of Virginia, state board as well as semi-annual scientific meetings;

Additionally, current goals include annual or semi-annual attendance at the following meetings in order to present and receive feedback regarding the OIG semi-annual reports:

- DMHMRSAS Board
- DMHMRSAS Mental Health Planning Council
- Virginia Alliance for the Mentally Ill (V-AMI)
- Parents Association of Institutionalized Retarded (PAIR)
- Virginia Association of Community Services Boards (VACSB)
- PAIMI council: Protection and Advocacy for Individuals with Mental Illness of the Department for Rights of Virginians with Disabilities (DRVD) or of the DRVD predecessor, Virginia Organization for Protection and Advocacy (VoPA)
- Developmental Disabilities Council of the DRVD or VoPA.

# CHAPTER 2

## Inspections conducted during the Semi-Annual Reporting Period

### COMMONWEALTH CENTER FOR CHILDREN AND ADOLESCENTS
### STAUNTON, VIRGINIA
### WILLIAM TOOLE, DIRECTOR

**OIG REPORT # 56-02**

A Snapshot Inspection was conducted at Commonwealth Center for Children and Adolescents (CCCA) in Staunton, Virginia on March 6, 2002.

CCCA is the only state facility solely dedicated to the evaluation and treatment of persons under the age of eighteen. CCCA also serves the Commonwealth by conducting inpatient 10-day court ordered evaluations of children. The facility has a capacity of 48 beds.

Overall, the facility was noted to be safe, clean and provides a comfortable environment. There are four units, two for children and two for adolescents. All units are co-ed, though a nursing station separates the rooms that are occupied by one sex from the other. They do co- mingle in common areas but are prohibited from entering opposite sex bedroom or bathroom areas.

Staffing patterns were appropriate on the evening of this inspection. There were adequate numbers of staff present to safely and appropriately supervise these patients. CCCA operates 48 beds, the total census on the day of the visit was 38. There was a facility wide team building group activity going on in the gym for those who were able to leave their unit. Those who remained on the unit were generally there due to clinical instability. On the two adolescent units, the few patients remaining on the units were not engaged in formalized treatment activities at the time of the inspection.

**FINDINGS AND RECOMMENDATIONS**

**Finding 1.1:** Overall the facility was clean and well maintained but institutional in appearance.

**Recommendation:** Continue to assure that the maintenance of the overall facility includes the general upkeep of the bedroom areas, as previously planned. Consider adapting the use of visual materials for decoration noted in the school area in the living areas.

**Finding 2.1**: Staffing patterns were adequate.

**Recommendation:** Continue to provide adequate staffing patterns to meet the safety and treatment needs of the patients.

**Finding 2.2:** Staff had a wide range of clinical orientation to the management and treatment of children in this facility.

**Recommendation:** Work to promote clinical consistency through creating opportunities for mentoring and modeling therapeutic interaction with staff from second and third shifts.

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

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

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

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

**Finding 3.3:** For snack time, the majority of patients chose to purchase a canned soft drink and either potato chips or a candy bar.

**Recommendation:** Review the appropriateness of the choices available for the children and adolescents during evening snack time.

## CENTRAL STATE HOSPITAL
## PETERSBURG, VIRGINIA
## LARRY LATHAM, DIRECTOR

**OIG Report # 52 -01**

Central State Hospital is the primary service center for Virginia for adult mentally ill patients referred for forensic services requiring an inpatient psychiatric hospital setting. These services include stabilization services for individuals in jail who are assessed with acute symptoms of mental illness that can not be effectively treated in the jail setting, individuals awaiting trial who are in need of a competency to stand trial evaluation, restoration to competency treatment, and longer term services for persons adjudicated not guilty by reason of insanity (NGRI). Each of these subsets of the forensic services population require different treatment modalities and present a unique challenge to service providers. One of the challenges is to configure housing options that balance security, safety and treatment for these subsets.

Building 39, on the campus of Central State Hospital, is a maximum-security building, which houses only forensic patients. Forensic patients are also housed on two units in Building 96, a medium security building. These units are designated as "step-down" units for those forensic patients preparing to return to the community. Central State Hospital also has contracted with Riverside Jail for additional acute care forensic beds. This unit primarily serves individuals transferred from local jails. Building 39 provides both residential and programming services within the same building. There are six residential units. Three units are designed as acute care

units that have an operational capacity of 15 beds each. These are Wards 4, 6, and 8. The remaining three residential units, Wards 1,5,and 7 are designated for longer-term patients and have an operational bed capacity of 20 each. This building has been extensively renovated over the last several years. A census reduction project has greatly reduced crowded conditions within the building.

Specific findings were based on observations, interviews and documentation reviews. The sub optimal design of units in building 39 does not allow for adequate observation of areas wherein vulnerable patients can be victimized. A ward design more suited to forensic populations should be considered in long range planning. Patients do not feel safe and should be included in creating an environment with no-tolerance of violence. Central State hospital has a good system in place for managing the placement of groupings of patients on the various units within forensic settings. Communication between shifts in Forensics settings is not optimal and does not routinely include tech staff. This should be reviewed by CSH nursing administration. Access to a translator is essential in providing culturally competent services. Resources may prohibit daily access to a translator, however regular access, particularly in active treatment settings and treatment planning would facilitate recovery.

## FINDINGS AND RECOMMENDATIONS

**Finding 1.1:** The ward design in Building 39 is not optimal for maintaining staff observation of the bathroom and bedroom areas without specifically designated staff hallway monitors.

**Conclusion:** This expensive configuration of staff is the solution developed by the facility to provide continuous observation for the safety of patients during critical periods of transition within the residential areas. Unfortunately, the building was recently renovated and updated but does not allow for optimum monitoring of all patient movement. Given the parameters involved, it is our conclusion that CSH has administered a plan that is addressing areas of vulnerability within this unit design.

**Recommendation:** Maintain current monitor positions while continuing to review and develop ongoing measures for reviewing and enhancing safety. This ward design is not optimal for the particular population housed within it. Long term planning should include a unit design, which improves the capacity to monitor potential private areas such as communal bathrooms where vulnerable patients could be victimized.

**Finding 1.2:** Gender is one of several factors considered by CSH forensic administration in determining the placement of persons on a unit. **Conclusion:** The assignment of patients to individual units within the forensic settings is based on sound principles. CSH staff have researched this issue and have a good working policy in place that addresses the placement of more vulnerable patients including females.

**Recommendation:** Continue to conduct on-going review of patient placement in order to minimize anticipated risk to others.

**Finding 1.3:** The majority of patients interviewed did not feel safe on the forensic units.

**Conclusion:** The facility has implemented a number of safety measures in an effort to promote a safer environment. Given the feedback from the patients, it would be advantageous to utilize their information and concerns in addressing this on-going effort by creating an environment where safety is a known priority for both the staff and patients. A program, which openly involves patients in aggression prevention and management should be considered such as the following program from Atascadero State Hospital in California.

> Norm of non-violence. Although violence may occur, we challenge the notion that violence is to be expected in a forensic setting. The norm of non-violence pervades all interactions involving patients and staff and between patients. All members of ASH community, patients and staff alike, are personally responsible for the safety and security of the hospital environment.

**Recommendation:** Facility management and staff should work with patients to foster an awareness of safety that begins with facility orientation for all new inpatients.

**Finding 1.4:** Interviews with direct care staff indicated that on-going and updated communication is the most effective tool for providing security for both the patients and residents. **Conclusion:** There is currently inadequate clinical information exchange between shifts for staff, particularly direct care staff.

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

**Finding 1.5**: Interpretive services were inconsistently provided for a non-English speaking patient.

**Recommendation:** Availability of adequate translation services is essential in the provision of culturally competent services. Translators are to provide a reasonable degree of treatment and confidential treatment planning.

## EASTERN STATE HOSPITAL
## WILLIAMSBURG, VIRGINIA
## JOHN FAVRET, DIRECTOR

**OIG REPORT # 53-O2**

A Snapshot Inspection was conducted at Eastern State Hospital (ESH) in Williamsburg, Virginia January 9 - 10, 2002. The area of focus was the Hancock Geriatric Treatment Center (HGTC). The team of reviewers consisted of members of the OIG staff and a clinical consultant.

The Hancock Geriatric Treatment Center on the grounds of Eastern State Hospital (ESH) is one of three mental health facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), which serves the geriatric mentally

ill population. The other two facilities that provide services to the geriatric population are Piedmont Geriatric Hospital in Burkeville and Catawba Hospital in Catawba.

ESH has an operating capacity of approximately 520 patients. On the last day of the inspection, there was a census of 521 facility-wide; 221 of which were being served in HGTC.

ESH has been serving geriatric persons since its onset approximately 250 years ago. During the 1950's, ESH provided for geriatric services in Buildings 2, 25 and 28. During the next few decades, the census of the hospital grew dramatically to its maximum census of about 3500 patients. A movement occurred during the late 60's and early 70's to have geriatric care occur in free-standing facilities. In keeping with this direction of services, the current configuration of buildings was identified as the Hancock Geriatric Treatment Center in 1976. Since its designation as a separate Center within the operational capacity of ESH, the census of HGTC has remained stable.

Overall, HGTC was noted to be clean and comfortable with evidence of efforts to make the environment appear less institutional.

Eastern State hospital has been experiencing recruitment and retention problems among nursing staff for a number of years and administration has developed a variety of plans to ameliorate the situation. During the inspection, the team noted that the units inspected had staffing patterns, which were minimal at best. The majority of staff interviewed identified feeling increasingly stressed due to the persistent use of mandatory overtime to meet minimal staff to patient ratios.

Active treatment opportunities were observed for the higher functioning geriatric patients. Active treatment or other scheduled activities for the lower functioning individuals were minimal. The activities observed by OIG staff did not occur as described in the patient's treatment plan. They either did not occur or were significantly modified in terms of duration.

## FINDINGS AND RECOMMENDATIONS

**Finding 1.1:** Overall the physical environment of the Hancock Center was clean and comfortable, with evidence that effort has been made to decrease the institutional appearance.

**Recommendation:** Continue to promote efforts that result in softening and personalization of this harsh institutional setting.

**Finding 2.1:** The GAP (Geri-Active Program) is designed to meet the active treatment needs of the higher functioning geriatric patient.

**Recommendation:** The GAP program offers a variety of active treatment options for the minority of higher functioning geriatric patients. Administrative and clinical leaders must seriously re-evaluate the mission and model for active treatment for the remaining geriatric population at ESH.

**Finding 2.2:** Active therapeutic treatment options for lower functioning geriatric patients were minimal.

**Recommendation**: A review of active treatment activities for lower functioning patients is warranted in order to provide effective and appropriate options for this population.

**Finding 2.3:** Late afternoon and early evening activities in Building 34 were not taking place as scheduled.

**Recommendation**: A review of active treatment activities for lower functioning patients is warranted in order to provide effective and appropriate options for this population.

