# COMMONWEALTH of VIRGINIA

*Office of the Governor*

Mark R. Warner
Governor

December 1, 2004

To the General Assembly of Virginia:

I am pleased to forward the Inspector General's semi-annual report on his inspections of mental health and mental retardation facilities in Virginia. The independent oversight offered by the Inspector General remains an important feature of our efforts to improve behavioral health care in Virginia. I am very pleased by the energy and innovation that the newly appointed Inspector General, Jim Stewart, has brought to this position.

This report contains an overview of the Inspector General's reports during the past six months as well as outstanding recommendations of the Inspector General. I continue to be pleased at the collaborative relationship that the Department of Mental Health, Mental Retardation, and Substance Abuse Services has forged with the Office of the Inspector General. At the same time, the Inspector General remains a strong, independent voice for patients, reporting directly to me.

I look forward to continuing to work with the Inspector General, Secretary Woods, the Commissioner of DMHRMSAS, and with the General Assembly as we move forward with the important work of reforming behavioral health care in the Commonwealth.

Sincerely,

Mark R. Warner

MRW/wlm

# *COMMONWEALTH of VIRGINIA*

*Office of the Inspector General*

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

November 23, 2004

To the General Assembly of Virginia:

The Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services is pleased to submit this semiannual report of activities for the period ending on September 30, 2004. This report is issued in accordance with the provisions of Va. Code § 37.1-256.1, which specifies that the Office report on the significant activities and recommendations of the Office during the immediately preceding six-month period.

The mission of the Office is to serve as a catalyst for improving the quality, effectiveness and efficiency of services for people and their families whose lives are affected by mental illness, mental retardation, and substance abuse disorders. The primary goal of the Office this period has been to redesign the process for inspecting state facilities to enable more effective system-wide assessment and the formulation of recommendations that will improve care across all facilities. We have made every effort to involve a wide range of stakeholders in this process of redesign.

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

Sincerely,

James W. Stewart, III
Inspector General

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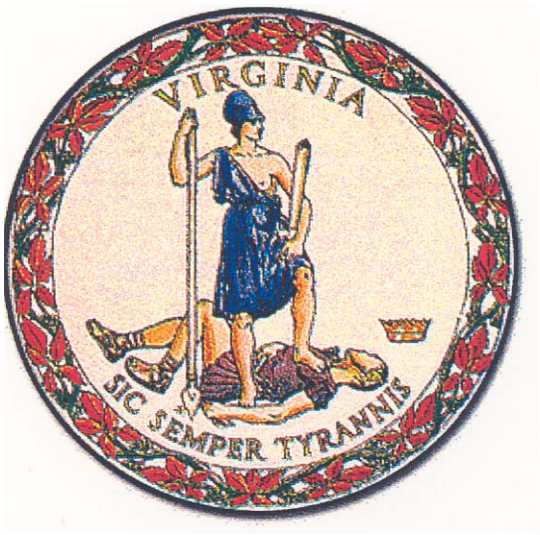


# Office of the Inspector General
# For Mental Health, Mental Retardation
# And Substance Abuse Services

Semiannual Report
April 1, 2004 – September 30, 2004

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# FORWARD

The Office of the Inspector General (OIG) for Mental Health, Mental Retardation and Substance Abuse Services is pleased to submit this semiannual report of activities for the period ending on September 30, 2004. This report is issued in accordance with the provisions of Va. Code § 37.1-256.1, which specifies that the OIG report on the significant issues related to the administration of the publicly funded services system.

This is the first full reporting period since Governor Mark Warner appointed Inspector General James Stewart in February 2004. During this six-month period, the OIG undertook a strategic planning initiative to refine the mission of the Office and to identify strategic goals that will build on the accomplishments of the past four years while setting appropriate new directions for the future. A summary of this planning effort is provided in this report.

The semi-annual report outlines the accomplishments of the OIG from April 1, 2004 through September 30, 2004. Information regarding the inspections that have been conducted at state facilities is included, as well as summaries of other significant monitoring and review activities. It is through these activities that the OIG serves as a catalyst for improving the effectiveness, efficiency and the quality of services provided by the publicly funded mental health, mental retardation and substance abuse services system.

# HIGHLIGHT OF ACTIVITIES

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

  Six Primary Inspections were conducted at the following DMHMRSAS facilities:

  - Central Virginia Training Center
  - Northern Virginia Training Center
  - Southeastern Virginia Training Center
  - Southside Virginia Training Center
  - Southwestern Virginia Training Center
  - Virginia Center for Behavioral Rehabilitation

  Four Secondary Reviews were conducted at the following DMHMRSAS facilities:

  - Eastern State Hospital (2)
  - Southwestern Virginia Mental Health Institute (2)

- **Five reports were completed.** All of the completed reports have been released for posting to the OIG website, except reports of the Secondary Inspections. Completed reports included:

  - Report #97-04 Southwestern Virginia Mental Health Institute
  - Report #98-04 Eastern State Hospital
  - Report #99-04 Virginia Center for Behavioral Report Rehabilitation
  - Report #100-04 Southwestern Virginia Mental Health Institute
  - Report #101-04 Eastern State Hospital

  Reports associated with the reviews conducted at the five training centers were not completed prior to the release of this report and will be combined in a separate document during the next reporting period.

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

- The OIG **reviewed approximately 500 critical incidents** during this six-month period. Additional follow-up was conducted on 78 of the critical incidents.

- Monthly quantitative data was received and reviewed from the sixteen DMHMRSAS operated facilities. **Nine (9) follow-up inquiries were completed** regarding this data.

- A formal review was completed of DMHMRSAS Departmental Instruction 313(QM) 04 Clinical Services Quality Management Committee and Departmental Instruction 201(RTS) 03 Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in DMHMRSAS Facilities. Several sections of the Virginia Code were reviewed for the General Assembly's Code Commission.

- There were a number of opportunities for the OIG to participate in activities relevant to the mental health, mental retardation and substance abuse services community through the completion of **9 presentations within the state and the federal level.**

- Members of the OIG **attended eight conferences or training events** regarding issues relevant to quality improvement and the mental health, mental retardation and substance abuse services system.

- The OIG responded to **29 concerns, complaints and inquiries** from citizens, consumers and employees regarding a variety of issues during this reporting period.

# MISSION STATEMENT AND GOALS

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

In developing the strategic plan for FY 2004-2006, the OIG redefined its mission as follows:

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

Three goals with corresponding objectives were developed for accomplishing this mission. The goals and objectives are as follows:

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

**Strategic Objective:**

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

**Ongoing activities in support of this goal:**

- Conduct systemic inspections of state facilities
- Conduct targeted evaluation projects of community programs
- Continuously review administrative and service data to identify trends
- Review critical incident reports
- Review and comment on policies, procedures and other documents

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

**Strategic Objective:**

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

**Ongoing activities in support of this goal:**

- Report on significant problems and deficiencies in the system
- Make recommendations for systemic improvement
- Ensure OIG representation on selected work groups

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

**Strategic Objectives:**

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

## ACTIVITIES OF THE OFFICE

## A. INSPECTIONS

The OIG conducted ten unannounced inspections during this reporting period. This included six primary inspections and four secondary inspections. The OIG performs at least one unannounced inspection annually at each of the state facilities operated by DMHMRSAS. The inspection schedule was revised during this reporting period so that the reviews correspond with the state's fiscal year instead of the calendar year as in the past.

### PRIMARY INSPECTIONS

The purpose of a primary inspection is to evaluate a broad array of components of the quality of care delivered by the facility and to make recommendations regarding performance improvement. Primary inspections are defined as routine comprehensive reviews of quality indicators such as the provision of active treatment within the context of the total environment of care. This includes, but is not limited to, the availability of adequate staff, the assurance of human rights and the adequacy of residents' access to medical care. The OIG conducted primary inspections at the Virginia Center for Behavioral Rehabilitation (VCBR) in Petersburg and all of the state's five training centers - Central Virginia Training Center (CVTC) in Lynchburg, Northern Virginia Training Center (NVTC) in Fairfax, Southeastern Virginia Training Center (SEVTC) in Chesapeake, Southside Virginia Training Center (SVTC) in Petersburg, and Southwestern Virginia Training Center (SWVTC) in Hillsville.

**Virginia Center for Behavioral Rehabilitation**

The OIG conducted a primary inspection of the VCBR. VCBR is the maximum-security residential treatment program operated by DMHMRSAS for persons committed as sexually violent predators pursuant to Va. Code 37.1-70.1 et seg. The facility is temporarily located in Petersburg on the Southside Virginia Training Center (SVTC)

Campus. This facility became operational in July 2003. The first admission occurred in December 2003.

Review activities included interviews with administrative, clinical, and direct care staff, as well as staff in the DMHMRSAS Central Office. A tour of the facility was conducted and included the observation of active treatment programming, as well as interviews of residents. Documentation reviews included resident records, and approved policies, procedures and training schedules.

The facility is currently addressing issues associated with meeting the challenge of developing and implementing an integrated treatment program while simultaneously focusing on issues relevant to making the facility operational, such as hiring adequate staff, developing policies and procedures, and implementing the human rights regulations. DMHMRSAS and facility management are to be commended for securing the physical plant and accomplishing other tasks associated with opening a new facility in such a short period of time. The report and the DMHMRSAS plan of correction are included in Addendum A.

**Systemic Review of the DMHMRSAS Training Centers**

The OIG conducted a systemic review of all five training centers operated by DMHMRSAS. These centers provide ICF/MR level services for persons with mental retardation. Inspections were conducted at each of the facilities through the application of thirty-two (32) quality statements. The quality statements were identified through interviews completed by the OIG with the training center facility directors, directors of CSB mental retardation services, parents, representatives of advocacy organizations, staff of DMHMRSAS Central Office, and other stakeholders.

The quality statements are as follows:

<u>Domain I / Mission and Values:</u>

1. The facility has a clear mission statement.
2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.

<u>Domain II / Access and Admissions:</u>

1. Policies and Procedures that govern admission are consistent with the facility's mission statement.
2. Admission to the facility is based on a thorough assessment of each client's needs and level of functioning.
3. The facility has a mechanism in place for addressing emergency admissions.

Domain III / Service Provision and Consumer Activities:

1. Activities are designed to facilitate socialization, skills acquisition and community integration.
2. Clients are actively engaged.
3. Activities occur as scheduled.
4. Residents are supported in participating in off-grounds activities.
5. The facility provides adequate outreach and discharge planning services to facilitate the client's transition to the community.

Domain IV / Facility Operations

Safe Environment**:**

1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.
2. There are adequate safeguards to protect clients from abuse and neglect.
3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.
4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.
5. Residents and their authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.
6. Medication usage is appropriately managed.
7. There are mechanisms to address areas of concern regarding staff safety.

Living Environment:

1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.
2. The residential environment is clean, odor free and well maintained.
3. There is evidence that the residents are being taken care of by the facility.
4. The facility provides for access to primary health care that is coordinated and comprehensive.
5. The facility has a mechanism for accounting for resident's money.

Staffing Patterns:

1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.
2. Direct care staff turnover, position vacancies and other forms of absenteeism are low enough to maintain continuity of client supports and care.
3. Direct care staff possesses the competencies necessary for providing services.

System Performance:

1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.
2. There is a system for continuous quality improvement.

3. Consumers and other stakeholders have an active role in program development and quality improvement activities.

Domain V / Community Relationships:

1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in its service area.
2. The facility has taken steps to understand the satisfaction of external stakeholders with the facility's services:
    a. Community Services Boards
    b. Parents and/or legal guardians
    c. DMHMRSAS Central Office
3. The facility management and direct care staff have a working understanding of the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.
4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.

Even though the inspection process for the training centers was initiated during this reporting period, the systemic review report and the five individual facility reports will be recommended for release as a single document during the next reporting period once all reports have been completed.

**SECONDARY INSPECTIONS**

A secondary inspection is conducted in response to a specific concern or complaint received by the OIG. Secondary inspections often involve confidential information regarding consumers or employees. As a result, these reports are not released on the OIG website. Four secondary inspections were completed at the following facilities during this six-month reporting period:

Southwestern Virginia Mental Health Institute in Marion (2)
Eastern State Hospital in Williamsburg (2)

## B. REPORTS

The OIG completed five reports during this six-month period. Reports are generated as a tool for performance improvement and provide DMHMRSAS with findings and recommendations regarding observations related to a number of quality indicators. DMHMRSAS develops a plan of correction (POC) for each recommendation made by the OIG. Implementation of the POC is monitored by the OIG until successful resolution has occurred. A report is not considered complete until a POC has been approved and the full report forwarded to and approved by the Office of the Governor.

