Maine Department of Mental Health and Mental Retardation
Augusta Mental Health Institute

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JOHN R. McKERNAN, JR.
Governor

SUSAN B. PARKER
Commissioner

September 18, 1989

Susan B. Parker, Commissioner
Department of Mental Health and Mental Retardation
State Office Building, Room 400
State House Station #40
Augusta, Maine 04333

Thru: William B. Deal, M.D.
Chairman, Health Consortium, Inc.
c/o Maine Medical Center
Portland, Maine 04101

Subject: Final Report of the Interim Superintendent

Dear Commissioner Parker,

This report is presented in two parts. Part I is an overview of the key issues in the reports of the Medical Records Task Force and the Primary Care Study Group; Part II contains some of my thoughts after four months of management responsibility at AMHI.

PART I

1) Report of the Medical Records Task Force (Appendix 1).

There are four major recommendations in this report:

a) The department must be managed by a qualified, credentialed medical records professional.

b) The department must be reorganized. Responsibilities must be assigned along with appropriate authority and support if the department is to be effective.

c) It is clear that better security of the actual record needs to be implemented and enforced.

d) Much of the equipment is antiquated and will require replacement.

I believe that with a qualified manager who has been given proper authority and support in running the department, most of the issues raised will be quickly corrected.

2. Report of the Primary Care Study Group (Appendix 2)

I am in full agreement with this report. I will comment on four of the sixteen issues raised:

Issue 1 This issue is being addressed. The current Clinical Director has indicated to the Chief of the State Forensic Service and me that he intends to work in some form of staff clinical role as soon as a replacement is "on board" at AMHI.

There is a specific recruitment effort in progress for a new Clinical Director.

Issue 3 There is a clear requirement for an additional primary care physician. There needs to be a separate "On Call" list of primary care physicians, to be available to consult with the on-duty Physician Assistant. If necessary, this "On Call" physician would come to AMHI to examine and treat the patient.

AMHI is recruiting a Chief of Medical Services. This individual must be a well-trained, board certified, educator type physician, who will be aggressive in developing and instituting the necessary changes.

Issue 4 This is a major recommendation. The current practice of holding "sick call" in the clinic is the source of many problems. Many patients require escorts; records are frequently left in the clinic until the attending physician can complete his notes. Clearly, this recommendation will require space on each unit as well as certain basic equipment. I believe that when the fourth primary care physician is hired, this recommendation should be implemented.

Issue 15 I fully support the establishment of an Ethics Committee. Committee membership must include concerned non-AMHI personnel. Clear guidelines should be developed before the committee starts to deal with issues. I would recommend that this committee be established as a "board committee"

PART II

I want to share with you my thoughts about AMHI.

At my request, the Consortium formed specific task groups to evaluate and make recommendations for several areas of concern. Their reports have provided specific recommendations as well as several general systems recommendations that will minimize the chance for recurrence of these issues.

Each and every member of these study groups has my sincere "Thank You" for an outstanding professional job well done. These consultants did this work in addition to meeting the responsibilities of their regular positions. We are indebted to each of them.

I have identified four general issues, the resolution of which, I firmly believe will put in place some reasonable "checks and balances" for the future well-being of AMHI. They are:

a) Recognition of what AMHI is;
b) Leadership;
c) Organization;
d) Prompt vertical integration of the Mental Health System.

While they are all interrelated, I will address each one separately.

a) Recognition of what AMHI is: AMHI is a hospital. Hospitals are a unique combination of program, facilities and resources. Hospitals tend to be demand driven and therefore require flexibility in their ability to respond to shifts in volume or program.

AMHI's basic mission is to provide care to the mentally ill at the institutional level (hospital). AMHI's buildings are old and do not meet most of today's standards. This problem must be corrected, but the solution will require a major capital expenditure. Much of AMHI's clinical and administrative equipment is outdated and should be replaced. It is clear to me that AMHI has suffered from benign neglect at the budget table for many years. The issue before us is to be sure that the trend does not start again.

Hospitals require many and varied credentialled professionals. These individuals usually are in short supply, have multiple employment options, many can practice independently, and are usually highly compensated and their level of compensation is subject to quick and large changes.

These facts tend to cause many problems in a rigid statewide personnel system. Some combination of options must be developed that will allow for the hospital to recruit and more importantly retain its professional staff and at the same time be held accountable for whatever changes are made.

At the present time, there needs to be a compensation review of the following professional categories: Registered Pharmacists, Physician Assistants, Clinical Psychologists, Physical Therapists and Occupational Therapists. AMHI is or will experience serious recruitment/retention problems for these specialties.

b) Leadership: Again, let me state "AMHI is a hospital". As such, its CEO must be an experienced, competent hospital administrator. The hospital has a large contingent of very dedicated, well-qualified professionals. These professionals can provide the clinical knowledge base that the CEO needs to assimilate on the job, but one cannot become an effective hospital administrator by on-the-job training at AMHI.