**Finding 2.3:** Records reviewed reflected limited documentation linking treatment needs to discharge readiness and the justification for continued hospitalization.

**Recommendation**: Promote better utilization of the clinical talent participating in the treatment planning conferences. Improve concentration by the teams on issues related to preparation of patients for discharge, as evidenced in the records.

**Finding 3.2:** Staffing shortages are critical for nursing services in the Hancock Center.

**Recommendation**: Administrative and clinical leaders must seriously re-evaluate the mission and model for the goals of serving the geriatric population. Increase staffing levels as needed for active, effective patient treatment rather than basic patient care if this is determined to be the treatment goal for the Hancock Center.

## NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
## FALLS CHURCH, VIRGINIA
## MOHAMMAD EL-SABAAWI, DIRECTOR

**OIG REPORT # 49-01**

An unannounced Snapshot Inspection was conducted at the Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Virginia on November 9, 2001.

Overall, the facility was noted to be clean and comfortable. The facility continues to work on making the environment appear less institutional. Added security measures were noted.

Staffing patterns were noted to be adequate to provide an appropriate level of supervision and staff-patient interaction.

The facility administration has developed and enhanced both the medical and active psychosocial rehabilitation treatment needs for this adult chronically mentally ill population. This was demonstrated through observations of daily activities, staff and patient interactions and record review of treatment plans. Historically, access to medical treatment and psychosocial rehabilitation were areas of deficiency identified by the Department of Justice at NVMHI.

## REPORT FINDINGS AND RECOMMENDATIONS

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

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

**Finding 1.2**: There is a new security measure in place that involves the use of car tags for the identification of vehicles.

**Recommendation:** Continue efforts at creating a safe and secure environment.

**Finding 2.1:** Staffing patterns for nursing services were adequate.

**Recommendation:** Continue to provide adequate staffing patterns.

**Finding 2.2:** Direct care staff were knowledgeable regarding policies and procedures relevant to abuse and neglect.

**Recommendation:** Continue to promote staff awareness of abuse and neglect.

**Finding 2.3:** Mandatory overtime was uncommon.

**Recommendation:** Continue to provide a supportive environment for maintaining and retaining staffing patterns that enables overtime use to remain rare.

**Finding 2.4:** Nursing notes were consistently documented and identified significant issues associated with patients' treatment and continued need for hospitalization in the records reviewed.

**Recommendation:** Continue to maintain appropriate and timely nursing notes in accordance with written policies and procedures.

**Finding 3.1:** The Psychosocial Rehabilitation program (treatment mall) continues to evolve in response to patient experience and individual treatment goals.

**Recommendation:** Continue to adapt the treatment mall so that rehabilitative needs of the current patients are addressed. Consultation with Central State Hospital regarding matching patient needs with the complex schedule may be helpful.

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

**Recommendation:** Continue to strive for successful linkages for all patients at the time of discharge. It is recognized that this is a process that is undergoing significant ongoing evolution and enhancement.

**NORTHERN VIRGINIA TRAINING CENTER**
**FAIRFAX, VIRGINIA**
**MARK DIORIO, DIRECTOR**

**OIG REPORT # 48-01**

A primary inspection of Northern Virginia Training Center (NVTC) was conducted on September 9-11, 2001. NVTC was the first of five facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services to have been found to be in violation of the Civil rights for Institutionalized Persons Act by the United States Department of Justice. Many improvements have occurred at this facility as a result. The findings of merit included findings of adequate staffing present. This includes adequate access to direct care staff as well as access to a rich supply of professional staff. There are sufficient numbers of staff present at NVTC such that a Center of Excellence has been able to be developed which provides access to these professionals by those with MR living in a community setting. There is a broad array of treatment activities available to residents, especially during weekday hours, which are designed to promote maximal achievement of individual abilities. Center-based resident training programs as well as employment in the community are available. There is appropriate access to primary care physicians as well as a psychiatrist. The access to medical care after hours is well coordinated. Direct observation of numerous encounters revealed treatment with dignity and respect by staff of all levels. The use of seclusion or behavioral restraint is rare. There is a stable, established nutritional management program in place. The grounds are well maintained. Internal living units are generally warm and appropriate with some units being more homelike and less institutional than others.

Recommendations for performance improvement were made in several areas. A review of current security policy and staff in-service training is in order. The current situation within NVTC wherein the same person conducts the management of quality assurance, risk management and abuse investigations should be reviewed with DMHMRSAS. There is inherent conflict of interest in this situation that could impair objectivity in the protection of residents. Additional recommendations encourage NVTC to undertake a review of ongoing clinical documentation such that professional interventions are appropriately recorded.

Overall, this well maintained environment has addressed many of its past challenges and continues to demonstrate its commitment to providing quality services to its residents.

**FINDINGS AND RECOMMENDATIONS**

**Finding 1.1:** Throughout the inspection, staff were observed to interact with the residents in a manner that reflects treatment with dignity and respect.

**Recommendation:** Continue to foster an environment that treats the residents with dignity and respect.

**Finding 1.2**: The advocate at NVTC addresses issues relevant to human rights through monitoring, training and contact with residents and staff.

**Recommendation 1.2a:** Continue to support the advocate's visible presence for staff and residents in order to maximize awareness regarding issues relevant to abuse and neglect.

**Recommendation 1.2b:** The OIG will coordinate a meeting with the State Human Rights Director to review the new changes, the purpose for these changes and the impact these may have on the consumers.

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

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

**Finding 2.1:** Incidents of isolated time-out and restraint are infrequent.

**Recommendation:** Continue to maintain a treatment environment that fosters the limited use of locked time-out and restraint.

**Finding 3.1:** Residents have an array of active treatment opportunities available for skill building and independent living.

**Recommendation:** Continue to emphasize the individualized nature of active treatment opportunities at NVTC.

**Finding 3.2:** The facility has an established nutritional management program.

**Recommendation:** Review nutritional management plans for all residents to assure that dates reflect the most current assessment.

**Finding 3.3:** Clinical Management Meetings occur at regular frequencies on a given unit.

**Recommendations:** None. Although a great number of staff hours go into a meeting of this nature, it appears to have uses on many levels.

**Finding 3.4:** Annual individualized program plans (IPP) as constructed were based on professional assessments and a review of objective and supported observational data by an interdisciplinary team.

**Recommendation:** Enhance documentation regarding identified problems, which are noted outside of the formalized annual process by including them on the problem list; outline the plan of action and justification for interventions.

**Finding 3.5:** Physical and Occupational Therapy services are sufficiently staffed and well integrated into consumer care at NVTC.

**Recommendation:** Continue to support and enhance the integration and expansion of these vital services.

**Finding 4.1:** Staffing patterns appear to be adequate to meet the activity level of patients.

**Recommendation:** Continue to maintain adequate staffing patterns.

**Finding 4.2:** The grounds are well maintained, providing a park like appearance, which is described as open to the community.

**Recommendation:** Continue to maintain the grounds and peaceful atmosphere at NVTC. On behalf of the residents within this facility, a review of the risks vs benefits of the current security practice is warranted.

**Finding 4.3:** During the initial evening visit, staff were lax in identifying team members and ascertaining the reason for the team's presence, compromising facility security.

**Recommendation 4.3a:** Review the current security practice with regards to the risks Vs benefits for residents. OIG requests evidence that this critical issue was deliberated as soon as it occurs.

**Recommendation 4.3b:** Retrain staff as to current expectations regarding unknown persons being present at the facility.

**Finding 4.4:** Efforts at making this institutional setting appear more "home-like" were variable.

**Recommendation:** Broaden the effort to enhance the physical living environments for all NVTC residents.

**Finding 5.1**: NVTC has appropriate access to primary care services.

**Recommendation:** None. There is good access to primary care at NVTC.

**Finding 5.2:** There is adequate access to psychiatric care at NVTC.

**Recommendation:** There is adequate access to a psychiatrist at NVTC. It is recommended that the documentation of the psychiatrist be reviewed.

**Finding 5.3:** The NVTC Psychiatrist has developed a mechanism for the tracking of individuals who are on more than one psychotropic medication.

**Recommendation 5.3a:** Consider incorporating this useful information in the individual clinical record.

**Recommendation 5.3b:** Consideration should be given toward convening a meeting of psychiatrists employed by training centers in Virginia to understand the wide variability in use of different types of medications for a similar clinical population.

**Finding 6.1:** NVTC has collaborative relationships with several colleges and universities throughout the Commonwealth.

**Recommendation:** Continue to support public-academic relationships through providing internship and practicum sites as well as supporting research within the facility.

**Finding 6.2:** NVTC is working to establish a cooperative opportunity with local dentists and the Medical College of Virginia School of Dentistry that would promote increased access to dentists trained to serve persons with mental retardation and other developmental disabilities.

**Recommendation:** None.

**Finding 7.1:** Northern Virginia Training Center's Regional Community Support Clinic provides specialized services to individuals residing in the community.

**Recommendation:** The development of this model throughout other training centers in Virginia would facilitate successful community transition for many residents.

**Finding 7.2:** This facility has established a number of continuous improvement projects.

**Recommendation:** Continue in identifying, evaluating and monitoring continuous improvement projects.

**Finding 8.1:** NVTC maintains a culturally diverse staff.

**Recommendation:** This is an issue for many employers in the northern Virginia area including Northern Virginia Mental Health Institute. Perhaps consultation with professional human resource managers could enhance the ability of NVTC to engage and promote staff of different cultures as well as develop awareness and sophistication of supervisory staff at NVTC in working with employees of many different cultures.

## NORTHERN VIRGINIA TRAINING CENTER
## FAIRFAX, VIRGINIA
## MARK DIORIO, DIRECTOR

**OIG REPORT # 55-02**

**FINDINGS AND RECOMMENDATIONS**

**Finding 1.1:** Overall, the cottages that the team visited were clean, comfortable and well maintained.

**Recommendation:** Continue to provide an environment that meets the clinical and personal needs of the residents in each unit. Pursue the establishment of the intern opportunity.

**Finding 1.2:** The recently established visitors policy regarding security practices was inconsistently applied in the cottages toured.

**Recommendation:** It is recognized that this is a new policy. Additional training for staff regarding the appropriate protocol for the identification and tracking of visitors to the facility is warranted.

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

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

**Finding 2.2:** Staffing patterns were adequate for meeting residents' basic care and active treatment needs.

**Recommendation:** Continue to provide an appropriate level of staffing based on acuity needs of the residents.

**Finding 3.1**: The evening activities observed were designed for the basic care and meeting daily living activities of the residents.

**Recommendation:** Continue to assess the needs of each client and offer appropriate activities to meet those needs.

## PIEDMONT GERIATRIC CENTER
## BURKEVILLE, VIRGINIA
## WILLIAM PIERCE, DIRECTOR

**OIG REPORT # 58-02**

A Snapshot Inspection was conducted at Piedmont Geriatric Hospital in Burkeville, Virginia during March 25, 2002. Piedmont Geriatric Hospital is the only facility solely dedicated to serving persons with serious mental illness over the age of sixty-five. Currently, the operating census for this facility is 135.