The completed reports are as follows:

Report #97-04 Southwestern Virginia Mental Health Institute

| | |
|---|---|
| Report #98-04 | Eastern State Hospital |
| Report #99-04 | Virginia Center for Behavioral Rehabilitation |
| Report #100-04 | Southwestern Virginia Mental Health Institute |
| Report #101-04 | Eastern State Hospital |

All reports that are released by the Governor's Office are posted on the OIG website. Reports that contain specific identifying consumer information or are designated as peer review documents remain confidential and are not posted.

## C. SPECIAL PROJECTS

During this reporting period, the OIG initiated the development of an audit plan for conducting a system-wide review of the use of seclusion and restraint within the facilities operated by DMHMRSAS. Kevin Huchshorn, RN, a nationally recognized expert in the prevention of seclusion and restraint, is working with the OIG in the development of the audit plan. Ms. Huchshorn, Director of Technical Support for the National Association of State Mental Health Directors, met with OIG staff, members of the DMHMRSAS Central Office administrative staff and facility representatives to stimulate discussions regarding the best approach for effectively capturing the progress to date within the facilities in reducing the use of seclusion and restraint. Once the audit plan is completed, reviews of the state facilities will begin.

## D. DATA MONITORING

### Critical Incident Reports

Documentation of critical incidents, as defined by Virginia Code § 51.5-39.12, is forwarded routinely to the OIG for review and monitoring. Approximately 500 critical incident (CI's) reports were reviewed during this semi-annual period. The OIG conducted an additional level of scrutiny and follow up for 78 of the reviewed CI's. The information gathered from the additional inquiries was used to identify potential problems within state facilities and to track trends in areas of concern.

### Quantitative Data

In order to track potential areas of risk within the facilities on a routine basis between periodic inspections, the OIG instituted a system of monthly statistical reporting by facilities in January 2002. This report over time has enabled the identification of trends within facilities. Areas that are monitored through this report include, but are not limited to, facility census, seclusion and restraint use, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect. During this six-month reporting period, the office identified nine areas of concern from this data and initiated requests for clarification. All of the responses provided by the facilities were satisfactory.

## E. FOLLOW-UP REPORTING

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

Follow-up reviews were conducted at the facilities that maintained active findings prior to the inspections conducted during this reporting period. Only NVTC and SWVMHI had satisfied their previous active findings. The follow-up review for Eastern State Hospital is included in this report. Follow-up reviews for the training centers will be addressed in the next semi-annual report once all documents have been completed.

## F. REVIEW OF DEPARTMENT INSTRUCTIONS AND REGULATIONS

During this semi-annual reporting period, the OIG reviewed and made comments on the following Departmental Instructions and proposed Va. Code amendments.

- DI 313(QM) 04 – Clinical Services Quality Management Committee - This departmental instruction calls for the Inspector General's involvement as an ad hoc member of the quality services peer review committee developed by the DMHMRSAS Central Office.
- DI 201(RTS) – Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in DMHMRSAS Facilities
- Reviewed proposed recodification of Title 37.1 as drafted by staff in the Division of Legislative Services.

## G. PRESENTATIONS AND CONFERENCES

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

- Virginia Mental Health, Mental Retardation and Substance Abuse Services Board Volunteer Recognition Luncheon
- Charlottesville-Albemarle County Mental Health Association
- State Human Rights Committee
- Joint meeting of the Virginia Association of Community Services Board and state facility directors
- Henrico County Drug Court's first Graduation
- Parents and Associates of the Institutionally Retarded (PAIR)
- NAMI / Northern Virginia Chapter
- KOVAR Institute

- 7th Annual Conference of the Association of Governmental Accountants

Conferences and Trainings attended by staff members of the OIG:

- Association of Inspectors General Conference in Baltimore
- Community Integration Training regarding Olmstead, Restructuring and Recovery
- Governor's Uninsured Conference in Northern Virginia
- Reducing Seclusion and Restraint: Creating Culture Change and Transformation Conference by DMHMRSAS in Richmond
- Virginia Executive Institute
- 2004 Redefining Quality Conference in Philadelphia
- National Teleconference on Olmstead by SAMSHA
- Polycom Training on evidence-based practice for schizophrenia

## H. MEETINGS

The OIG participated in a variety of forums that addressed issues relevant to mental health, mental retardation and substance abuse services and to state government:

- DMHMRSAS Facility Directors' Meetings
- Virginia Mental Health, Mental Retardation and Substance Abuse Services Board Meetings
- DMHMRSAS Medical Director's Meetings
- VOPA DD Advisory Council
- State's Human Rights Committee Meeting
- VOPA PAIMI Advisory Council
- DMHMRSAS Restructuring Meetings
- Central Office Quality Management Committee Meetings
- Leadership Team of the VA Association of Community Services Boards
- DMHMRSAS Reinvestment Conference Planning Committee
- Secretary of Health and Human Resources Aging Action Task Force
- Governor's Department Head Meetings
- Secretary of Health and Human Resources Department Head Meetings

## I. INTERFACING WITH OTHER AGENCIES

The OIG met with the following agencies and organizations for the purpose of planning or project collaboration during this reporting period:

- Board of Directors of the County Behavioral Health Institute
- Department of Health
- Department of Medical Assistance Services – Systems Change Grants for Community Living Quality Improvement team meetings
- Department of Mental Health, Mental Retardation and Substance Abuse Services
- Department of Social Services
- Federal Substance Abuse and Mental Health Services Administration
- Medical Examiner's Office
- Office of the Attorney General
- Office of the Lt. Governor
- VA Office of Protection and Advocacy
- Many of the local Community Services Boards

## J. COMPLAINTS, CONCERNS AND INQUIRIES

The Office of the Inspector General responded to 29 concerns, complaints and inquiries from citizens, consumers and employees regarding a variety of issues during this reporting period.

Eight of the contacts were non-complaint requests for information or assistance. Four of these contacts were referred to DMHMRSAS. One was referred to the Board of Medicine. Three of the calls were addressed by the OIG.

There were nine complaints regarding community programs or services. Each of these was referred to either a state or local agency for resolution. Five were referred to community services boards, two to the State Human Rights Committee and one each to the State Corporation Committee and DMHMRSAS.

There were 12 complaints regarding the care and treatment provided in DMHMRSAS facilities. The OIG took action on each of these. Four complaints resulted in on-site reviews or telephone contacts because of the nature of the complaints. The remaining eight were referred to the appropriate facility for response. Each facility reported the outcome of their investigation to the OIG. Each of the complaints will be reviewed by the OIG during the next facility inspection.

## ADDENDUM A

# COMPLETED FACILITY REPORTS
# APRIL 1, 2004 – SEPTEMBER 30, 2004

**SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE**
**CYNTHIA MCCLURE / FACILITY DIRECTOR**

**OIG REPORT #97-04**
**SECONDARY INSPECTION**

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

**EASTERN STATE HOSPITAL**
**JOHN FAVRET / FACILITY DIRECTOR**

**OIG REPORT #98-04**
**SECONDARY INSPECTION**

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

**VIRGINIA CENTER FOR BEHAVIORAL REHABILITATION**
**C.C. MURPHY / FACILITY DIRECTOR**

**OIG REPORT #99-04**
**PRIMARY INSPECTION**

| | |
|---|---|
| **Facility:** | Virginia Center for Behavioral Rehabilitation<br>Petersburg, Virginia |
| **Date:** | July 13 and July 16, 2004 |
| **Type of Inspection:** | Primary Inspection / Unannounced |
| **Reviewers:** | James W. Stewart, III<br>Cathy Hill, LPC |

**Sources of Information:** Interviews were conducted with administrative, clinical, and direct-care staff, as well as staff in DMHMRSAS Central Office. Residents were also interviewed. Documentation reviews included, but were not limited to: resident records, selected Policies and Procedures, and facility training materials. A tour of the residential and treatment areas was conducted. Activities and staff/resident interactions were observed.

**Areas Reviewed:**
Section One /Treatment Environment
Section Two / Active Treatment Program
Section Three /Access to Medical Care
Section Four / Application of Human Rights
Section Five/ Use of Seclusion and Restraint

**Introduction:**
Virginia has joined a number of states in enacting legislation that allows for the civil commitment of persons found to be sexually violent predators upon completion of their mandatory prison sentence. The Supreme Court declared (Kansas vs. Hendricks) that the civil commitment of sexually violent predators is constitutional.

The Civil Commitment of Sexually Violent Predators (§ 37.1-70.10.) outlines the following:

> *Any person committed pursuant to this article shall be placed in the custody of the Department of Mental Health, Mental Retardation and Substance Abuse Services for control, care and treatment until such time as the person's mental abnormality or personality disorder has so changed that the person will not present an undue risk to*

*public safety. The Department of Mental Health, Mental Retardation and Substance Abuse Services shall provide such control, care and treatment at a facility operated by it, or may contract with private or public entities, within or without the Commonwealth, and with other states to provide comparable control, care or treatment. At all times, persons committed for control, care and treatment by the Department of Mental Health, Mental Retardation and Substance Abuse Services pursuant to this article shall be kept in a secure facility. Persons committed under this article shall be segregated by sight and sound at all times from prisoners in the custody of a correctional facility. The Commissioner may make treatment and management decisions regarding committed persons in his custody without obtaining prior approval of or review by the committing court.*

The Civil Commitment of Sexually Violent Predators Act became effective April 2, 2003. One provision of this act establishes the Department of Corrections' Commitment Review Committee (CRC). It is the responsibility of this committee to screen and evaluate prisoners that have been convicted of a sexually violent offense and scored 4 or more on the RRASER prior to their mandatory release date. The CRC recommends if the person should be released, be conditionally released, or civilly committed as a sexually violent predator.

It is only through defined legal processes that a court can determine that a person, through clear and convincing evidence, requires civil commitment. Once commitment occurs the person is placed in the custody of the DMHMRSAS.

Persons committed as sexually violent predators to the custody of DMHMRSAS are admitted to VCBR. Interviews with administrative and treatment staff defined the mission of the facility to be two fold: assuring public safety and the provision of treatment. One of the challenges for this facility is that it does not clearly fit the definitions traditionally associated with either a correctional facility or a mental health facility but it must meet many of the expectations required of both systems.

VCBR is the maximum-security residential treatment program operated by DMHMRSAS for individuals civilly committed as sexually violent predators (SVP). The facility, which became operational in July 2003, is temporarily located in Petersburg on the Southside Virginia Training Center (SVTC) Campus. It has been projected that the facility will be maintained at this temporary site for a period of no greater than three years. The facility has an initial operating budget of 5.8 million dollars over the next two years. Interviews revealed that the estimated annual cost per bed is $80,000 at this temporary site. The projected annual cost per bed once the facility is in its permanent location is around $68,000.

The main facility consists of two residential buildings. Because of space limitations, administrative offices are housed in a separate building outside the secured compound. Conversion of this site to a maximum-security facility began in April 2003 with the addition of perimeter fencing, razor wiring and motion detectors around the two primary residential and treatment buildings. The buildings were renovated to include increased

security measures such as closed circuit cameras in the common areas, magnetic doors, steel mesh wire and shatterproof windows. Each building contains two residential treatment areas consisting of a day room, staff offices and/or treatment areas, a communal bathroom and shower area, nine bedrooms and a seclusion/restraint room.

The current arrangement of bedrooms can house 36 residents, if each resident is assigned to a single room. While the facility could house 72 residents if all the residents were double bunked, interviews with administration revealed that the maximum operating capacity has been determined to be 48 residents. This allows for 12 person residential units with the current configuration of designated programming space. The designation of 12 persons per unit will require double bunking of several residents. This will only occur after all clinical and security considerations have been thoroughly examined.

To house more than 12 residents within the current unit design would severely restrict available program space limiting its effectiveness. The alternative would be to create additional treatment space within the fenced area through new construction or the purchase of temporary prefabricated units.

The first admission to the facility occurred in December 2003. The census on the day of the inspection was nine residents. It is projected that the tenth resident could enter the facility within the next 14 to 60 days. At that time, the management team will decide whether to place that person in the currently occupied residential unit or open the next unit.

It has been projected that the program will receive approximately 2 admissions per month through 2008. If the projected admission rates are correct the program in its current location, will have 21 residents by January 2005, and be at the previously identified maximum operating capacity by February 2006.

## SECTION ONE / TREATMENT ENVIORNMENT

**Finding 1.1: The residential areas were clean and well maintained.**

A tour was conducted of the one opened residential unit. The living areas were clean and well maintained. The furniture was adequate to meet the needs of the residents. Each bedroom contained a bed, wardrobe, desk and chair. Residents have the opportunity to retain personal items in their rooms as long as the items have been approved and do not present a security risk. Communal bathrooms were designed to afford the residents some privacy.