There are other areas of the hospital where qualified professionals must possess leadership skills. One can look at the new organization chart and readily identify the positions where the need for leadership and professional skills will be on a par.

c) Organizational Issues: AMHI needs to be organized as a hospital. It needs clearly defined lines of authority. Individual managers must understand their managerial, as well as their clinical/administrative responsibilities.

They must be empowered to meet these responsibilities and of course called to account for their successes as well as their failures. This all sounds pretty basic and it is, but for many at AMHI this will be new and threatening. Most will rise to their particular challenge, but unfortunately some may not succeed. Administration and the unions will have to work together with these individuals on a case-by-case basis for the good of the patients, all of the employees, and the hospital as a whole.

d) Vertical Integration: AMHI is but one component of the Mental Health Delivery "System". At this time, my impression is that it is not yet a system, but rather a fragmented group of individual elements. Dr. E. Fuller Torrey says as much in his report of his August visit to Maine. I do not envision a state operated system, but rather a system that has performance standards, quality of care standards. A system that places the community providers at financial risk if they do not meet those standards (much like AMHI discovered that it was at financial risk when it failed to meet Medicare standards). The Department is moving in this direction.It needs to be encouraged to continue its efforts (some community agencies will resist this effort, calling it intrusive).

One issue I did not have time to follow-up on relates to the Advocates. My issue here is not with a particular avdocate, but rather the need for clarification of the rules under which the Advocates operate. As an example, control and copying of medical records. Can the Advocate, at 2:00 a.m., take a chart off a ward for review? Can he make copies of that chart? Can he refuse to return the chart when told to do so by the person in charge of the hospital (the NOD) at 2:00 a.m.? If this had been a regular AMHI employee, this would have been considered a serious breech of policy and resulted in some form of disciplinary action. Not so in the case of the Advocate. There needs to be a resolution of this whole issue before a major legal problem confronts the Department.

I want to express my sincere appreciation to you, your staff, and especially the staff at AMHI. I have gained a profound respect for them. They sincerely want to resolve the issues that face the hospital. They want to get on about the business of providing quality care. They are proud of what they do and they want the citizens of this state to be proud of AMHI. Their understanding, support and cooperation made my job infinitely easier.

Respectfully submitted,

William J. Thompson
Interim Superintendent

WJT/tmc

SPECIAL MEDICAL RECORDS TASK FORCE

FINAL REPORT

SEPTEMBER 7, 1989

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REPORT CONTENTS

INTRODUCTION

In May, 1989, Augusta Mental Health Institute Acting Superintendent, William Thompson, invited medical record representatives from the consortium hospitals to meet with him and discuss institutional medical record concerns. Specific problems were not stated at that time and the consortium members were asked to identify a problem list and develop a plan for corrective action. As a result of that meeting, a proposal (Appendix A) was developed for Mr. Thompson which identified specific goals, processes to be followed and the individuals from the consortium hospitals who would participate and contribute.

The first step in the process was a review of all of the recommendations from previous surveyors, followed by a meeting of the medical record consortium members to discuss a tentative plan of action to identify the problems. This was followed by an on-site visit to AMHI reviewing documentation, procedures, and discussing operations with key individuals. Appendix B is a profile of the Medical Record Department, as understood by this task force. Following this meeting, the group was able to identify three major problem areas and two committees were formed to develop recommendations.

MEDICAL RECORD DEPARTMENT FUNCTION AND ORGANIZATION

The committee on Medical Record Department Function and Organization reviewed the current AMHI Medical Record Department organizational structure, qualifications for medical record management positions, as well as current procedures in place within the Medical Record Department.

ASSESSMENT

1. There is a demonstrated need for a qualified credentialed medical record professional as Manager of Medical Records. Many of the procedural and organizational problems are a direct result from the lack of direction from a qualified medical record individual.

2. The current procedure for recording and monitoring record deficiencies was found to be incomplete, fragmented, inconsistent and repetitive.

3. DSM Coding is currently being performed by personnel outside of the Medical Record Department.

4. Abstracting of statistical data from patient records is not currently being performed by the Medical Record Department.

5. The current procedure for processing admissions is duplicative in nature. Original documents are removed upon admission and an abstract of information is placed on the current record because of lack of sufficient room on the nursing units for the entire medical record.

6. No productivity measures/standards have been developed in the Medical Record Department.

7. The transcription of clinical reports that become a permanent part of the medical record is decentralized throughout the institution. In addition, the equipment utilized for transcription is antiquated.

8. The Medical Record Department has been provided sufficient space to enable personnel to function in an efficient manner and to maintain medical records on all patients so that they are easily accessible.