Overall, the facility was clean and well maintained. Staffing patterns were adequate, however the facility continues to seek to increase RN staff in order to have adequate coverage during the evening and night shifts. Patients are provided with a variety of activities, appropriate to their level of functioning and cognitive abilities.

FINDINGS AND RECOMMENDATIONS

**Finding 1.1:** Overall, the facility was clean and well maintained but institutional in appearance.

**Recommendation:** Continue to provide a well-maintained environment while exploring new ways to adapt the facility for this population. Observe safety precautions with the proper disposal of gloves.

**Finding 1.2:** Renovations are underway with little disruption to patients and services.

**Recommendation:** Continue to minimize any disruption to patients and services during the renovation project.

**Finding 2.1:** Staffing patterns were minimally adequate.

**Recommendation:** Enhance staffing ratios so that there is more access to RN staff per patient.

**Finding 2.2:** Nursing coverage during the evening and night shifts does not provide for 1 RN per unit.

**Recommendation:** Continue to pursue the hiring of these positions for the well being of these often medically complicated and fragile patients.

**Finding 3.1:** This facility assures that residents are engaged in active treatment and other learning opportunities.

**Recommendation:** Continue to provide meaningful and engaging activities.

**Finding 3.2:** Linkages between active treatment, barriers to discharge and the treatment planning process was evident in records reviewed.

**Recommendation:** Consider the active sharing of this process with other facilities serving segments of the geriatric population.

**SOUTHEASTERN VIRGINIA TRAINING CENTER**
**CHESAPEAKE, VIRGINIA**
**ROBERT SHREWSBERRY - DIRECTOR**

**OIG REPORT # 54-02**

A Snapshot Inspection was conducted at Southeastern Virginia Training Center in Chesapeake, Virginia on Sunday and Monday, February 17-18, 2002. The purpose of the snapshot inspection was to conduct an unannounced review of this facility with a primary focus on three essential areas that are directly related to a facilities capacity to provide quality care. The areas are: the general conditions of the facility, staffing patterns and concerns and the activity of patients.

During this weekend and holiday (President's Day) inspection, it was noted that SEVTC functioned with minimum staffing patterns. This pattern of deploying skeleton staffing crews was a central theme throughout this inspection and can be linked to each area of concern identified, such as the unsanitary conditions observed, unsupervised residents, and limited opportunities available for the completing of individualized active treatment programs by staff for residents requiring a 1 on 1 level of supervision. This facility has taken steps in the past to rectify this situation but despite some improvements must continue to make adequate staffing patterns a priority in order to address the safety, treatment and health needs of the residents.

**FINDINGS AND RECOMMENDATIONS**

**Finding 1.1**: The living environment in Building 29 was unsanitary and presented hazardous situations for residents.

**Recommendation:** Insufficient numbers of staff can not safely manage resident needs and maintain a safe environment. SEVTC needs to review practices for building maintenance to assure that cleanliness and safety standards are maximized within existing resources. This is not likely to be able to be permanently resolved without additional resources.

**Finding 1.2:** Improper disposal of a razor blade by a staff member was observed.

**Recommendation:** Assess the need to re-train staff on the proper disposal of sharps and hazardous waste.

**Finding 2.1:** Staffing numbers were at the minimum required level.

**Recommendation:** Review staffing deployment to assure that patterns meet the level of supervision necessary to safely manage basic body functions as well as provide for active treatment needs of the residents.

**Finding 3.1:** Residents were observed to be engaged in a variety of leisure actives for a limited amount of time.

**Recommendation:** Continue to provide a variety of activities to address both the leisure and active treatment needs of the residents. Review staffing patterns to assure that the treatment needs of the residents are adequately addressed.

## SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
## MARION, VIRGINIA
## GERALD DEANS, DIRECTOR

**OIG REPORT # 51-01**

A primary inspection was conducted at Southwestern Virginia Mental Health Institute (SWVMHI) on December 6, 2001. SWVMHI is one of eight mental health facilities operated by the Commonwealth that provides services to persons with a primary mental illness diagnosis. SWVMHI was originally founded in 1887 and at one time served a population of approximately 1600 patients. Services, except for the adolescent unit, have been consolidated in the Bagley Building since 1990. The adolescent unit is scheduled for consolidation during 2002.

The facility currently has an operational bed capacity of 177. The majority of patients served by the facility are adults, however, there is a 16 bed adolescent unit on the campus. This facility is accredited by the Joint Commission and holds Medicare and Medicaid certifications through the Center for Medicare and Medicaid Services (CMS- formally HCFA).

The facility is located in Smyth County on approximately 100 acres. SWVMHI receives persons from 24 counties and 8 cities in Southwestern Virginia. The facility works closely with nine area Community Services Boards.

SWVMHI staff were observed in a number of settings to treat the patients with dignity and respect. Staff interviews reflected a good working knowledge of abuse and neglect policies and procedures. There has been a steady decrease in the use of seclusion and restraint as a result of increased training of staff in recognizing early warning behaviors and alternative interventions. The facility was clean, comfortable and well-maintained. There is appropriate access to medical and psychiatric care. The facility has implemented a comprehensive psychosocial rehabilitation treatment mall that incorporates the Boston Center for Psychiatric Rehabilitation philosophy. Interviews with patients revealed a good working knowledge of their own treatment goals and the medications.

SWVMHI is facing difficulties in retaining direct care staff positions. Limited programming space is impairing the full implementation of the treatment mall. Security is a significant concern at this facility, which provides services to a number of individuals transferred from the local jails. There have been difficulties with visitors bringing in drug related contraband, such as prescription medications like Oxycontin. SWVMHI has undergone a number of environmental changes over the past year as a result of an on-going renovation project. Additional renovations have been targeted so that the 16 bed adolescent unit can be moved into the primary services and residential building.

### FINDINGS AND RECOMMENDATIONS

**Finding 1.1:** Throughout the inspection, staff were observed to interact with the patients in a manner that reflects treatment with dignity and respect.

**Recommendation:** Continue to foster an environment that treats the residents with dignity and respect.

**Finding 1.2:** The advocate at SWVMHI addresses issues relevant to human rights through training, contact with patients and staff and monitoring of clinical activities.

**Recommendation 1.2:** Continue to support the advocate's involvement and availability to patients in order to maximize awareness regarding issues relevant to human rights, complaints and abuse and neglect.

**Finding 1.3:** Staff had a good working knowledge of issues associated with abuse and neglect.

**Recommendation:** Continue to provide staff training and awareness regarding issues relevant to abuse and neglect.

**Finding 2.1:** There has been a reduction in the use of seclusion and restraint in the facility.

**Recommendation:** Continue to foster an environment that strives to reduce the use of S/R except in emergency situations of imminent risk.

**Finding 3.1:** Efforts to make this facility appear more home-like were noted. The environment was observed to be clean, comfortable and well maintained.

**Recommendation:** Continue to maintain this facility in a manner that fosters recovery.

**Finding 3.2:** There is inadequate space for effective programming.

**Recommendation:** SWVMHI is working closely with the Central Office to explore options for expanding rehabilitative programming space.

**Finding 3.3:** Both staff and patients expressed concerns regarding security on the acute units.

**Recommendation:** Continue to explore methods for enhancing security of both patients and staff.

**Finding 4.1:** The facility has been working towards a fully integrated psychosocial rehabilitation program.

**Recommendation:** Continue to enhance this program while focusing on renovations that would allow for increased programming space.

**Finding 4.2:** There is an array of activities available for patients during the evenings and weekends.

**Recommendation:** Continue to expand programming options for patients during the evenings and weekends.

**Finding 5.1:** The patients at SWVMHI have adequate access to primary care physicians.

**Recommendation:** Continue to provide this level of coverage.

**Finding 5.2:** The facility has a minimum of one physician on site 24 hours a day, seven days a week.

**Recommendation:** Continue to provide 24 hour onsite access to a physician.

**Finding 6.1:** SWVMHI has collaborative relationships with several colleges and universities throughout the Commonwealth and the surrounding states.

**Recommendation:** Continue to support public-academic relationships through providing internship and practicum sites as well as supporting research within the facility.

**Finding 7.1:** The facility is in process of moving the adolescent unit to the Bagley Building.

**Recommendation:** Complete the move of this unit to the Bagley building as planned.

**Finding 7.2:** The facility has instituted a security enhancement project.

**Recommendation:** Continue to develop this service.

**Finding 8.1:** Staff identified space and the turnover in direct service assistant positions as the greatest challenges facing the facility.

**Recommendation:** Continue to address the issue of staff turnover.

**Finding 8.2**: Facility has undergone several environmental renovations during the past year.

**Recommendation:** Continue to complete planned changes in such a manner as to minimize the disruption of services.

## SOUTHWESTERN VIRGINIA TRAINING CENTER
## HILLSVILLE, VIRGINIA
## DALE WOODS, FACILITY DIRECTOR

**OIG Report #50-01**

A snapshot inspection was conducted at the Southwestern Virginia Training Center (SWVTC) in Hillsville, Virginia on December 2 &3, 2001. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three quality of care areas. During this type of inspection, the team reviews (based on observations, interviews and the review of supporting documentation) the following: the general conditions of the facility, including cleanliness and comfort; whether there are adequate numbers of staff; and the availability of activities designed to assist patients in their recovery/skills building. The team for this inspection was comprised of two members of the OIG and a consumer consultant.

Overall, the facility was noted to be clean and comfortable. Many efforts at making the facility festive for the holidays were noted. Residents were visibly excited about the preparations and planned events. Residents were engaged in a variety of appropriate evening activities.

The facility's ability to hire additional staff members has resulted in a dramatic reduction in the use of mandated overtime. Staff expressed an increase in morale with the recent hiring of restricted fulltime direct care workers. Staff also expressed concern regarding the stability of these essential positions due to uncertain resources beyond the current fiscal year.

## FINDINGS AND RECOMMENDATIONS

**Finding 1.1:** The facility was noted to be clean, comfortable, home-like and well maintained.

**Recommendation:** Continue to maintain this environment.

**Finding 1.2:** Efforts to create a festive and safe holiday environment were noted.

**Recommendation:** Continue annual effort to create a festive but safe residential environment.

**Finding 1.3:** Throughout the inspection, staff were noted to be aware of other security/safety concerns.

**Recommendation**: Continue to foster a secure and safe environment.

**Finding 2.1:** Overtime hours have significantly decreased over the past few weeks.

**Recommendation:** This facility can not continue to function without adequate numbers of staff.

**Finding 2.2:** Staff verbalized an increase in morale over the past several months.

**Recommendation:** Look for opportunities for staff participation as the practices of leave time use and self-scheduling are being discussed.