A telephone designated for residents' usage was on the living unit. Smoking is permitted in designated outside areas and at designated times. Smoking occurs under staff supervision. Residents have access to approved recreational areas. Behind the residential area is a basketball court.

DMHMRSAS in conjunction with the Department of Corrections (DOC) did a nice job in converting this facility into its current usage as temporary quarters for this program.

**Recommendation: Given the temporary status of this facility, the OIG does not have any specific recommendations at this time.**

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**Finding 1.2: The facility design and security procedures are adequate to assure a secure environment for the projected maximum census. Security staffing is adequate for the current census but will need to be expanded to accommodate the full census at this site.**

The process of recruiting and retaining qualified personnel for this program has been challenging. Interviews with administrative staff indicated that in its current location, the facility is competing with three other state operated facilities and a federal prison in its efforts to hire sufficient numbers of qualified direct care staff. This does not include the added market competition that exists with private providers and/or private industry.

In addition to the issues associated with a competitive market, it is often difficult to find qualified individuals who have chosen to work with this challenging population. The facility has experienced some turnover in staff but this has been limited. The turnover is not unexpected as both facility management and staff are in the process of determining the best "fit" for this population.

The first complement of staff hired for this facility was security personnel, many of whom were hired in July 2003. Senior security personnel, in conjunction with DMHMRSAS Central Office staff, initially focused on assessing security risks and establishing security protocols, including the preliminary training of residential unit security staff. Interviews with management and security staff indicated that security protocols were well established prior to the admission of the facility's first residents. The facility Operations Manager provides supervision of the security staff and has been actively reviewing and adapting the current practice protocols into facility policy and procedures.

**Recommendation: None.**

## SECTION TWO / ACTIVE TREATMENT

**Finding 2.1: The facility has adopted a model of treatment widely used with this specially defined population. The model employs a cognitive-behavioral and relapse prevention approach to treatment.**

A review of program offerings, interviews with staff and residents, and observations of a group session revealed that the facility has initiated a program of the structured treatment. The treatment program, which is grounded in cognitive-behavioral treatment approaches, consists of five phases. Each phase is consistent with a corresponding number of overall program treatment goals. Advancement to the next phase of treatment is dependent on each resident's progress with the prescribed treatment goals for each stage. Resident are not required to participate in the treatment process but are reminded that reintegration into the community is contingent upon their successful completion of the program.

The phases, as currently identified, are as follows:

- Phase I focuses on the individual's acknowledgment of his behavior and its impact both on his life and that of his victims. This phase also consists of the completion of a comprehensive assessment and evaluation for the purpose of identifying short-term treatment objectives through the formulation of a treatment plan. Residents are encouraged to actively participate in the development of their treatment plan.
- Phase II assists the residents in developing the motivation necessary for engaging in increasingly in-depth self-examination regarding each person's pattern of sexually abusing others and the associated distorted thought patterns. Residents gain insight regarding their personal patterns of sexual arousal, aggression and cycle of offending. Residents will begin the process of interrupting their patterns of offending through self-disclosure and peer feedback.
- Phase III focuses on skills acquisition, application and integration. Residents will become increasingly aware of their personal areas of high risk and learn techniques for either staying out of or dealing with these situations. Anger management, progressive relaxation techniques, stress reduction and appropriate social interactions will be emphasized during this phase. Residents in this phase are expected to act as appropriate role models and provide leadership on their living units.
- Phase IV practices skills generalization through increased opportunities to demonstrate both behavioral and attitudinal changes. There will be increased opportunities for the residents to interact with their natural support systems during this phase of treatment. Residents are clearly expected in this phase to demonstrate treatment concepts through more pronounced behavioral control.
- Phase V represents discharge readiness and transition into the community. Relapse prevention plans, a consistent demonstration of behavioral control, and the successful development of effective coping strategies must be evident. The resident's ability to effectively demonstrate these skills will result in the forwarding of a petition for conditional release to a less restrictive environment to

the court of jurisdiction for review. This summary enables the individual to be considered for transition to a less restrictive environment.

The program designed for use at this facility is consistent with the model widely used in other states providing for the treatment of sexually violent predators in similar secure settings. DMHMRSAS Central Office staff consulted with several leading experts in this field of treatment throughout the development of this model.

Interviews with clinical management staff indicated that the facility is reviewing the possibility of developing a pretreatment phase for those persons not motivated to participate in active treatment. This phase will focus on assisting the resident in acclimating to the facility and providing adequate structure and support so as to diminish disruptive or maladaptive behaviors while fostering appropriate responses within the setting and motivating the resident to become actively engaged in treatment.

The facility has designed a program of active treatment, which includes scheduled treatment sessions held throughout the day.

**Recommendation: None.**

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**Finding 2.2: Current staffing for treatment activities is not adequate to provide a full program of active treatment for the current residents. Recruitment is underway to fill treatment positions.**

The program design includes engaging residents in active treatment programming activities throughout the day. Sessions are divided into morning and afternoon activities. During the tour of the facility, a member of the OIG review team observed a morning treatment session. Seven of the nine residents were present. Six of these were attentive, if not actively participating in the group discussion. Only one person was not at all engaged. Even though he was not engaged, the person was not disruptive to the process. The session was held in a space surrounded by tall dividers that did not reach the ceiling. A single security officer was posted on the opposite side of the divider, out of view however, the officer was able to hear the discussion. The issue of confidentiality was raised as a concern during interviews with residents. The ability of security officers to hear residents' disclosures is disconcerting for some persons still acclimating to the facility.

In the session that was observed, the therapist actively engaged the participants in a therapeutic discussion of their deviant behavioral history. The therapist was respectful, appropriately active, and was able to keep the discussion on track.

Interviews and observations revealed that afternoon therapeutic activities are provided on a limited basis. The residents reported that during the afternoon sessions they are, for the most part, not actively engaged in treatment. Several residents have identified this as a

concern to the human rights advocate. Observation of afternoon activities during the facility tour noted one resident playing a video game, two residents playing a card game with each other, two others playing solitaire, and one resident just sitting. One resident appeared to be writing a letter. Two staff members were present but neither was engaged in activities with the residents.

The team was informed that the facility had recently hired a recreation therapist, whose primary responsibility will be to develop and initiate afternoon therapeutic activities that are consistent with the individualized treatment goals of each resident. It was anticipated that this person would begin employment in the next two weeks. Nursing staff will also provide educational groups on topics such as nutrition, health management and other related topics as increased staff are hired to support these activities.

Administrative staff reported that the facility plans to offer a variety of programming options during the evenings and weekends as well. Included are activities designed for identifying and increasing leisure skills, such as arts and crafts and recreational activities. Educational opportunities will also be provided. Other offerings will include anger management, relaxation techniques, stress management classes, and current events discussions. Implementation of these activities is contingent upon the addition of qualified staff.

The facility director was hired in October 2003. One of his primary tasks has been the recruitment of staff. In addition to the management for operations and support personnel, the staffing for treatment at current and capacity levels for this facility are as follows:

| | **Number of Staff Currently** | **Number of Staff at Capacity** |
|---|---|---|
| **Clinical** | | |
| Clinical Director (PhD) | Hired (12/03) | 1 |
| Psychologists II | 1 | 2 |
| Rec. Therapists | 1 | 2 |
| Social Workers (MSW) | 1 | 4 |
| Direct Care Associates | 2 | 20 |
| Educational Instructors | 0 | 2 |
| **Medical** | | |
| Primary Care Physician | 1 (FT) | 1 |
| Nursing | 3 | 7 |
| Consulting Psychiatrist | 1 (PT) | 1 |

**Recommendation: Take additional steps that will enable implementation of the full treatment program quickly. If recruitment for permanent staff will not be completed in a reasonable period of time, identify and implement alternative**

**methods to engage treatment staff, such as contracting with hourly professional staff on a temporary basis.**

**DMHMRSAS Response:**
VCBR has filled two of the most critical clinical positions. A licensed clinical social worker and recreation therapist began work on August 10, 2004. On September 7, 2004, the facility implemented a new treatment schedule that provides an additional twelve hours of structured treatment activities per week, bringing the total of treatment activities provided to eighteen hours per week. We are also providing educational services for 60-90 minutes per week. We believe this is comparable to other SVP facilities .VCBR continues to recruit for another social worker and unit psychologist. The facility anticipates filling these positions by January 1, 2005.

## SECTION THREE / ACCESS TO MEDICAL CARE

**Finding 3.1: The system developed for providing medical care is adequate to address both the acute and chronic care needs of the residents. Nursing staff will need to be expanded as census increases and nursing responsibilities for participation in active treatment programming are initiated.**

VCBR has a full-time primary care physician. The physician is on-site Monday through Friday during the day shift and on-call after hours, including holidays and weekends. The facility has made arrangements to contract with a local practice to provide coverage when the primary physician is on vacation. In addition, the facility has contracted with a consulting psychiatrist to provide services as needed.

On-site plans of care are managed by nursing personnel. The facility currently has three full-time nurses, plus a nurse administrator. Agency nurses are used to supplement any absences of the current employees. The nurses conduct the residents' initial assessment. Vital signs are taken daily during the first three days following admission and monthly after the completion of this initial physical assessment period.

All residents undergo a complete physical examination by the physician within twenty-four hours of their admission. Acute and/or chronic medical problems identified are noted on the patient's treatment plan. Nursing staff documents the course of treatment on care plans and manage the day-to-day interventions outlined on the plans. It is the responsibility of nursing personnel to communicate to the appropriate authority any medical concerns that could have an impact on a resident's ability to function within the treatment program or which may present security concerns.

The facility uses a sick-call system for the provision of non-emergency medical care. Residents are asked to complete a form outlining their chief medical complaints. The

form is then forwarded to the nurse on duty for review. The nurse makes the arrangements for the residents to be seen. Specialized care is provided in the community through the use of consultants or, as appropriate, at Hiram W. Davis Medical Center. Security personnel are assigned to accompany the resident to off campus outpatient appointments and special hospitalizations.

**Recommendation: None.**

## SECTION FOUR / APPLICATION OF HUMAN RIGHTS

**Finding 4.1: An advocate has been assigned to the facility. The advocate is actively involved in providing oversight and consultation to this program through training, contact with residents and staff, and the monitoring of program development relevant to human rights concerns. Residents and staff understand how to contact the advocate.**

The advocate who has primary responsibility for Piedmont Geriatric Hospital has been assigned as advocate for VCBR. The advocate participates in many information-sharing forums with administrative staff in order to keep abreast of issues that may be relevant to human rights, particularly as this program progresses. She has provided consultation to administrative staff regarding the development of policies and procedures and the resident handbook. She conducts staff human rights orientation and training. Interviews with staff describe a good working relationship with the advocate.

The advocate meets with residents to review their rights. She also meets regularly with residents in response to identified concerns or complaints. All four of the patients interviewed were able to identify the advocate and how to get in touch with her. A poster providing contact information was located on the wall in the residential day room area.

The States Human Rights Committee (SHRC) will serve in lieu of a local human rights committee for this facility. This decision was reached after careful consideration and in order to provide this population with a complaint process that is more structured and requires less time to complete. The committee will hear appeals on behalf of the residents regarding any unresolved complaints or concerns relevant to the human rights regulations.

**Recommendation: None.**

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**Finding 4.2: VCBR is operating without established policies and procedures in a number of areas that govern facility operations, including critical policies that govern practices for exemptions to the human rights regulations.**

The DMHMRSAS Human Rights Regulations state that the regulations apply to individuals "committed to the custody of the commissioner as sexually violent predators, except to the extent that the commissioner may determine these regulations are not applicable to them." The regulations also provide guidance regarding the process by which the Commissioner may notify the SHRC chairperson of any exceptions to the regulations. Notification of the exemptions occurred in October 2003. These exemptions are scheduled to be reviewed again in October 2004.

To date the facility has not finalized the policy and procedures manual governing its operations. This is particularly critical for the policies and procedures that govern patients' rights such as residents access to mail, telephone usage, visitation, the use of seclusion and restraint, and segregation for which exemptions were authorized by the Commissioner in October 2003.

The Policies, which have been approved include:

- Medical Assessments
- Special Hospitalizations and Off Campus Health Services
- Emergency Medical Responses
- Abuse and Neglect Reporting and Investigations
- Resident Fund Accounts
- Searches of Persons and Property
- Staff Transportation of Residents

Interviews indicated that a number of policies have been drafted but have been delayed due to the review process, which includes the rerouting of drafted policies once comments are integrated. It was reported that this process has taken ninety days or longer for a single policy to be completed.