**Finding 2.3:** At best, the current staffing patterns are marginally adequate.

**Recommendation:** This critical situation will need to be addressed. Continue to work with the Central Office to assure adequate staff coverage.

**Finding 2.4:** Review of five charts revealed that there has been a considerable gap in access to a psychiatrist.

**Recommendation:** This gap in access to a psychiatrist should be brought to the attention of the Central Office so that assistance for this situation can be addressed through the state facility medical directors.

**Finding 3.1**: A variety of evening activities were available for residents.

**Recommendation**: Continue to provide array of evening activities

**Finding 3.2**: Daytime activities demonstrate the facility's effort to maximize active treatment.

**Recommendation:** Continue to review and deploy staff in the most effective manner for maximizing active treatment opportunities for the residents.

**Finding 3.3:** A number of special activities have been arranged for the residents throughout the holiday season.

**Recommendation:** Continue annual holiday activity efforts.

# Chapter 3

## Active Findings and Recommendations

This chapter contains findings and recommendations made by the OIG that had not been resolved as of December 2001. Many of the issues identified within these reports cannot be resolved in short time frames. Many time implementing and considering changes involve time to develop policy, train staff or change actual practice. This is to be reviewed as an ongoing process. Emergent conditions are immediately brought to the attention of the Commissioner and Governor if not immediately rectified satisfactorily.

### CATAWBA HOSPITAL
### PRIMARY INSPECTION, JUNE 15, 1999
### OIG REPORT # 2-99

**Finding 2.1:** Catawba has focused on the reduction of the use of seclusion and restraint.

**Recommendation:** Challenge staff to further reduce level of S/R.

*OIG Comment - The use of Seclusion and Restraint at this facility continues to be an issue which receives much study and attention, and seems proportionate to the seriousness that the staff here places on considering the pro's and con's of its use as a clinical safety measure. Staff at all levels, have been included in the debate over the benefits and costs of its use and a great deal of research has been reviewed on this topic. At present, the facility has established a goal of reduction and elimination of Seclusion and Restraint, with the practical goal being decreasing its use while ensuring safety for patients and staff. A nationally recognized expert on the topic is coming to the facility this summer to address staff. Overall trends Seclusion and Restraint are in fact down at the facility, in spite of a significant increase in the number of acute unit beds since the fall of 2000. It is clear that the facility is considering the myriad factors involved with this complex issue. This finding is ACTIVE.*

**Finding 2.2:** Patients are not consistently briefed following use of seclusion and/or restraint.

**Recommendation**: Perform and document post seclusion and restraint debriefing.

*OIG Comment - The facility has been delayed in its implementation of standard, post Seclusion and Restraint debriefing for staff and patients to process the incident. The team was told that the reason that this has taken some time is because it was assigned to the Performance Improvement Team, which was studying the entire Seclusion and Restraint issue. Currently, policy and procedure at the facility instructs staff involved to conduct a debriefing following all such incidents. Records reviewed during the visit did not reveal documentation that this is occurring. It is expected that a newly devised form, with a section for Post-Incident Processing, will be implemented within the next quarter, and that the staff training this summer will include this practice. This finding remains ACTIVE.*

**Finding 3.2:** The treatment planning process at Catawba runs well.

**Recommendation:** Pursue a more meaningful role for the patient in the treatment planning process.

***OIG Comment** - The treatment plan process and instrument has been a focus of ongoing quality improvement. The written plan is completed within 24-48 hours of admission and the treatment teams meet daily. These changes reflect the increase in the acute population at the hospital. As part of the facility's effort to improve the treatment planning process, staff has been trained and is more actively engaging patients during the treatment plan conference. Ongoing improvements were identified and discussed therefore this finding is ACTIVE.*

**Finding 3.3:** The Treatment Plan itself is not effective in writing a concise template for patient care.

**Recommendation:** Focus on the content of the treatment plan to create a document that provides a foundation for the direction of care.

***OIG Comment** - While the process of treatment planning has been streamlined, and an automated template has been implemented, the documentation of patient treatment is not consistently well reflected on the written plan. Staff interviews reveal more practical and updated service information than is noted in the written treatment plans. It seems as though this process is still being refined. This finding is ACTIVE.*

**Finding 3.4:** Certain Catawba patients would benefit from a special behavior treatment team or consultant.

**Recommendation:** Select a management level point person and begin dialog with staff at ESH, CSH or NVMHI to understand how their behavior consult programs work. Work towards sending staff from Catawba to one of these facilities to observe and do "mini-internship" with one of these special behavior consult teams.

***OIG Comment** - Staff at this facility participated in Behavior Analysis training provided by the DMHMRSAS. Since then, they report increasing efforts to apply these techniques for particular patients that may predictably benefit from such plans. These strategies are designed and implemented through the Psychology Department and are integrated into relevant aspects of the patients' treatment experience. It was also noted that the Director of Psychology visits units during the evening shifts, in order to provide direct supervision and support for use of behavioral interventions. We look forward to monitoring the implementation of these strategies with patients. This finding is ACTIVE.*

**CATAWBA HOSPITAL**
**SNAPSHOT INSPECTION - JULY 10, 2000**
**OIG REPORT # 26-00**

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

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

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

**CENTRAL STATE HOSPITAL**
**RESPONSE TO SNAPSHOT INSPECTION, JUNE 18, 1999**
**OIG REPORT # 3-99**

**Part II, Question #6** - Conclusion/Recommendation: Communication regarding observed behaviors and comments made by patients within the shift that this event occurred was not optimal. Reasons for this omission of communication within this shift will need to be explored.

***OIG Comment*** *- The facility has implemented several tools for increasing communication but ongoing improvements are warranted. This finding is ACTIVE.*

**CENTRAL STATE HOSPITAL**
**RESPONSE TO SNAPSHOT INSPECTION, JULY 1, 1999**
**OIG REPORT # 5-99**

**Finding 6.1:** A patient was placed in restraints during the inspection. Observation of this event raises concern that the treatment culture at CSH is still using restraints inappropriately.

**Recommendation:** Clinical staff needs further mentoring and training in the use of restraint in emergency situations only.

***OIG Comment*** *- Staff training has occurred and seclusion and restraint data is tracked and monitored monthly. OIG staff would like to review actual documentation of restraint episodes. This finding is ACTIVE.*

**CENTRAL STATE HOSPITAL**
**RESPONSE TO SNAPSHOT INSPECTION, AUGUST 10, 1999**
**OIG REPORT # 7-99**

**Finding 2.5:** In-service training on Communication and Documentation is well under way throughout all three units in Building 93, the admissions building.

**Recommendation:** Continue to develop and enhance communication lines among staff in admissions and throughout the facility.

***OIG Comment*** *- The facility has implemented several tools for increasing communication but ongoing improvements are warranted. This finding is ACTIVE.*

**CENTRAL STATE HOSPITAL**
**RESPONSE TO SNAPSHOT INSPECTION, NOV. 30 & DEC. 3, 1999**
**OIG REPORT # 14-99**

**Finding 3.6:** If staff had communicated in a more efficient way, appropriate management may have occurred earlier.

**Recommendation:** Communication among professional staff is an on-going problem at this facility and was involved in this event. We request information in response to this report that provides an update on general issue of communication within units since the onset of the Ward Manager Initiative (restructuring).

***OIG Comment** - During follow-up review, it has been demonstrated that an effort has been made to improve communication at the direct care level. The morning report has directly impacted the quality of communication within the facility management. In addition the reorganization of the facility seems to have had a positive influence on promoting improved communication throughout the facility. A review of communication materials indicates that further improvement is warranted. This finding is ACTIVE.*

**CENTRAL STATE HOSPITAL**
**SECONDARY INSPECTION ON INCIDENT OF MARCH 9, 2000**
**APRIL 27, 2000**
**OIG REPORT #20-00**

**Finding 2.3:** There is limited ability for staff at one facility to learn from adverse events at another facility.

**Recommendation:** The Department of Mental Health, Mental Retardation and Substance Abuse Services should set up a mechanism such as a performance improvement (PI) Team to review this missing opportunity. The system as a whole is currently not benefiting from the experience of individual parts of the system.

***OIG Comment** - With the recent changes in administrative structure in Central Office additional practices may be implemented. At this point there is not evidence that Sentinel event reviews at one facility are of benefit, in terms of improving quality of care, at all the facilities. This finding is ACTIVE.*

**CENTRAL STATE HOSPITAL**
**RESPONSE TO SNAPSHOT INSPECTION, JULY 17, 2000**
**OIG REPORT # 29-00**

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

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

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

**CENTRAL VIRGINIA TRAINING CENTER**
**RESPONSE TO PRIMARY INSPECTION REPORT**
**JULY 11-13, 2000**
**OIG REPORT # 27-00**

**Finding 1.3:** CVTC promotes an environment that recognizes and supports the value of individual resident choice.

**Recommendation:** Continue to promote a treatment environment that promotes client choice while maximizing independence.

*OIG Comment - The facility continues to foster the use of a client-centered philosophy in developing active treatment and resident choices. The facility has an on-going dialogue, which has been enhanced by the involvement of OT and PT staff in event reviews and risk management meetings, regarding the balance needed in fostering independence while being mindful of risk reduction and resident rights. Interviews during the September 2001 inspection revealed that additional initiatives regarding treatment planning and active treatment is underway by the facility. This finding is ACTIVE.*

**Finding 2.1:** The use of locked time-out is prohibited at this facility.

**Recommendation:** None. While we support the behavioral principle involved with exclusionary time out, we did not have the opportunity to directly observe the actual practice of this at CVTC. It may be useful for psychology staff to initiate an intra-facility peer review system as a performance improvement project wherein direct care staff adherence to exclusionary time out and other behavior treatment plans are reviewed.

*OIG Comment -Interviews revealed that as noted the facility does not use locked time-out. Two residents currently have restrictive programs that use restraints. There have been several incidents of the use of emergency application of restraints. These events are reviewed with behavioral plans implemented, as appropriate. The facility has recently hired a PhD psychologist who will be working closely with staff of various disciplines to review the reliability and validity of the data collected and the implementation of the written behavioral plans. This finding remains ACTIVE.*

**Finding 3.1:** Individualized active treatment is provided that is based on specific client needs as identified through review of objective and supported observational data by a knowledgeable interdisciplinary team.

**Recommendation:** It is recommended that the staff continue to provide individualized active treatment that is based on clients' needs but to keep in mind that the immediate goal of treatment is movement to the next less restrictive setting.

*OIG Comment - Interviews revealed that the facility is currently conducting a comprehensive review of the provision of active treatment within this setting. This was in part a result of an unannounced visit from CMS (formally HCFA). This has included a review of the individualized plans as well as the delivery of services. CVTC has consulted with other training centers, but*

*primarily with NVTC regarding the function of QMRPs within that system and the most effective deployment of staff to maximize active treatment goals and efforts. This finding remains ACTIVE.*

**Finding 3.2**: The treatment plans reviewed at CVTC were comprehensive, individualized and community oriented.

**Recommendation:** Continue to document care and create treatment plans in this manner.

***OIG Comment** - Interviews established that the facility is currently involved in the review of individual treatment plans as a part of the focus of the overall examination of the implementation of active treatment within the setting. Staff are reviewing the plans to determine if the goals established are individualized; address resident strengths and the supportive services necessary for movement towards community living. The plans are evaluated for implementation. Supervisory monitoring of the plans has become a routine part of the review. 10 records were reviewed. As the facility is engaged in a comprehensive review of this process, this finding remains ACTIVE.*

**Finding 5.1:** CVTC has a system in place to provide primary care to its residents on a regular basis.

**Recommendation:** Continue to recruit for an internist.

***OIG Comment**- Interviews during the September 2001 inspection revealed that the facility is not recruiting for an internist at this time. This facility has hired a full-time neurologist. Interviews related that CVTC has been very satisfied with this individual, who functions in a large part as a primary care physician. The person also participates on several committees and has been instrumental in working closely with the residents' families regarding the management of physical health concerns. This finding is ACTIVE.*

**Finding 5.3:** Access to psychiatric services for residents outside the unit where the psychiatrist is housed may be compromised due to only one psychiatrist being available for the entire facility.

**Recommendation:** Consider mechanisms for increasing access to the psychiatrist such that every resident currently on or in need of psychoactive medication have access to a psychiatrist a minimum of one face-to-face visit every three months.

***OIG Comment**- Interviews revealed that the facility continues in its efforts to increase psychiatric time. The contract involvement of a psychiatrist from WSH has been discontinued due to time limitations of that individual. The facility has approached several local psychiatrists in an effort to replace the one day a month availability provided by that contractor but has been unsuccessful in recruiting a candidate. Some discussion occurred with several other facilities regarding the possibility of sharing psychiatric coverage but this was not successfully completed. The facility continues to operate with one full-time psychiatrist. It was noted on the date of this inspection that approximately 40% of the residents are prescribed psychotropic medications. This finding is ACTIVE.*

**CENTRAL VIRGINIA TRAINING CENTER**
**JOINT INSPECTION: DEPARTMENT FOR RIGHTS OF VIRGINIANS WITH DISABILITIES & THE OFFICE OF THE INSPECTOR GENERAL**
**December 4-8, 2000**

**Finding 1.1:** More than half of the six hundred and fifty residents at CVTC require wheelchairs to move about.

**Recommendation:** See finding and recommendation #3.3 and 2.11.

***OIG Comments-*** *Of the residents at the center during the visit, 251 rely on wheelchairs for daily mobility. Others use wheelchairs mainly for transportation to and from program components. CVTC has been prioritizing the evaluation of wheelchairs and the rehab engineer for the facility has, to date, inspected 120 of the 360 chairs used for transport. These assessments will continue at a rate of 2 per month, and will target chairs for replacement or removal. This finding remains ACTIVE.*

**Finding 2.3:** There are an insufficient number of Rehabilitation staff employees.

**Recommendation:** Develop a method for increasing the presence and effect of OT and PT staff at CVTC through restructuring of current workload and use of contract or external professionals to build an enhanced focus on injury prevention and safety.

***OIG Comments-*** *During the September 2001 follow-up inspection, it was learned that the facility now advertises the full salary range for these critical positions. One full time Physical therapist and one full time Physical therapy assistant have been added to this department. On October 10, 2001, they will re-advertise for one more of each of those positions. Two full-time Occupational Therapists have been hired; one started in September and one was still in the process. Also, two, Certified Occupational therapy assistants have been interviewed and are pending offers for employment. Additionally, in an effort to help with recruitment, the facility is offering a stipend and on-site housing for OT and PT students in need of a practicum. This finding remains ACTIVE.*

**Finding 2.4:** Most employees were not aware of the disproportionate number of resident injuries at CVTC when compared to other training centers.

**Recommendation:** Consideration should be given to the initiation of a facility-wide injury prevention and reduction program.

***OIG Comments -*** *A review of the minutes from a shift supervisor meeting on May 17, 2001 indicated the significance that the CVTC administration is placing on increasing the awareness of injury rates and safety issues. The Facility Director and Risk Manager did a joint presentation on this issue and directed the supervisors to review this with all staff. The facility has also developed a Steering Committee to foster greater integration between the Rehabilitation department and regular center staff. This Steering Committee is further responsible for making spot inspections of treatment and living areas. Falls risk assessments have been completed on*

*every resident and will henceforth be updated annually. This finding will remain ACTIVE until the tremendous efforts made at CVTC substantiate an increased awareness of patient injuries.*

**Finding 2.5:** Qualified Mental Retardation Professional (QMRP) staff are potentially well positioned to develop a proactive role in physical management issues and injury preventing.

**Recommendation:** Enhance the knowledge base of QMRP staff so that they can work for their assigned residents at the unit level to promote prevention of injuries and assist with ID team review of repeated injuries. These staff could also assist medical staff in looking for situations that might benefit from referral to OT and/or PT staff.

***OIG Comments-*** *Interviews revealed that the Assistant Director of Program Services meets monthly with the QMRP's and the assistant program managers. This meeting includes review of data on client injuries and has focused on methods for improved physical management of consumers. The administration is also considering organizational changes that would promote more effective use of the skills of QMRP staff. This finding remains ACTIVE until these roles have been solidified.*

**Finding 2.6:** Some residents at CVTC have had physical management treatment programs developed.

**Recommendation:** Re-prioritize the effort to have a physical management plan for each resident. Consider prioritizing those who have had one or more serious injuries.

***OIG Comments-*** *An interview with the Director of Physical Therapy revealed that he has designed a prioritization process related to injury rates, for the development of physical management plans on each consumer. To date, 150 plans have been completed and implemented, and the staff will continue to work on these at a rate of two per month until they have been completed facility wide. From now on, the physical management plans will be updated as needed, but no less than annually along with the care plans. This finding remains ACTIVE.*

**Finding 2.12:** Staff shortages at CVTC are critical.

**Recommendation:** Central Office needs to work with the leadership of CVTC to address several issues related to staff shortages.

***OIG Comments*** *- Since July, CVTC has hired 46 direct care staff and has offers pending to another 22 employees. They have added a shift differential to entice second and third shift workers, especially certified nurse assistants and med aides. They have also continued to emphasize the recruitment of professional staff across disciplines, especially nursing, and psychiatry. CVTC was able to hire a Ph.D. level psychologist with Behavior analysis training experience. Administration staff has also participated in a task force including community health care workers, who are also struggling to increase efforts to recruit skilled staff. This finding remains ACTIVE.*

**Finding 3.2:** The population density (number of residents) per living area is high given the extent of disability in individuals currently residing at CVTC.

**Recommendation:** Continue to work toward this goal of ten persons per living unit.

***OIG Comments*** *- From July 2000 to July 2001, there has been a reduction in 33 residents at the facility and administration has reduced the operating bed capacity. However, they continue to experience difficulty in placing consumers in community settings, partially due to severity of impairments, family opposition, and less community capacity. The stated goal at CVTC continues to be 10 residents per living area and they are working toward this through appropriate placement of individuals. This finding remains ACTIVE.*

**Finding 3.3:** The majority of wheelchairs in use and observed at the facility by the inspection team were not optimized to fit an individual's needs.

**Recommendation:** Work to maximize proper positioning in appropriate wheel-chairs. Outdated and dangerous wheelchairs should be eliminated.

***OIG Comments*** *- The rehabilitation engineer at CVTC is evaluating 360 transport chairs and has done 120 as of the September follow-up review. He has also completed requested assessments on 13 regular chairs since a new referral form has been introduced at CVTC. The Director of Occupational Therapy has also obtained a simulator chair, which is helpful in designing proper positioning of consumers in their wheelchairs. This finding remains ACTIVE.*

**Finding 3.6:** Floors are over-waxed and non-absorbent throughout the facility.

**Recommendation 3.6a:** Re-evaluate the possible injury prevention role of non-slip socks or lightweight shoes for some individuals.

***OIG Comments****- During the tour conducted, it was noted that the floors appeared less waxed than previously observed. There are also new non-slip mats in place and the staff is researching new cleaning products that promote greater stability of surfaces. CVTC is also considering the purchase of a flexible rubber surface for those floors in areas being renovated. The environmental management committee reviews all related purchases and products. It was also recognized that each unit is in the process of creating a safety chart, with pictures, to increase awareness of hazards from clothing. This finding is ACTIVE.*

**Recommendation 3.6b:** Consider Staff training on the role that clothing such as shoes, socks, and the length of pants can play in promoting safe walking and movement.

***OIG Comments*** *-During the tour conducted, it was noted that the floors appeared less waxed than previously observed. There are also new non-slip mats in place and the staff is researching new cleaning products that promote greater stability of surfaces. CVTC is also considering the purchase of a flexible rubber surface for those floors in areas being renovated. The environmental management committee reviews all related purchases and products. It was also recognized that each unit is in the process of creating a safety chart, with pictures, to increase awareness of hazards from clothing. This finding is ACTIVE.*

**Recommendation 3.6c:** Evaluate the current floor waxing products. Explore possibilities for a less shiny surface that may provide less glare and less risk of slipping.

***OIG Follow-up Comments*** *- During the tour conducted, it was noted that the floors appeared less waxed than previously observed. There are also new non-slip mats in place and the staff is researching new cleaning products that promote greater stability of surfaces. CVTC is also considering the purchase of a flexible rubber surface for those floors in areas being renovated. The environmental management committee reviews all related purchases and products. It was also recognized that each unit is in the process of creating a safety chart, with pictures, to increase awareness of hazards from clothing. This finding is ACTIVE.*

**Recommendation 3.6d:** As part of any renovation projects, consideration should be given to the possibility of industrial carpeting or other surface that would be more suitable to the needs of the individuals residing in these settings. Consider anti-skid flooring strips where appropriate.

***OIG Comments*** *- During the tour conducted, it was noted that the floors appeared less waxed than previously observed. There are also new non-slip mats in place and the staff is researching new cleaning products that promote greater stability of surfaces. CVTC is also considering the purchase of a flexible rubber surface for those floors in areas being renovated. The environmental management committee reviews all related purchases and products. It was also recognized that each unit is in the process of creating a safety chart, with pictures, to increase awareness of hazards from clothing. This finding is ACTIVE.*

**Finding 3.7:** Many other physical attributes of the buildings and units are outdated and pose a risk for injury to clients (e.g., floors, ramps, hand rails, grab bars and attachments on walls).

**Recommendation:** Conduct a facility wide environmental assessment to determine what changes need to occur immediately to protect resident safety. Use rehabilitation staff to thoroughly assess the physical environment and make recommendations for change according to the federal guidelines for universal access in buildings and according to the needs of the current residents.