Interviews revealed that the responsibility for drafting the policies has changed hands several times since the program began operations. Members of the Central Office's Office of Health and Quality Management were initially involved in drafting the policies and procedures. It was reported that responsibility for completing this task was transferred to the facility just prior to this inspection. Facility administration has established a committee for the purpose of completing this task. The facility projects that the policy and procedures manual will be completed no later than December 2004. Interviews revealed that this facility's unique status within the mental health, mental retardation and substance abuse service delivery system has made the development of policies and procedures more challenging because there are not established standards of care that can be used as a foundation for their development.

The completion of the policy and procedures manual is a critical task for this facility. Practices are being established because of the need to provide structure and consistency within the treatment environment that may not reflect the actual policy once it is finalized. This has the potential of creating confusion for both the staff and residents.

The longer it takes to formulate and approve policies, the greater the risk that current practice will become the "institutionalized" standard of care.

**Recommendation: Streamline the process for drafting and approving policies and procedures in order to complete this task as quickly as possible.**

**DMHMRSAS Response:**
DMHMRSAS acknowledges that the process for new policy development at VCBR has been particularly cumbersome as is often the case with a new unit and with the need in this case of close collaboration with the Office of the Attorney General. A primary consideration in the development of policies at VCBR has been preventing misinterpretation and contradiction with DMHMRSAS Departmental Instructions, Human Rights regulations and the Code of Virginia. VCBR has hired an employee whose primary duties include drafting and organizing policy development. The facility has also designated appropriate employees to develop and revise policies relevant to their departments. The facility is holding weekly meetings to update the status of policies in progress. We expect to have all policies with Human Rights implications completed by January 1, 2005. The policy development team meets weekly to review policy status and to assign policy development to specific staff members who are responsible for enacting and enforcing those policies. The SHRC advocate, Anne Stiles, meets regularly with the policy development team and keeps in touch by email nearly daily.

**Finding 4.3: Staff have a working knowledge of issues associated with abuse and neglect.**

The staff members interviewed had a working knowledge of the policy and procedures associated with identifying and reporting abuse and neglect. All were able to appropriately identify the reporting process as outlined by the facility policy. All described the importance of staff treating the residents with dignity and respect. The majority indicated that it was the responsibility of staff to model appropriate social interaction with the residents and to monitor interactions so as to prevent situations that could result in neglect or abuse.

All the residents interviewed indicated that the interactions between staff and residents are generally positive. Staff were described as courteous, friendly and respectful.

**Recommendation: None.**

## SECTION FIVE / USE OF SECLUSION AND RESTRAINT

**Finding 5.1: The use of seclusion and restraint is governed by the provisions outlined in the DMHMRSAS Human Rights regulations except for the exemptions issued on October 31, 2003.**

Residents are provided a copy of the Resident's Handbook following admission to the facility. The handbook outlines the program's rules of conduct. Residents are provided an orientation to the handbook including being notified of the range of consequences associated with displays of physical violence within the setting.

Seclusion and restraint are restrictive procedures utilized in Virginia under clearly prescribed emergency situations when there is an imminent risk of harm to the consumer or others, and only in the event of failure of other interventions. Staff at the facility have received training in therapeutic interventions that are designed to de-escalate the types of behaviors that might lead to emergency situations.

The following exemptions to the human rights regulations have been authorized for this facility:

- The facility is permitted to use restraints as a security measure during the transport of residents beyond the secure perimeter.
- The facility is permitted to extend the time limit for an authorization for seclusion.
- The facility is permitted to use administrative isolation.

Segregation or isolation is a technique utilized in correctional facilities for the purpose of maintaining control over potentially escalating risk factors/behaviors that may impact facility safety. Administrative staff reports that the use of isolation in this facility will be defined by policy and procedures.

The facility has not implemented the use of these restrictive procedures in the absence of an approved policy. When a situation arises that can not be handled through therapeutic interventions, the facility utilizes the services of local law enforcement because they have clearly established guidelines for actions designed to decrease the risks to the public and for containment of an emergency situation.

**Recommendation: Prioritize the completion of the policies and procedures governing the use of restrictive procedures and practices associated with the exemptions in order to assure residents rights and provide staff with clear guidelines for handling emergency and other situations.**

**DMHMRSAS Response:**
The Department recognizes the need to prioritize policies and procedures involving safety, security and human rights. VCBR has written and submitted policies regarding seclusion and restraint, separation and other policies involving human rights to the Attorney General's Office as well as the State Human Rights Committee (SHRC). The SHRC has approved the Seclusion and Restraint policy and the Separation Policy at this time. These policies are being followed at VCBR.

**SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE**
**CYNTHIA MCCLURE / FACILITY DIRECTOR**

**OIG REPORT #100-04**
**SECONDARY INSPECTION**

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

**EASTERN STATE HOSPITAL**
**JOHN FAVRET / FACILITY DIRECTOR**

**OIG REPORT #101-04**
**SECONDARY INSPECTION**

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

**ADDENDUM B:**

**EASTERN STATE HOSPITAL**
**RESPONSE TO PRIMARY INSPECTION**
**SITE VISIT OF SEPT. 25-26 & OCT. 3, 2000**
**OIG REPORT # 31-00**

**UPDATE SEPTEMBER 2004**

## SECTION ONE: TREATMENT WITH DIGNITY AND RESPECT

**FINDING 1.2: Challenging placements were identified as one of the primary issues facing the human rights advocates providing services for the acute admission unit, Building 2.**

**Recommendation: Maintain dialogue with facility, Central Office and the community regarding issues associated with community re-integration.**

**DMHMRSAS Response:**

| **6 Month Status Report: 7/1/01** |
|---|
| Eastern State Hospital has been participating in on-going meetings with Central Office and HPR-V CSBs to resolve barriers to placement and improve the discharge planning process. Utilization review of 100% of the patients in Admission Building is being conducted weekly to identify discharge ready patients. Discharges have increased as a result of these efforts. Lengths of stay have also been reduced. |

***OIG Comment -*** *Interviews revealed that this facility continues to deal with challenges associated with being able to match patient needs with available community resources. This finding is* ***ACTIVE.***

| **6 Month Status Report: 1/01/02** |
|---|
| ESH is implementing the new statewide Discharge Protocol by January 2, 2002. The initial hospital training has been completed and the Clinical Operations Director is working closely with Central Office to continue to improve the discharge planning process. During this report period clinical social workers previously assigned to the Hospital Community Liaison/Resource Department were reassigned to programs, with the focus on preparing patients for discharge and identifying needs to be addressed upon discharge. This action was the result of statewide implementation of the Discharge Protocol that places responsibility for discharge resource identification on CSBs. The median LOS was reduced by five days in October hospital-wide and it is currently 14 days in Acute Admissions. The Clinical Social Work Director continues |

100% utilization review with the Clinical Operations Director to maintain and/or decrease LOS.

**OIG Comment – Interviews indicated that the facility has demonstrated initiative in addressing difficult placement issues with respect to substance abuse and mentally retarded patients. As outlined in the status report, OIG team members were informed of increased community contact regarding placement issues and a restructuring within social work for focusing on preparing patients for discharge. These actions coupled with the initiation of the statewide Discharge Protocols by all facilities are evolving. This finding is ACTIVE.**

**6 Month Status Report: 07/01/02**

The Clinical Operations Director meets monthly with the case manager liaisons from the nine CSBs served by ESH, the Program Social Work Directors, and Central Office staff, to problem-solve and improve the Discharge Process. The Utilization Review Coordinators and Clinical Operations Director collaborate on all U.R. denials that effect discharge. There is ongoing review of all patients in the Hospital who are clinically ready for discharge and a new computer program has been developed and is in the process of being implemented to provide daily updates on all patients regarding clinical discharge ready status. The May 2002 Management Information Systems Report showed an increase in the number of discharges from January 2002 to May 2002.

***OIG Comment: (March 2003) DMHMRSAS and this facility have created a number of initiatives to address the community placement needs and other issues associated with working with persons with these special needs when hospitalization occurs. As these initiatives continue, this finding remains ACTIVE.***

**Update 05/01/03**

The Department appreciates the recognition of Eastern State Hospital's work with the communities to assist in increasing community placement. The Discharge Protocol continues to be used and the daily tracking of discharge ready patients is fully implemented. The discharge rate continues to increase. The majority of patients that are clinically ready for discharge are waiting for appropriate housing and/or day services. The CSB liaisons meet monthly with the ESH Clinical Operations Director and Program Social Work Directors to discuss strategies to discharge the more difficult placements. A Central Office Liaison attends these meetings. Focus is on the patients on the discharge ready list more than 30 days.

| **Update 9/21/04** |
| --- |
| ESH and HPR-V CSBs initiated the Reinvestment Project in November of 2003. This resulted in reduction of 43 acute beds in Building 2. The 43 beds remaining in the program are used for patients being transferred from the acute care beds in private hospitals.<br><br>The Clinical Operations Director and the Admission Coordinator are members of the Regional Authorization Committee that reviews and decides which patients need to come to ESH and makes recommendations for discharge to the community.<br><br>The statewide Discharge Protocol is being followed Hospital-wide and the Program Social Work Directors and Clinical Operations Director continue to meet monthly with a representative from Central Office. In spring, 2004, this meeting was expanded to include a regional discharge assistance program that was started as part of the Reinvestment Project. Currently we are meeting weekly to review and prioritize plans to discharge patients with more challenging needs in the community. A monthly report is submitted to VOPA on discharge ready patients here over 30 days. The Human Rights Advocates are invited to attend and participate in these meetings. Each individual CSB Liaison met with one of the advocates and the Clinical Operations Director within the last year to review each of their patients on the discharge ready list. |

***OIG Comment: (October 2004) DMHMRSAS and this facility have continued to closely monitor and address the concern regarding challenging placements identified in the original finding. As a result of these efforts, this finding is INACTIVE.***

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## *SECTION TWO: THE USE OF SECLUSION AND RESTRANT*

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**Finding 2.2: Continuous observation of patients in seclusion is not a current practice in Building 2.**

Recommendation: ESH needs to review its policy regarding seclusion and update it in terms of consistency with new departmental instructions.

**DMHMRSAS Response:** ESH policy TX-450-35, *Emergency Use of Seclusion or Restraints*, is currently under revision to be consistent with Departmental Instructions and policies; and it will be finalized and implemented January 1, 2001.

| **6 Month Status Report: 7/1/01** |
| --- |
| ESH policy TX-450-35, *Emergency Use of Seclusion or Restraints,* has been revised |

and coordinated with all required clinical committees. As required by Departmental Instruction, a draft copy was forwarded to DMHMRSAS for approval prior to implementation. Policy will be implemented immediately after Central Office review. Estimated completion date is August 15, 2001.

***OIG Comment -*** *Interviews and observations indicated that the facility continues the practice of fifteen-minute observations of patients in seclusion instead of continuous observation. On the date of the inspection, a patient in seclusion was noted by the OIG team to be lightly tapping on the door asking if someone could "please talk to me". Although he appeared to be calm and appropriate, there was not a staff member present to observe or assist him. This practice places the patient at risk for harm and the facility at risk for liability of actions that occur while the patient is not being observed. One staff member volunteered that when the patient was in seclusion, it was the only "break" they had from him. Record reviews demonstrated that he was a challenging patient and often required one on one due to impulsive aggressive behaviors.*
*Staff indicated that delays from the Central Office in approving the draft policy governing seclusion and restraint prohibited its implementation. This finding is* ***ACTIVE.***

**6 Month Status Report: 1/01/02**

The facility has drafted a new policy TX-450-35 has been completed and revised in accordance with the new DMHMRSAS DI. The policy has been disseminated and is currently being taught to all direct care employees.

***OIG Comment –*** *Interviews and observations during the follow-up tour revealed that staff do not practice continual observation while patients are in seclusion. To the knowledge of the OIG, ESH is the only DMHMRSAS mental health hospital that does not practice continual observation. This finding is* ***ACTIVE.***

**6 Month Status Report: 07/01/02**

Staff members have been informed on the need to adhere to the practice of continual observation of secluded patients. We have made the changes to our policy and staff are continually monitoring seclusion and entries recorded on the patient monitoring sheets. Quality Management monitors six items on the sheets and results of the monitoring show an average of 97% of observation activities are documented on the patient monitoring sheets.

***OIG Comment: (March 2003) Observations and interviews with 6 of 8 staff revealed that constant visual observation DOES NOT occur for patients in seclusion. ESH policy TX 450-35 clearly states on page 3, 8 and 9. To continue this practice in conflict with hospital policy after being continued as active for a period greater than a year is unacceptable. Documentation in the records and interviews with staff and observations provided contradictory information. This finding is ACTIVE.***

| **Update 05/01/03** |
| --- |
| ESH policy on "Emergency Use of Seclusion or Restraint" number TX450-35 states that a patient who is in seclusion must be under constant observation. Further staff in-services on the policy will be given with an emphasis on those staff and supervisors working in Building 2. There will be new computer software for monitoring seclusion and restraint initiated in July. This software will help monitor adherence to the policy. In addition there is a system-wide initiative to decrease seclusion and restraint usage that will be piloted this fall. |
| **Update 9/21/04** |
| Patients who are placed in seclusion are on continuous observation. All of the nursing staff in Building 2 have been in-serviced on this policy. This policy has just recently (September 1, 2004) been revised. |

***OIG Comment – (October 2004) Interviews with staff, a review of monitoring sheets and patient records demonstrated that the facility has provided the training to staff necessary for the assurance of constant monitoring during the use of seclusion. However, as the review of the secondary inspection that involved the care and treatment of a patient while in seclusion raised the issue whether staff followed the requirement for observation as required per policy and training, this finding will remain ACTIVE.***

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**SECTION THREE: ACTIVE TREATMENT**

**Finding 3.6: Patients, dually diagnosed with both mental illness and mental retardation present a placement challenge for the facility**.

**Recommendation: Work with the Central Office in exploring alternate methods for meeting both the treatment and placement needs for this population.**

**DMHMRSAS Response:** DMHMRSAS continues to develop strategies to better meet the needs of the MI/MR population. The Director of Health and Quality Care, has discussed this issue in-depth with the ESH Medical Director and with other state facility Medical Directors; and they continue to explore and disseminate best practices for treating this population. The Central Office of Mental Retardation also has provided technical assistance to both facilities and communities in addressing treatment and placement needs for the MI/MR population.

DMHMRSAS supports ESH's ongoing efforts to improve treatment for this population, which includes:

- Designating one facility social worker to work exclusively hospital-wide with the MI/MR population regarding placement issues.
- ESH treatment teams aggressively referring appropriate MI/MR patients to the Behavioral Management Committee for individualized treatment plans to address problematic behaviors, which impede patient placement in the community.
- ESH staff continuing to attend, training on the treatment and resources for this population.
- ESH Liaison Director attending monthly HPR-V meetings of the CSB MR Directors to enhance facility and CSB linkage for treatment and discharge issues.
- ESH obtaining regular consultation from, a nationally recognized MR Behavioral Consultant, as needed for specific dually diagnosed patients using tele-conference technology.

**6 Month Status Report: 7/1/01**

Upon admission of an MR patient, the DMHMRSAS Office of Mental Retardation is notified via letter providing pertinent information, such as initial diagnosis on admission and results of any I.Q. testing available. A quarterly report is submitted denoting information on the above patients, including date of discharge, if applicable. Barriers to discharge continue to be aggressive patient behavior and waiver placement.

A Clinical Social Worker was assigned on January 15, 2001 to track the dually diagnosed MI/MR population, inpatient adult population, and to promote facilitation of timely and appropriate discharges by working closely with the treatment teams and MR case managers.

Facility staff attended MR training workshops, including Medicaid waiver training conducted by Behavior & Assessment Consultants. The Liaison Director and the MR/MI Social Worker have visited resource fairs to meet with service providers. The Clinical Operations and Liaison Directors attended individual services plan training and shared information with the MR/MI social worker and CSB staff. Training enhanced the hospitals ability to identify, pursue, and secure waiver entitlements.

A monthly report is prepared listing patients, diagnoses, and discharge efforts during the reporting cycle. The Community Liaison Director attends monthly HPR-V MR Director's meetings to enhance/increase facility and community communications concerning the MI/MR population. CSB Directors now actively seek alternative placement for MR patients.

A draft agreement between the Department and the CSBs will address the screening and placement needs of clients with MI/MR diagnosis. For individuals with dual diagnosis of MI/MR, both the admitting Mental Health Facility and the region's Mental Retardation Training Center shall confer to determine which institution can best serve the individuals needs.

***OIG Comment - –*** *Interviews indicated that this population continues to present a significant challenge to this facility. Administrative staff indicated that the majority of patients currently admitted and identified as exhibiting high-risk behaviors have both a diagnosed mental illness and mental retardation. This was also confirmed during staff interviews and record reviews. Placement continues to remain a significant difficulty because of the behavioral challenges. This finding is* ***ACTIVE.***

| **6 Month Status Report: 1/01/02** |
|---|
| Currently ESH has 22 adult patients with a Mild to Moderate Mental Retardation diagnoses. The new Discharge Protocol should assist in providing an ongoing mechanism to track this patient population relative to discharge. The Facilities Clinical Operations Director will continue to gather monthly progress reports on this population and work with the Hospital, CSBs and Central Office staff to develop appropriate placements outside the facility.<br><br>In addition, a DMHMRSAS Central Office work-group has been established comprised of representatives of MR and MH facility directors and CO MH and MR and operations representatives to discuss strategies to address the growing population. A decision should be made by the Spring of 2002 regarding what avenues the Department will take. |

***OIG Comment –*** *Interviews with staff indicated that this continues to be an ongoing problem. The facility continues to make contact with appropriate community providers in order to foster improved placement options. Resolution of this problem will require the Central Office address resources across the state for this challenging population. This finding remains* ***ACTIVE.***

| **6 Month Status Report: 07/01/02** |
|---|
| Currently ESH has 16 adult patients with a Mild to Moderate Mental Retardation diagnosis. The new Discharge Protocol is used to provide an ongoing mechanism to track this patient population relative to discharge. The Facility's Clinical Operations Director continues to gather monthly progress reports on this population and work with the Hospital, CSBs and Central Office staff to develop appropriate placements outside the facility. In addition, a DMHMRSAS Central Office Task Force has been established, comprised of representative of MR and MH facility directors, Central Office MH and MR, and operations representatives to discuss strategies to address this growing population as well as community and CSB representatives. This Task Force has met once with the Director of the National Association for Duel Diagnoses, who provided a presentation on promising programs. The Steering Committee of that group is now meeting to identify statewide programs and to consider a Statewide conference and regional planning to address this population. |

***OIG Comment: (March 2003) DMHMRSAS and this facility have created a number of initiatives to address the community placement needs and other issues associated with***

***working with persons with these special needs with hospitalization occurs. As these initiatives continue, this finding remains ACTIVE.***

| **Update 05/01/03** |
| --- |
| The Department appreciates the recognition of the work being done at ESH with this difficult population. ESH continues to have 16 adult patients with mild to moderate mental retardation diagnoses. ESH continues to monitor these patients and works with Central Office and CSB staff to develop suitable placements. Although the number has remained fairly constant, the actual patients have changed. Of these 16, several have been admitted and replaced others who were discharged. One of the ESH Program Social Work Directors continues to meet monthly with the CSB MR Directors. |
| **Update 9/21/04** |
| A monthly report is prepared listing all patients with a diagnosis of mental retardation. Included in the report are names of the patients, diagnoses, and discharge efforts during the reporting cycle. This is sent to the Hospital Director, clinical department heads and the M. R. Liaison from Central Office.<br><br>A representative for the Clinical Operations office attends monthly meetings with the HPR-V M.R. Directors to develop plans and resources for the mentally retarded population. The 28 patients in the Hospital who have a M. R. diagnosis on Axis II are dually diagnosed. Housing continues to be the largest barrier to discharge. |

***OIG Comments (October 2003) Interviews and a review of discharge summaries in three patient records revealed that the facility has developed a mechanism for identifying and addressing the discharge issues associated with the care and treatment of this special population at the facility, the dually-diagnosed (MI-MR) population. As the facility has actively engaged in pursuing discharge options for this population, this finding is INACTIVE.***

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**SECTION FOUR: Treatment Environment**

**Finding 4.2: Nursing staffs frequently work mandatory overtime to meet current staffing patterns.**

**Recommendation: Continue to explore alternate ways of meeting the staffing needs of the facility while lessening the amount of mandatory overtime for staff.**

**DMHMRSAS Response:** DMHMRSAS concurs and shares this concern about reducing mandatory overtime. At this time, the Office of Human Resource Development has identified nursing recruitment and retention as a systemic issue among all our facilities.

Central Office, therefore, is developing a centralized approach to this problem in order to raise the level of our efforts in nurse recruitment and retention system-wide.

The Central Office Director of Human Resource Development is heading a joint facility and Central Office work group for that purpose. The Director is consulting with each facility's Directors of Human Resources and Nursing Services to coordinate potential initiatives.

In addition, ESH over the past months has been active in addressing the mandatory overtime issue through creation of a "Nursing Task Force" in September. This task force focuses specifically on nursing recruitment and retention issues. Accomplishments of this Task Force thus far include:

1. Meeting with nursing staff on all three shifts at the Change of Shift reports to explain Task force goals and objectives.

2. Developed, distributed, and reviewed the results of a survey sent to all nursing staff to help address recruitment and retention. The survey sought to identify specific factors of dissatisfaction among the nursing staff as well as to identify ideas and suggestions for improvement related to retention. Completed in late November 2000, the survey identified mandatory overtime and staff scheduling as the major concerns. The Task force is actively seeking viable solutions to staff concerns.

3. Developed several committees to evaluate and make recommendations regarding key staffing issues, i.e., scheduling staff by patient acuity by program rather than by HPPD.

4. A nursing Intern Program is being developed and will be advertised in the *Virginia Gazette* and the *Daily Press* after the first-of-the year in an effort to recruit nursing students. The colleges targeted will be: Hampton University, Christopher Newport University, Old Dominion University, and Norfolk State University.

In addition, on Saturday, December 2, 2000, ESH Human Resources and the Department of Nursing conducted an Open House for Recruitment of Nursing Service Employees. On-the-spot applications were accepted, and interviews were conducted. Tours of the facility were offered to those interested applicants**.** Fifty applications were received (out of 66 attendees), and 45 staff were hired. The new hires included nine Registered Nurses, seven Licensed Practical Nurses, and 29 Direct Service Associates.

| **6 Month Status Report: 7/1/01** |
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| The Director of Nursing is on three task forces to seek solutions to the recruitment/retention issues that affect licensed nursing and health services care workers. Listed are efforts underway to meet our staffing needs while attempting to reduce |

mandatory overtime for classified nursing staff:

1. Nursing Taskforce was established March 2000.
2. Bonus for working voluntary overtime began December 2000. Lists were posted in each building began January 2001.
3. Attendance bonus for DSAs began in December 2000.
4. Pilot use of voluntary overtime to reduce number of hours of unplanned leave in Medical Services began December 2000.
5. Nursing Open Houses were held in January and April 2001. Another is planned for August 25, 2001.
6. A Referral Bonus Plan and in-band adjustment recommendations were sent to Central Office Human Resource Department for approval, June 2001.
7. Developing a partnership with Thomas Nelson Community College to provide nursing related courses on ESH campus. Anticipated beginning date of classes is in fall 2001.
8. Nurse internship program began May 2001. Four RN applicants were hired in June 2001.

The Director of Nursing is a member of the DMHMRSAS Nurses Executive Group with Central Office Human Resources Office to address recruitment and retention issues at the state level. She is also a member of the Nursing Summit Taskforces on general recruitment, retention issues and recruitment of minority nurses in Virginia. The Nursing Taskforce Committee has been disbanded and a Recruitment and Retention Committee has been established. The first meeting is scheduled for August 7, 2001

***OIG Comment - –*** *Interviews revealed that this continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Even though interviews revealed that the facility has made an effort to recruit and retain nursing staff, there are 42 vacancies currently in nursing staff positions. The facility has been discussing the possibility of developing and implementing a nursing program with a local community college that would include internships and job placement options. During the past three months, the facility has initiated a program of voluntary overtime with a small degree of monetary benefit. Staff interviewed related that voluntary overtime is viewed as separate from mandatory overtime resulting in a member agreeing to do some voluntary overtime then learning that they are expected to work as much as 16 hours of overtime in addition. This finding is* ***ACTIVE.***

**6 Month Status Report: 1/01/02**

The following efforts have been made to help with nursing moral and retention:

1. Meetings were held with the nurses on all three shifts at the change of shift to discuss issues impacting nursing care.
2. As a result of the Nursing Service survey, voluntary overtime is encouraged and has increased. The survey reviewed issues such as recruitment and retention and the use of overtime.
3. ESH indicated a special taskforce was developed and reviewed three acuity

systems for patient care. Staffing by patient acuity continues to be explored.