***OIG Comments*** *- Interviews and document reviews revealed that walk throughs have been conducted with a priority system for completing the work identified established. The priority system and the work accomplished was prioritized with items deemed potential risks to residents completed first. This finding is ACTIVE.*

**COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS**
**(Formerly, DeJarnette Center)**
**INITIAL PRIMARY INSPECTION, APRIL 28-30, 1999**
**OIG REPORT # 1-99**

**Finding 2.1:** DeJarnette has significantly reduced the use of seclusion and virtually eliminated the use of "mechanical restraint" over the last three years.

**Recommendation:** Revise the DeJarnette Center Seclusion and Restraint Policy to make terms consistent with reported Data printouts and new Departmental Policy as it is developed.

***OIG Comment-*** *The Center policy on Seclusion and Restraint was not revised in final draft form until April 2001, fully two years after the initial lack of clarity in definitions was cited in the first OIG inspection report. Administration anticipates training on the revised policy and procedure to be completed by the end of May 2001. It is clear that center staff recognize the issue of seclusion and restraint utilization as a serious issue and that there is some disagreement as to whether it should be used at all with this population, in this environment. There has been a corresponding debate about this issue within the treatment community and advocacy groups over the past several years. This seems all the more reason for the Center to move ahead with the adoption of a position that has been given careful consideration with clearly stated definitions and procedures for use that will regard client safety as the paramount concern. A deadline should be firmly established for implementation and review of relevant data by staff at a 3-6 month interval. This finding should remain ACTIVE.*

**Finding 2.2:** Post seclusion debriefing does not consistently occur following seclusion events.

**Recommendation:** Institute mandatory debriefing following each and every seclusion episode.

***OIG Comment-*** *Review of policy and procedures and records indicate that as of May 2001, debriefing following seclusion and restraint incidents is occurring. Inconsistent documentation of post seclusion and restraint debriefings was noted. This remains ACTIVE. Addendum, this finding has been since reviewed but not been through the OIG review process. As of early 2002, CCCA staff are consistently debriefing individuals post seclusion and have an exemplary data-documentation sheet for performing this function.*

**Finding 3.1:** DeJarnette serves a number of children with active substance abuse problems, but offers virtually no substance abuse treatment.

**Recommendation:** Add a formal substance abuse treatment component to the program.

***OIG Comment-*** *Issues related to the lack of a substance abuse program was first noted in April 1999. These issues have been commented on in 4 out of 7 reports developed by the OIG with no significant progress made until October 2000. After a false start in 1999, a substance abuse treatment model was not added to the Center until January 2001. A qualified substance abuse staff member was finally hired in October of 2000 and she has made a good start at developing an integrated model for motivational enhancement therapy. Training has been provided to all staff and application of a substance abuse assessment tool has been operationalized for clients 12 and over. Records are beginning to demonstrate that some substance abuse interventions are*

*being provided to identified clients, and discharge recommendations addressing community substance abuse treatment are routinely being made. Data continues to show that greater than 50% of the youth admitted to the facility are assessed as presenting with substance dependence. Debate among the Central Office and facility administration about whether or not the Center should be offering primary substance abuse treatment was the primary explanation for the delay. The simple fact that the data indicates that a majority of these youth present with this diagnosed, clinical disorder, seems a strong enough argument for providing treatment for it in the acute hospital setting. This finding is ACTIVE. See finding 3.2(OIG report # 10-99); finding 2.1 (OIG Report # 17-00); finding 2.5 (OIG Report #23-00).*

**Finding 3.2:** Activities and group programming schedules remain generic on DeJarnette Units.

**Recommendation:** Sharpen the activities and group programming.

***OIG Comment-****Efforts to improve individualized activity focused treatment was taken during the summer of 1999 and through the next fiscal year. By the summer of 2000, the Center had prepared to initiate a formal psychosocial program, using a modified treatment mall model. While this model had been abandoned by the May 2001 follow-up inspection, and the activities portion of treatment returned to being primarily unit-based, it was clear that resources for enhanced activities had been made available and the staff demonstrated considerable enthusiasm. However, questions remain as to how effectively the psychosocial portion of a client's treatment is integrated into their overall clinical care and individualized. This finding remains ACTIVE. See finding 3.3 (OIG report # 10-99); finding 2.4 (OIG report #17-00); finding 3.1 (OIG report # 22-00); finding 3.2 (OIG Report # 22-00).*

**Finding 3.3:** DeJarnette social work and psychology staff are not present on weekends so that they miss opportunities to directly interface with families picking up and returning patients from passes.

**Recommendations:** Accommodate family schedules by having professional staff available on weekends.

***OIG Comment-*** *Review of this issue, during the May 2001 Follow-up inspection, revealed considerable resistance to increasing the availability of the professional staff during evening and weekend hours, so as to better accommodate the schedules of families. The OIG continues to be concerned that availability of face-to-face interventions with professional staff is not a routine part of treatment for children and their families. For an acute care residential facility for youth, which is trying to reduce its Length of Stay rates, solid linkage with families and community resources is important. This finding remains ACTIVE.*

**Finding 8.2:** DeJarnette is currently without a clearly articulated mission regarding its niche in the spectrum of providers of public and private mental health services to children.

**Recommendation:** Articulate clearly the intended role for DeJarnette Center within the Treatment spectrum of public and private providers for Children and Adolescents in the Commonwealth of Virginia. Adopt admission, discharge, and outreach policy that mirrors this expectation.

*OIG Comment- Since the inspection in April 1999, the Center has been working with the Central Office to more clearly define its Mission and role within the service delivery system. The May 2001 follow-up inspection revealed that a retreat has been scheduled for the summer of 2001, to continue to address this issue. While it is recognized that Mission and Value clarification should be a dynamic process at any agency, the persistence of this lack of clarity at the Center is particularly critical to the operation of Virginia's primary child and adolescent treatment facility. Unclear definition of role and purpose undoubtedly influences all aspects of clinical care, program development and administrative operations. This finding has also been commented in finding 5.1 (OIG Report # 17-00). This finding is ACTIVE.*

**COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS**
**(Formerly, DeJarnette Center)**
**SNAPSHOT INSPECTION - OCTOBER 3, 1999**
**OIG REPORT #10-99**

**Finding 3.1:** Professional Staff (primary therapist) services are not available for families on weekends.

**Recommendation:** Arrange professional staff schedules in order to accommodate the needs of families including evening sessions and weekend appointments.

*OIG Comment - As of May 2001, the need for and lack of regular, professional staff presence during evening and weekend hours to better accommodate the schedules' of families' has not diminished or been corrected. Staff has made minimal concession to this issue by agreeing to be available on an " as needed" basis, but it continues to be evident that there is resistance to making these accommodations. It has been noted repeatedly that an acute care facility treating children and adolescents needs to maximize the clinical time available for this population and their families, especially in light of decreasing lengths of stay and the need for proactive discharge planning. This finding is ACTIVE, see finding 3.3 (OIG Report # 1-99).*

**Finding 3.2:** The facility has incorporated as substance abuse track to their programming.

**Recommendation:** The facility will continue to develop and expand the scope of this essential service (substance abuse treatment).

*OIG Comment- This finding is ACTIVE; see related findings and comments. These are 3.1 (OIG Report # 1-99); finding 2.1 (OIG Report # 17-00); finding 2.5 (OIG Report #23-00).*

**Finding 3.3:** Organized activities will continue to develop and expand the scope of this essential service.

**Recommendation:** Develop a plan for reviewing current activities and implement a set of facility-wide treatment opportunities that would more specifically address an individual's treatment needs.

*OIG Comment- A model for active treatment for clients was planned for during the FY 2000, and piloted during the summer of that year. Since then, the Center has returned to a primarily unit-based model of activities' therapy. There has been an infusion of resources for activities*

*staff and materials, and the staff demonstrate enthusiasm and creative thinking. However, it remains to be demonstrated how effectively this model is at incorporating activities into each individual child's, overall plan of care. For example during the May 2001 follow-up inspection, the records reviewed, while having considerable documentation of a clients' participation in a menu of activities, did little to indicate linkage or progress made on problems as outlined on the treatment plans. Since the Center has invested considerable resources into enhancing the availability of activities that presumably have therapeutic value, it would be in the facility interest to better demonstrate how the given activities actually constitute active treatment. This finding is ACTIVE; see finding 3.2 (OIG report # 1-99); finding 2.4 (OIG report #17-00); finding 3.1 (OIG Report #22-00); finding 3.2 (OIG report # 22-00).*

**COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS**
**(FORMERLY DEJARNETTE CENTER)**
**PRIMARY INSPECTION FOLLOW-UP: MARCH 30, 2000**
**OIG REPORT # 17-00**

**Finding 1.1:** DeJarnette has experienced a recent increase in the use of mechanical restraints.

**Recommendation:** Training in the form of direct supervision or in-service format should be instituted that emphasizes the need for documentation to correspond with the intensity and risks associated with the actual clinical picture.

***OIG Comment*** *- Issues concerning the use of seclusion and restraint have been a topic addressed at most of the facilities within the Commonwealth. The Central Office issued a new Departmental Instruction (DI), which resulted in an updated policy being drafted at the facility, dated April 11, 2001. According to the administration training, which is mandatory for all staff involved with consumers, has been scheduled to take place during the month of June 2001. The new policy has added a section on debriefing of consumers following seclusion and restraint events, and documentation reviewed in consumer records during the May 2001 follow-up visit demonstrated that these debriefings are occurring inconsistently. It should also be noted that there appears to be some conflict within the new policy and procedure and interviews with staff regarding the definition of physical restraint and "hands on" holds/approaches. Training should clarify this distinction and the policy updated to reflect intended practice. This finding is ACTIVE; see finding 2.1 (OIG report # 1-99).*

**Finding 1.2:** Limited coverage was available during the absence of the facility human rights advocate.

**Recommendation:** OIG recommends coverage for the Central Office State Human Rights Director to review advocate(s).

***OIG Comment*** *- During the May 2001 Follow-Up inspection, the inspection team discovered that no progress has been made in filling the vacant position at Western State Hospital. In addition, the team was informed of the impending retirement of the current Commonwealth Center advocate. This will leave an alarming shortage of Human Rights coverage for both facilities. This finding is ACTIVE.*

**Finding 2.1:** DeJarnette Center does not have a program of services for providing substance abuse treatment.

**Recommendation:** DeJarnette Center finalizes plan for adding a formalized substance abuse treatment program. Educational groups alone are not sufficient. The individual hired to provide this service should have at a minimum several years of experience working with adolescents and have a Master's Degree, supported by courses and supervision specific to substance abuse treatment. (A CSAC certification alone is not sufficient.)

***OIG Comment** - This finding has been persistent since Inspections from this office began in April 1999. Presently the following action has occurred. A master's level clinician was hired and oriented in October 2000. This individual appears to be well qualified and competent for the position. It is understood that the role of this position, as directed by the Central Office, is primarily one of program development and oversight. The program, which has since been developed, has focused on assessment, education and integration of SA treatment into the existing therapy process for these consumers. Staff training has occurred for direct care and professional staff in assessment and Motivational Enhancement therapy techniques. The SASSI is administered for all admissions over age 12, and urinalysis for drug screening is done on all admissions. Staff interviewed were pleased with the training that they had received, but there was some confusion regarding the extent to which SA services were to be provided by the various disciplines comprising the clinical teams. Documentation reviewed, indicates that these Substance abuse/dependence issues are noted on the Master treatment plans. A review of discharge plans reflects a heightened awareness of including these issues in the recommendation for follow-up treatment. Staff noted that the active treatment component of the overall care for individuals has incorporated some education about substance abuse awareness.*

*It is difficult to assess the efficacy of this program because of its relative new implementation, only within the past six weeks. A concern is that the Transtheoretical Model of Change, which has been chosen by this facility for its substance abuse treatment program, does not readily lend itself to evaluation of effectiveness. This is particularly true with the method by which active treatment and individual and group therapy are documented. Another potential difficulty with the plan to integrate SA services into the present model for therapy at the facility, is that substance abuse problems, already noted by the center to be over 50% for teenagers admitted, will be relegated to a less central focus for treatment than may be warranted. Finally, the response of staff in interviews' raises concern that substance abuse treatment remains diffuse within the clinical plan of care for individuals. This finding is ACTIVE; see related finding 3.1 (OIG Report #1-99); finding 3.2 (OIG Report # 10-99); finding 2.5 (OIG Report # 24-00) .*

**Finding 2.4:** The facility is preparing to implement a modified "treatment mall" for patients.

**Recommendation:** Collaborate with other facilities in the development of this plan and the continuation of the treatment mall throughout the year.

***OIG Comment** -It was noted during the May 2001 follow-up inspection that the facility has tried different models for improving active treatment. It did initially offer a modified treatment mall during the summer of 2000, and continued the schedule of recreation and rehabilitation services once the school year resumed, during evenings and weekends. This finding is ACTIVE.*

**Finding 5.1:** DeJarnette and the Central Office have made progress in the articulation of a clearer role for this facility.

**Recommendation:** Continue to create an identity as a quality resource for the care and treatment of children and adolescents.

*OIG Comment - Based on the May 2001 follow-up visit, it has been noted previously that this facility has history of reviewing its mission. Since it is the primary of only two state operated facilities for children and adolescents within Virginia, it is particularly important that its' role be clearly understood. The facility has scheduled a retreat to re-evaluate its' mission and values statements within the month of June 2001. It is recognized that the Center has undergone considerable change and challenge within the larger context of the changing roles of the public and private mental health care system, over the past 5 years. Since this undoubtedly influences the care available for this population it is especially critical that this issue be resolved. Interviews reveal that confusion regarding the facilities' mission is ongoing and creates anxiety among staff. This finding is ACTIVE; see finding 8.2 (OIG Report #1-99).*

**COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS**
**(Formerly DeJarnette Center)**
**SECONDARY INSPECTION, October 12, 2000**
**OIG REPORT #23-00**

**Finding 3.1:** Patients were observed to be involved in structured leisure activities.

**Recommendation:** Continue to develop activities that have a clear treatment, rehabilitation focus.

*OIG Comment: The psychosocial programming provided at the Center continues to develop and evolve. It will need to be monitored regularly to determine how well integrated these treatment components are into an individual client's overall plan of care, and also, to determine the extent to which youth are engaged in an individualized active treatment process at the Center. There have certainly been resources added to the activities department, and these staff seemed genuinely enthusiastic about their role and interaction with the clients. This finding is ACTIVE; see related findings 3.2 (OIG report # 1-99); finding 3.3 (OIG Report # 10-99); finding 2.4 (OIG report #17-00); finding 3.2 (OIG Report # 22-00).*

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

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

*OIG Comment: The facility has tried different models for improving active treatment. It did initially offer a modified treatment mall during the summer of 2000, and continued the schedule of recreation and rehabilitation services once the school year resumed, during evenings and weekends. Review of materials and staff interviews, during the May 2001 follow-up inspection, reveal that the Center has returned to a unit-based model whereby regularly scheduled activities are operating the evening and weekend hours. Instead of offering these activities during the*

*upcoming summer of 2001, the Center has contracted with local school personnel to provide an enrichment program focusing on the arts and sciences. Administration informed the team that curriculum materials have been ordered by the Activities Therapy department, and staff mentioned that they have been reviewing a Life skills curriculum that has been purchased by the facility by the SA coordinator. One concern about this menu of activities is that no structured curriculum has been formulated which outlines the goals and objectives for each topic. This creates difficulty in accurately evaluating whether and which of the services delivered can be demonstrated as having a useful effect on a consumers' identified problems. There is ongoing concern that these activities do not have a clear mental health acute care therapeutic focus and may not be individually tailored to meet the unique needs of a particular child. This finding is ACTIVE; see finding 3.2 (OIG report # 1-99); finding 3.3 (OIG Report # 10-99); finding 2.4 (OIG report #17-00); 3.1 (OIG Report # 22-00).*

## COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
**(Formerly DeJarnette Center)**
**SECONDARY INSPECTION, JUNE 9, 2000**
**OIG REPORT # 24-00**

**Finding 2.3:** This patient developed difficulty clinically within several days of her discharge.

**Recommendation:** Assure as a part of the documented discharge planning process that every discharged patient knows what to do when emergencies arise as an outpatient.

*OIG Comment - During the May 2001 follow-up visit, the review team was informed by the administration that emergency preparedness plans were now discussed routinely at discharge and documented on the discharge planning form. However, the randomized review of records, demonstrated no documentation of these plans for discharged clients. It is therefore impossible, from a risk management perspective, to assess whether this is, in fact, occurring. This finding is ACTIVE.*

**Finding 2.4:** The clinical therapy offered appeared to be of a general support nature.

**Recommendation:** The Psychology Chief should formally review the content of therapy as it is currently being practice and documented, and make appropriate revisions to this vital process.

*OIG Comment - During the May 2001 follow-up visit, it was clear that the Center, within the Psychology Department, has undertaken very formalized and expensive training in specific Cognitive/Behavioral therapy technique. As of this review, this technique has been formally applied to two children. OIG recognizes that Cognitive Therapy is a valuable tool, however it will need to be modified considerably, given the level of acuity and complexity combined with the short length of stay of patients at CCCA. It seems to be taking considerable time to introduce skill building and problem solving methodologies into the current therapy process for the children and youth served at the Center. This finding is ACTIVE.*

**Finding 2.5:** This patient had longstanding problems with substance abuse but received virtually no treatment of this while an inpatient.

**Recommendation:** No new recommendations at this time. DeJarnette is currently working on hiring a substance abuse treatment provider.

***OIG Comment*** *- It was noted during the May 2001 Follow-Up visit that the client in question during the secondary inspection was noted as having a substance abuse disorder but with little to no substance abuse treatment during her hospitalization. While this was not believed to be a factor in the tragedy, it was a glaring reminder of the lack of progress, which the facility made on the implementation of SA services. This finding will remain active. Interviews with staff made it evident that SA clinical interventions are not well integrated into the overall treatment experience. The OIG is committed to continuing to track the implementation of a SA program at the Center. This finding remains ACTIVE; see related finding 3.1 (OIG Report # 1-99); finding 3.2 (OIG report # 10-99); finding 2.1 (OIG Report # 17-00).*

**Finding 3.3:** Follow-up with this client had occurred.

**Recommendation:** No recommendations are made regarding routine administrative follow-up.

***OIG Comment*** *- Although it was stated that routine follow-up occurs between clients who have been discharged and the social work department within 30 days of discharge, the documentation reviewed during the follow-up visit in May 2001, was inconsistent in making note of any such contacts. This finding is ACTIVE.*

**COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS**
**(Formerly DeJarnette Center)**
**SECONDARY INSPECTION, October 12, 2000**
**OIG REPORT #33**

**Finding 2.3** Increased safety measures have been put in place by the facility as a result of this incident.

**Recommendation:** Review policies and the environment for additional safety procedures that may be incorporated or added to current practice.

***OIG Comment*** *- Interviews during the follow-up visit indicate that a risk management specialist from the Central Office conducted an on-site review of safety procedures at the Center in January 2001. Reportedly the report is still pending. The delay in the completion and submission of the report has created a considerable delay in the implementation of any of the recommendations, which are within the fiscal ability of the Center. The target date for completing this process was February 15, 2001. The Central Office should expedite submission of this report so that enhancement of the facility safety procedures can be undertaken. This finding is ACTIVE.*

**Finding 2.4:** An internal investigation of potential abuse and neglect pursuant to Department Instruction 201 (RTS00) was conducted.

**Recommendation:** We suggest that timeframes for this Departmental Instruction be reviewed such that this process facilitates appropriate resolution of these difficult situations.

***OIG Comment*** *- The time frame involved in processing in Abuse and Neglect investigations has improved since the time that this initial finding was made. However the OIG requests additional information on the current status of timeframe expectations. This finding is ACTIVE.*

## HIRAM W. DAVIS MEDICAL CENTER
## RESPONSE TO PRIMARY INSPECTION, JULY 13-14, 1999
## OIG REPORT # 6-99

**Finding 4.2**: Living space for patients is too limited.

**Recommendation:** Clinicians, management and activity staff from HWDMC, SVTC, and CSH should meet with DMHMRSAS Architecture and Engineering staff to explore possibilities of creating better treatment space at HWDMC when the upcoming renovations occur.

*OIG Comment - The facility was under renovation during this inspection. Changes had occurred that allowed for an increase in space designed to meet the treatment needs of the patients and staff office and other workspace. Plans were identified for additional environmental changes including an increase in the development of adaptive equipment. This finding is ACTIVE. See finding 1.1 (OIG report #38-01)*

**Finding 4.3:** Staff has tried to make this very institutional building appear more home-like.

**Recommendation:** None.

*OIG Comment - Observations and interviews recognized the facility's efforts at making the setting more home-like. In the area where the renovation of the pony walls had been completed improvements were noted. Personal items of the patients were displayed. Two patients showed the team pictures and stuffed animals that helped them to feel more connected to their families. As the main projects are yet to be completed, this finding remains ACTIVE.* ***See finding 1.1 (OIG report #38-01)***

**Finding 8.1**: HWDMC staff is anticipating a major renovation project within the next two years.

**Recommendation:** Prepare staff and patients as soon as possible to minimize the negative impact of the construction on patients and staff.