4. The Nursing Intern Program for nursing school students entering their senior year resulted in the recruitment of seven (7) nursing interns into the program in June 2001. The students returned to school in August 2001. The brochures (under revision) will be mailed to all nursing schools in Virginia in January 2002 for the summer 2002 program.

Open Houses were also held on Saturday, March 24, 2001 and Saturday, August 25, 2001 to recruit and interview for Nursing Services.

***6 Month Status Report 7/01/01 Updates:***

1. The attendance bonus for DSAs continues.
2. The bonus for working voluntary overtime continues.
3. The pilot use of voluntary overtime to reduce the number of hours of unplanned leave in Medical Services has been successful.
4. The Nursing Open House planned for August 25, 2001 was held and was successful in recruiting DSAs.
5. The referral bonus plan for RNs, LPNs and DSA IIs was approved.
6. The nursing taskforce has been dissolved after completing the task of reviewing the overtime and recruitment issues which are being reviewed through the statewide taskforce.
7. An RN applicant through the recruitment process was hired July 30, 2001.
8. The partnership with Thomas Nelson Community College is currently on hold. Presently the College is reviewing their program accreditations

The Recruitment and Retention Committee meeting scheduled for August 7, 2001 was canceled due to the resignation of the Director of Nursing.

However, DMHMRSAS Central Office is addressing work-force needs system-wide through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. On December 14, 2001 the Committee sponsored a daylong special meeting, *Charting the Course*, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Nationally known experts provided information on workforce trends and on innovative strategies for developing and retaining workers in healthcare. Subsequent meetings will be held over the next six months to develop strategies/recommendations for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the Secretary of Health and Human Services.

***OIG Comment*** *- Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. Nursing staff indicated that community facilities had become increasingly competitive making working "for the state" less attractive. In addition, staff interviewed related that voluntary overtime although viewed as separate from mandatory*

*overtime results in nursing staff working as much as 16 hours of overtime per week. This finding is* ***ACTIVE.***

| **6 Month Status Report: 07/01/02** |
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| The facility is in the process of preparing to offer two (2) courses on ESH campus in collaboration with several administrative staff members from Thomas Nelson Community College. The response has been overwhelming in terms of interest by ESH staff. There are currently four (4) intern students from the surrounding colleges in ESH Summer Nursing Internship Program. One (1) RN who attended the Internship Program last summer has been hired. This individual was motivated to become a certified nurse's aide after completion of the program last summer and has been working as a DSA II while completing her course requirements. Although minimal, this success is as a result of the Internship Program.<br><br>Meetings have been held with nurse management to clarify the use of voluntary overtime versus mandatory overtime. |

***OIG Comment: (March 2003) Interviews with administrative and direct care staff, a review of staff schedules, and observations revealed that the facility had the compliment of staff present on the units as scheduled. This is accomplished through a variety of techniques including the extensive use of overtime. The facility has worked to increase the use of voluntary overtime in order to reduce frequency of mandatory overtime. ESH continues in its efforts to recruit and retain its nurses. This finding is*** ***ACTIVE.***

| **Update 05/01/03** |
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| **The recruitment for nurses at ESH is a continuous process. Central Office Human Resources has recently created and filled a workforce enhancement position. There are several programs being discussed with local community colleges to look at ways the facilities can "grow their own" nurses by offering educational incentives to the direct care staff.**<br><br>The budgetary constraints felt by all State offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, we are offering more alternative scheduling to the nurses and this has been received positively. ESH will continue to make every effort to hire nurses to meet the required HPPD. Since providing a safe environment for the patients and staff is a priority for ESH, this effort will continue to require overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible. |
| **Update 9/21/04** |
| 1. As a member of the DMHMRSAS Nurses Executive Group, recommendations have been made for the realignment for the Registered Nurses (RN's) working in |

the Psychiatric Hospitals for the Commonwealth of Virginia. This has been a collaborative effort with the Central Human Resources Office. The goal is to submit the proposal to the General Assembly for this year (2004).

2. ESH is providing financial assistance to the largest number of employees ever who are attending school to become RN's. Eight (8) nursing staff are attending school and three (3) employees from other disciplines are attending, giving a total of eleven (11) employees attending TNCC and are taking courses to meet the requirements for the RN curriculum.

Voluntary overtime is continuing to be used whenever possible to avoid mandatory overtime. Recruitment and retention of nursing staff remains a high priority for ESH. However, the outside competitive salary offers is making this increasingly difficult. Each building maintains a rotation list to ensure fairness in terms of mandatory overtime. There is also a Nursing Operating Procedure in place for managing overtime. Alternative shifts are utilized where permitted, i.e. 12 hour shifts. Some staff prefer an alternative shift rather than an eight (8) hour shift. All efforts possible are made to reduce overtime, while providing adequate patient care. It was thought that the reinvestment initiative would result in RN's from the proposed program closure be transferred to other RN vacancies. However, due to the critical shortage of RN's in the program, there were none to transfer into other vacant positions.

***OIG Comment (October 2004) – ESH in conjunction with the Central Office has demonstrated an on-going and concerted effort in addressing the overtime issues associated with the identified nursing shortage at the facility. Interviews with staff revealed that nursing has developed strategies that allow for greater flexibility in scheduling and managing overtime, which staff revealed as beneficial. Even though the use of overtime remains an important issue and will be monitored by the OIG through the facility's monthly reports, for the purpose of this report this finding will become INACTIVE.***

## SECTION EIGHT: FACILITY CHALLENGES

**Finding 8.1: Recruiting and retaining nursing staff has proven to be extremely difficult facility-wide.**

**Recommendation: Work with the Central Office in developing solutions to the overall and on-going shortage of nursing personnel at this facility.**

**DMHMRSAS Response:** Concur. See response to Finding 4.2.

**6 Month Status Report: 7/1/01**

Recruitment and retention of licensed nursing staff is a nation-wide issue that we are

addressing at the local and department level. See response to Finding 4.2.

***OIG Comment -*** *– Please refer to response in Finding 4.2. This finding is* ***ACTIVE.***

**6 Month Status Report: 1/01/02**

The Human Resource Department provided the Office of Health and Quality Care in Central Office, with a notebook of studies and an update of activities to enhance recruitment of nurses at ESH. These include:

1. An In-Band Adjustment for Retention of 37 LPNs, effective 12/10/01 has been approved. This is of varying amounts and aims to bring the LPNs closer to the median salary for LPNs.
2. ESH is collecting data to support a new hiring range for DSA IIs, which would make ESH more competitive in the labor market.
3. ESH is reviewing data about RN IIs and is reviewing options at developing an In-Band Adjustment for retention.
4. The part time hourly pool of RN IIs has been enlarged from 14 and now stands at 18 FTEs.
5. RNs who retired from ESH are actively being recruited to work as WE-14 employees. A program was presented at the ESH Retirees Association and letters were mailed to retiree homes.
6. RNs who resigned from ESH are being recruited to return.
7. A revised brochure is being presented to mail to schools of nursing in Virginia to recruit senior nursing students to summer interns at the facility in 2002.
8. LPN vacancies were placed in continuous recruit.
9. The Educational Assistance Committee has approved several applicants for assistance to attend nursing school; these employees would owe ESH time as an RN when they pass their nursing boards.

Retention efforts have focused on assisting nurses to transfer to other programs or units at ESH when there are vacancies and when the employee needs to work with different patients. The DMHMRSAS Central Office is addressing work-force needs system-wide through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. On December 14, 2001 the Committee sponsored a daylong special meeting, *Charting the Course*, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Nationally known experts provided information on workforce trends and on innovative strategies for developing and retaining workers in healthcare. Subsequent meetings will be held over the next six months to develop strategies/recommendations for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the Secretary of Health and Human Services.

***OIG Comment -*** *Interviews revealed that this continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Even though interviews revealed that the facility has made an effort to recruit and retain nursing staff,*

*there are 42 vacancies currently in nursing staff positions. The facility has been discussing the possibility of developing and implementing a nursing program with a local community college that would include internships and job placement options. During the past three months, the facility has initiated a program of voluntary overtime with a small degree of monetary benefit. Staff interviewed related that voluntary overtime is viewed as separate from mandatory overtime resulting in a member agreeing to do some voluntary overtime then learning that they are expected to work as much as 16 hours of overtime in addition. This finding is* ***ACTIVE.***

**6 Month Status Report: 07/01/02**

The Human Resource Department Central Office, has prepared a notebook of studies and an update of activities to enhance recruitment of nurses at ESH.

1. An In-Band Adjustment for Retention for 37 LPNs, effective 12/10/01 has been approved. This is of varying amounts and aims to bring the LPNs closer to the median salary for LPNs.

2. ESH collected data to support a new hiring range for DSA IIs, which would make ESH more competitive in the labor market. The new hiring range was not approved for use due to fiscal constraints.

3. ESH is reviewing data about RN IIs and wants to develop an In-Band Adjustment for retention.

4. The part time hourly pool of RN IIs has been enlarged and now stands at 18 FTEs. The hourly pool of LPNs has been expanded and now stands at 7.5 FTEs.

5. RNs who retired from ESH are actively recruited to work as WE-14 employees. A program was presented at the ESH Retirees Association and letters were mailed to their homes. Two ESH retirees have returned as part-time hourly RNs.

6. RNs who resigned from ESH are being recruited to return with some success, i.e. re-employed four returning RNs

7. A revised brochure was mailed to schools of nursing in Virginia to recruit senior nursing students to work at ESH in the summer of 2002.

8. LPNs were placed in continuous recruit in the State Employment system.

9. The Educational Assistance Committee approved several applicants for assistance to attend nursing school; these employees would owe ESH time as an RN when they pass their nursing boards.

10. Retention efforts have focused on assisting nurses to transfer to other programs or units at ESH when there are vacancies and when the employee needs to work with different patients.

11. A referral bonus program has been instituted for RNs, LPNs and DSA IIs. Though available, no bonuses have been awarded to eligible employees for recruiting and referring new nursing staff.

***OIG Comment: (March 2003) Eastern State Hospital and the CO have been working together to develop strategies for recruiting and retaining nursing staff. Because there remain significant vacancies and because the recent pressures associated with reinvestment, this finding will remain ACTIVE.***

**Update 05/01/03**

**The recruitment for nurses at ESH is a continuous process. The DMHMRSAS Office of Human Resource Development has recently created and filled a workforce enhancement position. There are several programs being discussed with local community colleges to look at ways the facilities can "grow their own" nurses by offering educational incentives to the direct care staff.**

The budgetary constraints felt by all State offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, ESH is offering more alternative scheduling to the nurses and this has been received positively. ESH will continue to make every effort to hire nurses to meet the required HPPD. Providing a safe environment for the patients and staff is the priority for ESH; and this effort will continue to require overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible.

**Update 9/21/04**

3. As a member of the DMHMRSAS Nurses Executive Group, recommendations have been made for the realignment for the Registered Nurses (RN's) working in the Psychiatric Hospitals for the Commonwealth of Virginia. This has been a collaborative effort with the Central Human Resources Office. The goal is to submit the proposal to the General Assembly for this year (2004).

4. ESH is providing financial assistance to the largest number of employees ever who are attending school to become RN's. Eight (8) nursing staff are attending school and three (3) employees from other disciplines are attending, giving a total of eleven (11) employees attending TNCC and are taking courses to meet the requirements for the RN curriculum.

Voluntary overtime is continuing to be used whenever possible to avoid mandatory overtime. Recruitment and retention of nursing staff remains a high priority for ESH.

However, the outside competitive salary offers is making this increasingly difficult. Each building maintains a rotation list to ensure fairness in terms of mandatory overtime. There is also a Nursing Operating Procedure in place for managing overtime. Alternative shifts are utilized where permitted, i.e. 12 hour shifts. Some staff prefer an alternative shift rather than an eight (8) hour shift. All efforts possible are made to reduce overtime, while providing adequate patient care. It was thought that the reinvestment initiative would result in RN's from the proposed program closure be transferred to other RN vacancies. However, due to the critical shortage of RN's in the program, there were none to transfer into other vacant positions.