*OIG Comment - Construction on the pony walls had not been completed. Efforts to complete this with minimal disruption to the patients were noted. This finding remains ACTIVE.* ***See finding 1.1 (OIG report #38-01)***

## HIRAM W. DAVIS MEDICAL CENTER
## RESPONSE TO SNAPSHOT INSPECTION, NOVEMBER 15, 1999
## OIG REPORT # 12-99

**Finding 1.2:** The facility was clean and well maintained, although there was not adequate storage space.

**Recommendation:** Continue to maintain the facility while evaluating the issue of inadequate storage space.

*OIG Comment - The facility was under renovation during this inspection. Changes had occurred that allowed for an increase in space designed to meet the treatment needs of the patients and staff office and other workspace. Plans were identified for additional environmental changes including an increase in the development of adaptive equipment. This finding is ACTIVE.*

**Finding 1.3:** HWDMC has moved beds for CSH Forensics patients such that they are clustered together in one large room and may be more closely monitored as a group by the required 2:1 CSH Forensic staff.

**Recommendation:** None. This will be followed by future inspections.

*OIG Comment - Renovations have resulted in a shift in the clustering of CSH forensic patients. The arrangement continues to allow for maximum staffing patterns without the excessive deployment of personnel. Interviews indicated that the housing of these patients would reconvert to the previous arrangement once the renovations are completed. This finding is ACTIVE.*

**HIRAM W. DAVIS MEDICAL CENTER**
**RESPONSE TO SNAPSHOT INSPECTION, FEBRUARY 12, 2001**
**OIG REPORT #38-01**

**Finding 1.1:** The facility is currently under renovation.

**Recommendation:** None. We look forward to seeing the completed project.

*OIG Comments - Construction on the pony walls had not been completed. Efforts to complete this with minimal disruption to the patients were noted.*
*This finding is ACTIVE, see findings 4.2; 4.3; and 8.1 (OIG report #6.99)*

**NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE**
**RESPONSE TO SNAPSHOT INSPECTION, JANUARY 15-16, 2001**
**OIG REPORT #35-01**

**Finding 2.5:** The role of the facility in the discharge process has been clarified such that hospital staff are responsible for performing the discharge needs assessment and CSB staff are responsible for securing the resources.

**Recommendation:** Continue to use this paradigm for discharge planning and to maintain positive collaborative relationships with CSB staff. Encourage exchange of information regarding these efforts in sharpening up the discharge planning process across the state.

*OIG Comment - There had been a shift in the philosophy that guides discharge-planning processes. Staff reported increased communication with community staff, in an effort to reduce barriers to discharge. This paradigm shift had recently been introduced and not sufficiently tested for effectiveness. This finding is ACTIVE.*

**PIEDMONT GERIATRIC HOSPITAL**
**RESPONSE TO PRIMARY INSPECTION REPORT , SEPTEMBER 22-23, 1999**
**OIG REPORT # 9-99**

**Finding 3.5:** PGH is currently unable to track hours of active treatment.

**Recommendation:** PGH should continue to pursue acquiring this software.

*OIG Comment - The facility has started to track active treatment hours in several of the treatment tracks available. These were noted in the records reviewed. Plans are to continue to expand the tracking as well as effectiveness of involvement in active treatment programming. This finding remains ACTIVE.*

**PIEDMONT GERIATRIC HOSPITAL**
**RESPONSE TO SNAPSHOT INSPECTION, JULY 14, 2000**
**OIG REPORT #28-00**

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

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

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

## SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
## RESPONSE TO INITIAL PRIMARY INSPECTION
## MAY 30-31, 2000
## OIG REPORT #22-00

**Finding 1.2:** A standing LHRC has not been in place for this facility since 1997.

**Recommendation**: It will be important for the State's Human Rights Director to review this situation so that it does not happen again.

*OIG Comment - Interviews indicated that membership to the LHRC was aggressively pursued by the patient advocate in cooperation with the States Human Rights Director and the Facility. There had been some discussion regarding the combination of this committee with the LHRC affiliated with the local community services board since recruitment of members in this region is difficult. In spite of the problems in securing full membership including consumer representatives, the LHCR has been active in reviewing policy and procedures as well as addressing patient concerns such as behavioral plans during regularly scheduled meetings, which are held the 3rd Tuesday of each month. Given the ongoing difficulties in securing membership, this finding is ACTIVE.*

**Finding 3.3:** Behavioral Programming needs further development within this facility.

**Recommendation:** Implement the use of behavioral plans for individuals in which the use of seclusion has been utilized beyond a designated number of times.

*OIG Comment - Interviews and reviews of plans occurred during the follow-up inspection. The Director of Psychology has been reviewing the plans and associated data. He has been working with team psychologists in developing additional plans, as appropriate. There has been an increase in the number of patients with behavioral plans as well as individuals participating in a specialized token economy reinforcement program. The facility has 3 Master's level psychologists and 1 PhD psychologist. All are participating in the Behavioral Analysis Training required by the Central Office. This finding is ACTIVE.*

**Finding 3.4:** Treatment plans did not consistently link the patient's barriers to discharge to psycho-social programming.

**Recommendation:** Develop plans in ways that are meaningful to the patient and link for them how the treatment groups and sessions are directly related to their ability to live successfully in the community.

*OIG Comment - Interviews and record reviews revealed that the facility has been addressing this issue. Records demonstrated an increased emphasis on linking problems identified at the time of admission with barriers to discharge on the individuals' treatment plans. Members of the staff participated in the Readiness for Discharge Training offered by the Boston Center for Psychiatric Rehabilitation, which focused on the completion of Readiness Assessments. A discharge survey with patients focused on perceptions associated with the treatment planning*

*process, rehabilitation programming and readiness for discharge. Limited data was available regarding the outcome of this project. Patients interviewed during the follow-up inspection did not feel that they had the ability to participate in their treatment planning to the degree they wanted to do. All indicated that they had not been asked to identify personal barriers to discharge. This finding remains ACTIVE.*

**Finding 4.1:** The facility has a very institutional presence and appearance inside.

**Recommendation:** Efforts are needed to make this facility appear less institutional internally and allowing for increased opportunities for private and quiet areas.

***OIG Comment*** *- Observations were made of the facility's efforts to date in undertaking several projects to improve its overall appearance. Artwork was placed in the reception area. Other art projects were noted. Patient rooms had been more personalized with posters and drawings. Other improvement projects have been targeted as noted above. This finding remains ACTIVE until additional projects have had time to be completed.*

**SOUTHSIDE VIRGINIA TRAINING CENTER**
**RESPONSE TO INSPECTOR GENERAL REPORT- PRIMARY INSPECTION**
**DECEMBER 9 & 15, 1999; JANUARY 4 & 5, 2000; APRIL 3, 2000**
**OIG REPORT # 18-00**

**Finding 2.1:** The facility has established procedures for the use of locked time-out and the use of restraints. This does include the use of "training restraints" or program restraints.

**Recommendation:** The appropriate use of "program restraints" will need to be considered in the reworking of the Human Rights regulations.

**OIG Comment** - *The facility is awaiting the approved version of the DMHMRSAS directive, currently under review, in order to draft appropriate policies and procedures. This finding is ACTIVE.*

**Finding 3.1:** Several disciplines at SVTC do not meet the staff-to-patient ratios established for Northern Virginia Training Center by agreement between the Commonwealth of Virginia and the Department of Justice.

**Recommendation 3.1:** Central Office DMHMRSAS staff should work closely with SVTC leadership to develop a clear plan for the current inadequate ratio of professional staff to residents at this facility.

**OIG Comment** - *There has been an ongoing process demonstrated through interviews to enhance professional staff within the facility. Plans are to continue these efforts. It is felt that census reduction will be the key for attaining appropriate staff to resident rations for those positions. This finding is ACTIVE.*

**Finding 4.3:** Many of the larger, more traditional residential buildings, particularly like in Building 125, are dismal.

**Recommendation 4.3:** Once it is clear how these units will be used, effort should be made on behalf of the people who live and work in this building to make them less institutional in appearance.

**OIG Comment** - *Efforts have been made to create a less institutional environment. Interviews with staff have indicated that additional work is planned. This finding remains ACTIVE.*

**Finding 8.1:** SVTC does not have a clear vision regarding its evolving role in the treatment of the Mentally Retarded in the Central Virginia area.

**Recommendation:** A plan should be developed regarding the role and size of SVTC over the next several years.

**OIG Comment** - *The facility has designed a plan to focus on census reduction and currently has an identified 100 residents appropriate for discharge pending the availability of appropriate community placement. This finding is ACTIVE.*

**SOUTHSIDE VIRGINIA TRAINING CENTER**
**RESPONSE TO SECONDARY, JANUARY 29, 2001**
**OIG REPORT #36-01**

**Finding 1.5**: SVTC uses the data collected to initiate performance improvement projects.

**Recommendation:** Expand upon this performance improvement process to foster a targeted approach to comprehensive system enhancement. Other facilities, particularly other training centers may benefit from the knowledge as to how this risk management information system is used to lessen the ongoing risks of recurring injury to individuals as well as the prevention of injury for others with similar risk factors.

***OIG Comments*** *- Interviews and a review of current performance initiatives revealed that a number of identified projects are linked to the information obtained during the investigations and reviews of critical incidents. This finding is ACTIVE.*

**WESTERN STATE HOSPITAL**
**RESPONSE TO SECONDARY INSPECTION REPORT, AUGUST 11, 1999**
**OIG REPORT # 8-99**

**Finding 1.4:** Psychiatrist follow-up on patients transferred internally is generally appropriate.

**Recommendation:** Maintain the role of psychiatrist as attending when patients are internally transferred to increase continuity of care for the patient. This should be designated in the Physician's orders so that it is clear to all who the attending psychiatrist is. Psychiatrists should evaluate for and document recommendations regarding any forms of active mental health treatment that may be appropriate for the current situation of the patient.

*OIG Comments -Interviews and documentation reviews demonstrated that follow-up expectations have been clearly communicated regarding coverage for persons temporarily transferred to the unit for acute care. Recent records reviews by the facility reported that in eighteen cases all but one meet 100% of the outlined requirements, in the one case coverage was adequate but the documentation was not completed in a timely manner. This finding is ACTIVE*

**Finding 2.1:** Treatment plans for patients in the Medical Center are very variable in quality. They range from adequate to inadequate.

**Recommendation:** Treatment planning with patients located within the Medical Center at Western State Hospital will need to be improved.

*OIG Comments - Interviews and record reviews during the October 2001 inspection indicated that with the assignment of a team to this unit, treatment plans have been more consistently completed and implemented for the patients. The team has been mentored regarding the treatment planning process and expectations for review. Although some variation in quality was noted at the time of the August 2001 onsite follow-up, the facility has an established procedure for the plans to be accomplished. This finding is ACTIVE.*

**Finding 2.3:** The Medical Center building was very institutional in appearance, but was clean and well maintained.

**Recommendation:** Staff and long-term patients on this unit may want to look at short-term, inexpensive ideas that might give the unit a more domestic appearance.

*OIG Comments - Interviews revealed that staff did consider ways to make this setting appear less institutional. Minor improvements have been made. The unit still has the pony walls, which limits the decorating options. This finding is ACTIVE.*