***OIG Comment (October 2004) Interviews with administrative and nursing staff revealed that the facility has maintained a consistent effort at recruiting and retaining adequate nursing staff to provide for the care and treatment of the patients. It is understood that the facility will continue in its efforts as it has demonstrated since the time of the original finding in September 2000, therefore this finding will become INACTIVE.***

**EASTERN STATE HOSPITAL**
**UNANNOUNCED SNAPSHOT INSPECTION**
**JULY 9-10, 2001**
**OIG REPORT # 46-01**

**UPDATE SEPTEMBER 2004**

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## SECTION THREE: STAFFING PATTERNS

**Finding 3.1: The facility ensures that there are adequate numbers of staff present on each of the units.**

**Recommendation: Maintain staffing levels for effective patient care.**

**DMHMRSAS Response:** Nursing staffing levels are maintained at the hospital utilizing a combination of classified positions, hourly positions, contract staff, and overtime. To the maximum extent possible, given the staffing requirements, voluntary overtime is utilized as opposed to mandatory overtime. A regular financial bonus each pay period was developed and approved for nursing staff that are willing to sign up for this voluntary overtime. A second bonus payment plan was developed for nursing staff that accumulated no unscheduled absences during each pay period. Additional incentives and sign-on bonuses have also been developed to improve recruitment opportunities. During this 2001-2002 academic year, Eastern State Hospital is participating in the SHARPE (named in honor of Bob and Jane Sharpe, who have given funding to the College of William and Mary to support W&M students in working as volunteers to address compelling community needs and public issues enabling students to learn more about themselves, their world, and about the vital importance of using their skills, creativity and knowledge in an overall service to society) Community Partnership Program developed

by the College of William and Mary, that is utilizing the Department of Economic to study the nationwide nursing shortage, specifically as it relates to the shortage of Registered Nurses. The goal is to develop additional strategies that include intangible issues such as job satisfaction, dignity and respect in the workplace, and actions that can be taken to improve untoward situations that exist. The possible provision of employer-sponsored childcare for employees is also under continuing study. The hospital also held Nursing Services Open Houses to attract qualified applicants.

| **6 Month Status Report: 01/01/02** |
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| A regular financial bonus each pay period was developed and approved at ESH for nursing staff that are willing to sign up for this voluntary overtime. It is awaiting approval in Central Office. A second bonus payment was developed for nursing staff that accumulated no unscheduled absences during each pay period. This is also awaiting approval in Central Office. No sign on bonus has been developed to improve recruitment opportunities due to fiscal constraints. The additional incentive, which was developed and approved, was a new hiring range for the RN I positions.<br><br>The hospital held Nursing Services Open Houses on 12/02/00, 03/24/01 and 08/25/01 to attract qualified applicants. The December Open House resulted in the hiring of 3 RNs and 3LPNs. In March, 5 LPNs were recruited and hired. The August Open House netted 1 RN and 4 LPNs.<br><br>The students from William & Mary College, who are participants of the SHARPE Community Partnership Program, have conducted the survey regarding the Nursing shortage. The data process has been completed, and the students are scheduled to work on a data analysis of this project during the Spring 2002 semester. It is anticipated that the entire project will be completed by May 2002. This possible provision of employer-sponsored childcare for employees is still being discussed at the facility as an incentive. |

***OIG Comment –*** *Interviews and a review of staffing reports demonstrated that the facility uses a variety of methods to ensure that the numerical staff to patient ratios are met. This is accomplished through the use of overtime, part-time positions and contract employees. Nursing staff related that due to the acuity of the patients that minimum staffing ratios might not provide sufficient resources for the active treatment of patients. This finding is* ***ACTIVE.***

| **6 Month Status Report: 07/01/02** |
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| Voluntary overtime continues to be encouraged and is successful. There continues to be the utilization of contract nurses as well as the hourly pool RNs. The hourly pool of RNs was increased. These methods have proven to be successful. The Overtime Bonus Program for nursing staff has been approved and implemented. There is |

insufficient data to determine whether the program will increase recruitment or retention of nursing staff. The Attendance and Unplanned Leave Program has also been approved and implemented. Again, data is insufficient at this time to determine results or effectiveness. The concept of providing childcare service is still being formulated. However, due to the geriatric center relocation plan, facility space is limited. The three major issues evidenced by the SHARPE Nursing Research Project were 1) the benefits, 2) inadequate staffing and 3) respect. The Facility Director met with the Nursing Director, Medical Director and Human Resource Director to plan intervention for the identified issues. The successful intervention included regular advertisement in the newspaper and meetings with staff who have identified issues related to respect.

***OIG Comment: (March 2003) Interviews with administrative and direct care staff, a review of staff schedules, and observations revealed that the facility had the compliment of staff present on the units as scheduled. This is accomplished through a variety of techniques including the use of overtime. The facility has worked to increase the use of voluntary overtime instead of mandatory. The compliment of staffing does not always meet the patterns established by the settlement agreement, particularly in the use of RNs. ESH continues in its efforts to recruit and retain its nurses. This finding is ACTIVE.***

**Update 05/01/03**

The recruitment for nurses at ESH is a continuous process. Central Office Human Resources has recently created and filled a workforce enhancement position. There are several programs being discussed with local community colleges to look at ways the facilities can "grow their own" nurses by offering educational incentives to the direct care staff.

The budgetary constraints felt by all state offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, ESH is offering more alternative scheduling to the nurses and this has been received positively. ESH will continue to make every effort to hire nurses to meet the required HPPD. Since providing a safe environment for the patients and staff is a priority for ESH, this effort will continue to require overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible.

**Update 9/21/04**

Recruitment and retention efforts are continuous in the geriatric nursing area. However, recruitment in this area is very competitive with an ever-increasing number of Assisted Living facilities as well as doctor's offices and other health care employment. Recruitment and retention strategies will continuous here at ESH with the support of our Human Resource Department.

***OIG Comments (October 2004) Interviews with administrative and direct care staff, a review of staff schedules, and observations revealed that the facility's staffing patterns do not always meet the patterns established by the settlement agreement that outlines there will be one RN per unit per shift. In both of the secondary inspections conducted at the facility during this reporting period, the use of overtime and the lack of RN coverage were identified as issues relevant to the events. This finding remains ACTIVE.***

**Finding 3.2: Staffing shortage is critical for nursing.**

**Recommendation 3.2 A: There should be a review of current policies and practices for managing overtime to assure equity among staff.**

**Recommendation 3.2 B: Any new practices should be done with formalized staff input.**

**DMHMRSAS Response 3.2 A:** Nursing staffing levels are maintained at the hospital utilizing a combination of classified positions, hourly positions, contract staff, and overtime. To the maximum extent possible, given the staffing requirements, voluntary overtime is utilized as opposed to mandatory overtime. A regular financial bonus each pay period was developed and approved for nursing staff that are willing to sign up for this voluntary overtime. A second bonus payment plan was developed for nursing staff that accumulated no unscheduled absences during each pay period. Additional incentives and sign-on bonuses have also been developed to improve recruitment opportunities.

| **6 Month Status Report: 01/01/02** |
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| A regular financial bonus each pay period was developed and approved at Eastern State Hospital for nursing staff that are willing to sign up for voluntary overtime as well as a second bonus payment for nursing staff that accumulate no unscheduled absences during each pay period. This has been forwarded to Central Office for approval. There were no sign on bonus developed to improve recruitment opportunities at present. The additional incentive, which was developed and approved, was a new hiring range for RN staff.<br><br>As an effort to work on the Nursing shortage statewide the DMHMRSAS Central Office is addressing work force needs through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. The committee met on December 14, 2001 and sponsored a daylong special meeting, Charting the Course, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Follow-up meetings will be held over the next six months to develop strategies for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the sate Secretary of Health and Human Services. |

***OIG Comment -*** *Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. This ongoing problem is recognized by the Central Office as a significant statewide issue resulting in the establishment of its workforce steering committee. OIG team members have commented on this issue at ESH during previous visits and notes that despite efforts by the facility to alleviate this problem that it remains a significant source of concern regarding patient care and effective treatment. This finding is* ***ACTIVE.***

| **6 Month Status Report: 07/01/02** |
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| Mandatory overtime is utilized as a last option. However, patient and staff safety is the facility's top priority. With an increase in census, efforts were minimized to eliminate mandatory overtime. Staffing needs of units are carefully evaluated to reduce mandatory overtime. The agency has experienced some success with recruitment. The state salaries are not competitive with the private sector, especially with limited funds for annual pay increases. The Nurse Staffing Committee meeting format was changed. Each program's Nurse Manager meets with the nursing staff assigned to the program to problem solve the staffing issues related to coverage. This method allows more autonomy for the Nurse Managers to problem solve the staff shortages utilizing input from the staff involved. (An example of this is, the staff in the admission's program agreeing to pilot the Baylor Plan.) The psychosocial program does alternative scheduling to accommodate staff needs and providing nursing coverage for the units. (An example of this is, allowing staff to work weekends and have other days off during the week.) These are examples of meeting the staffs' needs as well as meeting the nursing coverage for the unit, resulting in a "win", "win" situation. |

***NO OIG REPONSE in 2003***

***OIG Comment (October 2004) The facility did not provide a separate comment for this recommendation. It was noted through interviews and review of nursing documentation regarding overtime that the facility has completed this task. There was also evidence that nursing and direct care staff were provided opportunities to participate in the decision-making process. This finding is*** ***INACTIVE.***

**DMHMRSAS Response 3.2 B:** All new recommendations and ideas have been developed through the utilization of a formalized Nurse Staffing Committee, consisting of key management and line staff that have both the knowledge of current conditions and the ability to effect significant and successful change.

| **6 Month Status Report: 01/01/02** |
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A formalized Nurse Staffing Committee reviews recommendations and ideas to effect significant and successful change. The Committee is examining the impact of the work environment on retention and is promoting a more positive image of Nursing Services throughout the facility. The Committee is also addressing other work related variables including work conditions, workload, and scheduling flexibility. Exit interviews are being reviewed to identify major factors of employee dissatisfaction.

***OIG Comment -*** *Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. This ongoing problem is recognized by the Central Office as a significant statewide issue resulting in the establishment of its workforce steering committee. OIG team members have commented on this issue at ESH during previous visits and notes that despite efforts by the facility to alleviate this problem that it remains a significant source of concern regarding patient care and effective treatment. This finding is* ***ACTIVE.***

**6 Month Status Report: 07/01/02**

Nurse staffing committee meetings have been conducted within the buildings showing the highest use of mandatory overtime. Additional improvement is being made. This involves more evenly distributing staff across the shifts, and increased utilization of 12 and 16-hour shifts, where preferred. In addition to this, other alternative strategies are being considered, i.e. some staff prefers working more weekends than weekdays. The staff morale is currently of high priority for nurse management, with feedback from the clinical nursing staff. Where possible, interventions for corrections are being put in place. Mandatory overtime is currently under consideration by the American Nurse's Association.

ESH has expanded Internet posting of jobs.

The Admission's Unit will pilot the Baylor Plan for one (1) year and then evaluate the use of this plan. **The Baylor Plan** provides Eastern State Hospital with the ability to offer a scheduling option to attract and retain Registered Nurses to work weekends. All Registered Nurse II positions are designated to be used for the Baylor Plan. Registered Nurses (RNIIs) on the Baylor Plan will work three (3) 12-hour shifts over their scheduled weekend – Friday, Saturday, Sunday or Saturday, Sunday, Monday. For the 36 hours worked they will be paid for 40 hours and receive full state benefits.

***OIG Comment: (March 2003) Interviews with administrative staff, a review of staff schedules and observations on the units revealed that this facility continues to***

***experience difficulty in maintaining the agreed upon requirements in the settlement agreement of one RN per unit per shift. The facility continues in its efforts to recruit and retain nursing personnel. Administrative staff indicated that additional shifting in nursing personnel may occur as a result of the current plan as outlined under the re-investment process, which proposes to close the acute admissions unit (Building 4). This finding remains ACTIVE.***

| **Update 05/01/03** |
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| See response to Finding 3.1.<br><br>Although the complete plans of the proposed reinvestment initiative are not yet determined, it is hoped that the RNs from the proposed program closures will be transferred into vacant positions in order to improve the RN staffing ratio in other programs. |

***OIG Comment (October 2004) The facility did not provide a separate comment for this recommendation. See the response in the previous finding and recommendation. (3.2A) This finding is INACTIVE.***

**EASTERN STATE HOSPITAL**
**SNAPSHOT INSPECTION**

**JANUARY 9-10, 2002**

**OIG REPORT # 53-02**

**UPDATE SEPTEMBER 2004**

## SECTION ONE: GENERAL CONDITIONS

**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.**

**DMHMRSAS Response**: Eastern State Hospital will continue its ongoing efforts to personalize and promote a home-like environment. Purchasing, in collaboration with Clinical Leadership in Hancock Geriatric Treatment Center, continues by shopping catalogs for safe and appropriate accessories and decorations for the Geriatric clients.

| **6 Month Status Report: 07/01/02** |
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Eastern State Hospital continues to enhance the therapeutic environment for geriatric patients. (Renovations to Building 28, 29, & 30 along with planned construction of a new geriatric activity building (Building 31), and the subsequent move of all patients from the Hancock Center must be considered when planning additional changes within the existing buildings in Hancock.) Requirements for the renovated facilities are currently being identified and consolidated for a funding request to the 2003 session of the Virginia General Assembly that will represent the balance of dollars that will be necessary to complete the geriatric relocation project.

***OIG Comment: Tours of the facility during the March 2003 inspection revealed that the facility has made some efforts to make the buildings that currently house the geriatric patients appear less institutional. As noted in the DMHMRSAS response, this facility has established a plan that includes the closing of the current configuration of buildings used as the geriatric treatment center and moving the services to buildings that still need to be renovated. As plans have not been finalized, this finding remains ACTIVE because of environmental concerns associated with the potential move.***

| **Update 05/01/03** |
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| DMHMRSAS has completed the necessary form (CC-2) and is selecting an architect. An appropriation of $4.6 million has already been made; and the request for an additional $11 million will be presented to the 2004 session of the General Assembly by Governor Warner. Funding will be provided through a public-private partnership with a lending institution. In the meantime, efforts will continue to maintain a therapeutic environment. |
| **Update 9/21/04** |
| A concept design was contracted for and prepared by Clark, Nexen Architecture, Engineering, Interior Design Inc. of Norfolk, Virginia in the Spring, 2004. This enhanced design calls for a new single-story 123,556 sq.ft. facility incorporating "state of the art" geriatric design, including individual patient rooms and bath facilities.<br><br>The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services has prepared a funding plan under the Commonwealth of Virginia Public-Private Education Facilities and Infrastructure Act of 2002 (PPEA). The Public Notice for proposal solicitation was published in the Richmond Times Dispatch on July 25, 2004.<br><br>An April 5, 2005 Notice to Proceed is planned. Based upon this date the following planning and construction schedule was developed:<br><br>April - November, 2005 (8 months) – Complete final planning and detailed design, prepare and issue financing package, and obtain preliminary entitlements and approvals.<br><br>December, 2005 – January, 2006 (2 months) – Close on financing, secure final entitlements and approvals, and complete buy-out of early trade packages. |

February, 2006 – March, 2007 (14 months) – Demolish existing buildings on another section of Hospital campus and construct and furnish the new geriatric treatment facility.

These facility enhancements delay the planned construction completion by 7 months, from August, 2006 until March, 2007.

In the meantime, efforts will continue in the current geriatric location to maintain a therapeutic environment.

***OIG Comment (October 2004) – The plan established by the facility, as noted in the updated information, has been outlined with specific timeframes identified. This finding will remain ACTIVE until progress on the actual project is underway***

## SECTION TWO: PATIENT ACTIVITY AND ACTIVE TREATMENT

**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.**

**DMHMRSAS Response:** The Clinical Leadership in Hancock Geriatrics Treatment Center and all discipline supervisors will ensure groups/activities are conducted according to the schedule, according to group objectives, and content as outlined in the specific program descriptions and based upon the patients' interests and needs. Monitoring of the process will be accomplished daily utilizing the Visual Patient Contact Application (VPCA). This is a computerized system, which measures time spent with patients related to structured treatment activities. Supervisors will review patient participation to identify patients who may be underserved through the group process and who may benefit from more individualized attention. The GAP subcommittee will oversee and coordinate these efforts through its monthly meetings and findings will be reported to clinical leadership.

**6 Month Status Report: 07/01/02**

Eastern State Hospital HGTC Clinical Leadership Team has developed a more comprehensive and complete review of active treatment activities with and for the lower functioning geriatric patients. Staff education is planned to increase staff's knowledge of and ability to articulate the daily active treatment that is occurring.

***OIG Comment: (March 2003) During this inspection, there was little evidence that programs for the lower functioning patients had been implemented. Activities did not occur as scheduled. A majority of staff members could not identify scheduled activities much less determine whether the groups were available. In some cases, they could not even locate a current schedule. Observations demonstrated that activities were not an entrenched part of services offered this population. Plans as outlined in the 7/02 status report have not been effective in resolving this issue. This finding remains ACTIVE.***

| **Update 05/01/03** |
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| ESH will in-service staff on the location of the individual patient schedules and the GAP/IGAP Master Schedule. ESH will further in-service staff on activities and active treatment, their similarities and their differences. Staff requiring GAP training will be identified and training dates established.<br>Programs that are unit specific to a ward will be highlighted on the Master Schedule. All disciplines will honor program contracts that allow rehabilitation staff opportunities for increasing programming for the lower functioning patients. This has been identified as an area of concern by the GAP sub-committee and discussed with Clinical Leadership. |
| **Update 9/21/04** |
| Active treatment for the lowest functioning patient is achieved through individual interventions focused on ADL needs that are not part of the master schedule of groups, but rather part of the patients' daily care. |

***OIG Comment (October 2004) – Interviews with staff and a review of records indicated that the facility has developed individualized plans for addressing the skill needs of each resident based upon their current level of functioning. There was evidence that these were being actively addressed. This finding is INACTIVE.***

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

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

**DMHMRSAS Response:** The Clinical Leadership in Hancock Geriatric Treatment Center will assess afternoon and evening patient care needs and routines. They will communicate the schedule and expectations to all staff. The treatment teams will identify relevant active treatment interventions for individual patients to improve function, or reduce loss of function. The estimated completion date for assessing the needs and identifying the interventions is May 31, 2002. Current scheduled GAP groups end by 3:00 p.m. Evening programming, when scheduled, begins at 6:00 p.m.

| **6 Month Status Report: 07/01/02** |
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Ongoing the facility does a complete review of the overall program and patients' daily schedule by the Clinical Leadership Team and GAP Subcommittee. This ensures that programs are occurring as scheduled and not conflict with individual patient care related activities.

A Master Schedule revision is currently being developed for implementation in July 2002.

***OIG Comment: (March 2003) Please refer to response for Finding 2.3.***

| **Update 05/01/03** |
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| ESH will remind staff that everyone is responsible for active treatment with the patient. Each staff will review the section on active treatment in the program manual. ESH will further inform staff that 1:1 programming for the low functioning patient is provided in addition to the regular posted GAP/IGAP schedules. This intervention is provided during "non-program" times to prevent conflicts with the posted schedules and/or other components of the patients' active treatment.<br><br>Please refer to the response for Finding 2.2. |
| **Update 9/21/04** |
| Active treatment for the lowest functioning patients focuses on individual care needs, which includes physical, mental, and social interventions. |

***OIG Comment (October 2004) – Interviews with staff and a review of records indicated that the facility has developed individualized plans for addressing the skill needs of each resident based upon their current level of functioning. There was evidence that these were being actively addressed. This finding is INACTIVE.***

**Finding 2.4: 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.**

**DMHMRSAS Response:** To promote improved utilization of the clinical staff's participation in treatment planning conferences, the HGTC program is implementing a computerized treatment planning system (Vista Care), which will reduce the overemphasis on the completion of forms. Vista Care requires the development of plans for particular patients based on triggered areas of the MDS (minimum data sets). This

would be beneficial to both higher and lower functioning patient groups. In addition, the recently implemented use of the "Needs upon Discharge" form will not only add to the consolidation and streamlining of paperwork, but will better focus the team's efforts on resolving discharge barriers in a more expedited fashion.

| **6 Month Status Report: 07/01/02** |
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| The program implemented was incorrectly identified as Vista Care when in fact, it is the VistaKeane System. As of June 13, 2002 the percentages of care plans entered into the VistaKeane System are:<br><br>Building 4: 100% completed; Building 32: 95% completed; Building 34: 25% completed; Building 36: 100% completed<br><br>Average HGTC/Medical Services: 80% completed {164 out of 206 completed}<br><br>Building 32 will be 100% complete by June 28th.<br>Building 34 will maintain its 2 plans per week implementation process. It is envisioned that by training more RNs (8) in computerized care plans, the efforts of MIS (new hardware and improved computer lines throughout HGTC) and patient transfers from B-32 with computerized care plans, all patient care plans will be computerized in HGTC. Estimated completion date for computerization of all plans is October 1, 2002. |

***OIG COMMENT: (March 2003) A review of 5 records revealed that improvements had been made in the documentation regarding linkages between assessments and discharge readiness. Progress notes outlining reasons for continued hospitalization, in general, lacked sufficient details for adequate justification. This finding remains ACTIVE.***

| **Update 05/01/03** |
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| ESH will have the HGTC Clinical Leadership review this finding and will in-service all HGTC professional staff on the requirement to adequately enter progress notes justifying reasons for continued hospitalization. |

***OIG Comment (October 2004) – A review of three discharge records and 2 active records revealed that there has been improvement in the documentation overall regarding the clinical justification for continued hospitalization for the geriatric population. The documentation of the records reviewed specifically during the secondary inspection regarding the care and treatment of a geriatric patient conducted during this provided adequate justification for continued hospitalization. This finding is INACTIVE.***

## SECTION THREE: STAFFING PATTERNS

**Finding 3.1: 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.**

**DMHMRSAS Response:** The assessment of the recruitment and retention of nursing staff is ongoing. Recruitment of nursing staff in Hancock Geriatric Treatment Center (HGTC) is difficult, in part, due to the required physical work involved with geriatric population. However, the staff that work in this area desire to do so. Through contract nursing staff are utilized, few of them desire to work with the geriatric patients. The above conditions often contribute to the need for mandatory overtime. There is a system in place for this and has been reviewed with the nursing staff. There is a mandatory overtime list, however, voluntary overtime is utilized first as well as hourly and contract staff. When these options are not possible, mandatory overtime is required. Once the nurse works overtime, his/her name goes to the bottom of the list.

Despite the above issues, the Nursing Department continues to recruit and retain nursing staff with strong support from our Human Resources Department. Since December 2001, we have hired eight (8) DSA's and one (1) LPN for duty in geriatrics. Additionally, two (2) Registered Nurses have been offered positions. Recruitment and retention is ongoing at ESH.

| **6 Month Status Report: 07/01/02** |
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| Voluntary overtime continues to be encouraged and has been successful. There continues to be the utilization of contract nurses as well as the hourly pool RNs. The hourly pool of RNs was increased. This method continues to be utilized with some success. |

***OIG Comment: (March 2003) Interviews with administrative staff, a review of staff schedules and observations on the units revealed that this facility continues to experience difficulty in maintaining the agreed upon requirements in the settlement agreement of one RN per unit per shift. The facility continues in its efforts to recruit and retain nursing personnel. Administrative staff indicated that additional shifting in nursing personnel may occur as a result of the current plan as outlined under the re-investment process, which proposes to close the acute admissions unit (Building 2).***

***This finding remains ACTIVE.***

| **Update 05/01/03** |
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| The recruitment for nurses at ESH is a continuous process. Central Office Human Resources has recently created and filled a workforce enhancement position. There are several programs being discussed with local community colleges to look at ways the facilities can "grow their own" nurses by offering educational incentives to the direct care staff.<br><br>The budgetary constraints felt by all state offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, ESH is offering more alternative scheduling to the nurses and this has been received positively. ESH will continue to make every effort to hire nurses to meet the required HPPD. Since providing a safe environment for the patients and staff is a priority for ESH, this effort will continue to require overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible.<br><br>Although the complete plans of the proposed reinvestment initiative are not yet determined, it is hoped that the RNs from the proposed program closures will be transferred into vacant positions in order to improve the RN staffing ratio in other programs. |

| **(Update – 10/25/04)** |
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| Efforts continue for the recruitment and retention of Nursing staff in Geriatrics here at Eastern State Hospital. The Human Resource Department continues to be supportive of this effort. For the year 2004, two Registered Nurses (RN's) have been hired who were formerly Licensed Practical Nurses (LPN's). Eastern State Hospital paid their tuition. One DSA II was promoted to an LPN; the hospital also paid her tuition. Efforts to "grow our own" continue. Presently the hospital is providing financial support to nine (9) nursing staff to complete their education. This is the highest number of staff Eastern State Hospital has provided this support to at one given time. Eleven (11) RN's and ten (10) LPN's have been hired in Geriatrics since of September of 2003.<br><br>There continues to be staff that are non-productive due to workmen's compensation.<br><br>Classes offered by Thomas Nelson Community Collage (TNCC) are being held on Eastern State Hospital campus. Recruitment and retention is an ongoing process. |

***OIG Comments (October 2004) Interviews with administrative and direct care staff, a review of staff schedules, and observations revealed that the facility's staffing patterns do not always meet the patterns established by the settlement agreement that outlines there will be one RN per unit per shift. In both of the secondary inspections conducted***

***at the facility during this reporting period, the use of overtime and the lack of RN coverage were identified as issues relevant to the events. This finding remains ACTIVE.***