RECOMMENDATIONS

1. Reorganize the Department of Medical Records under the direction of a qualified Manager of Medical Records, as illustrated in the Organizational Chart in Appendix C.

a. Identify the educational and experience requirements for departmental management positions (as defined in Appendix D).

b. Upgrade a current position into a Lead Transcriptionist position.

c. Redefine several departmental roles and perform a functional job analysis (FJA) on the following positions:
Manager of Medical Records
Medical Record Technician
Lead Transcriptionist
Transcriptionists (those individuals performing transcription duties)

d. A market analysis should be conducted outside of the State structure to determine a competitive wage for the positions listed above in item #2c.

3. Establish and document a detailed procedure for analyzing medical record deficiencies utilizing deficiency slips and tags. The implementation of this procedure may result in an increase in the number of incomplete records, since a detailed analysis in not currently being performed adequately.

   Once a good manual system for record deficiency monitoring has been implemented, a stand-alone PC-based deficiency and record tracking system should be evaluated to assist in this process.

4. A minimal data base with basic medical statistical information should be developed, or the institution should subscribe to an outside abstracting service.

5. All diagnosis and/or procedure coding should be performed under the auspices of the Medical Record Department. If sufficient expertise does not currently exist in the Medical Record Department, training needs to be provided.

6. Establish productivity monitors and develop standards, specific references made to transcription services.

7. Centralize all medical transcription services within the institution.

   a. The Medical Record Department should be responsible for the transcription of all clinical reports that become a permanent part of the medical record.

   b. Develop a policy regarding individuals authorized to utilize transcription services.

8. Contact a vendor of transcription equipment and request a review of the transcription needs of the institution.

   a. The needs should include centralized dictation equipment with the capability of management reporting.

   b. Consideration should be given to evaluating the use of the second shift to optimize utilization of expensive equipment.

9. Evaluate word processing equipment for the Medical Record Department to increase productivity and assist in the monitoring of work loads

MEDICAL RECORD CONTENT

The committee on Medical Record Content reviewed issues concerning the the quality and completeness of medical record documentation, the role of the Medical Record Committee, and the development of a non-integrated medical record.

ASSESSMENT

1. Repetition of like documentation elements noted very frequently (e.g. typed "Admission Note" contains information reflected on the face sheet; a handwritten Treatment Plan and a typed Treatment Plan contain the information). Individuals from different disciplines document some of the same demographics reflected on face sheet and information contained in physician's History and Physical, and Admission Note. One of the primary purposes of the medical record is to serve as a communication tool among professionals. The very repetitious nature of the documentation encountered makes it difficult to quickly identify and follow the salient aspects of the patient's care, treatment, and reaction to treatment and progress.

2. Opportunity for 14 different disciplines to document sequentially on the Progress Notes causes difficulty in following the patient's progress from a given discipline's perspective; reaction to therapy, status regarding achieving Treatment Plan goals and progression toward discharge.

3. The separate medical and psychiatric discharge summaries create concern relative to continuity of patient care issues. This is evidenced by some medical conditions requiring follow-up at discharge which are <u>not</u> discovered until <u>after</u> discharge. In one case, the Axis I diagnosis reflected on the medical and psychiatric discharge summary, did not concur. This conflicting documentation gives rise to medicolegal concerns.

4. Organization of medical record information hinders effectiveness and usefulness of the medical record.

5. Review of "Policy 15. Patient Records," reveals this to be a good document for Medical Record Department reference; however, through the years, it appears people meet standards "by developing a form" (not assessing current forms and needs with modifications to satisfy requirements).

6. Duplication of information contained on forms was encountered.

7. Too many forms exist (there are approximately 209 forms) creating confusion regarding purpose and use.

8. The Patient Care Committee handles many significant functions and thus, it does not have sufficient time to adequately address Medical Record Committee functions.

9. Flow for the qualitative and quantitative process by Medical Record staff is handled by at least four individuals: while this provides for a "checks and balances" system, a more simplistic approach may improve efficiency. A formal mechanism is established to handle "Discharge Summary Process - Deficiencies". The Patient Care Coordinator's office performs a concurrent qualitative and quantitative analysis function which corrects many deficiencies well before the patient is discharged.

10. There is a monthly case presentation at the Clinical Case Conference; this focuses on case management issues and not peer review from a Medical Record Committee function. The Medical Record Department is required to make five copies of a record and forward these copies to appropriate parties - these copies are not returned.

11. Group consensus favors implementation of the non-integrated record.

    a. Organizational or system problems have, in the past, been addressed by development of new forms, when in reality the organizational/system issues need to be resolved.

    b. Disciplines are not departmentalized which causes lack of accountability, responsibility, and ownership when issues pertinent to medical record documentation arise (e.g. social workers, psychologists, etc. are directly accountable to the Unit Director).

    c. There appears to be "a lot of good minds with independent personalities" which has contributed to the current state of affairs. Focus should be on format, not forms (professional practice standards).

    d. Lack of Administration's delegation of authority/ responsibility/accountability has contributed to some of the medical record documentation issues.

e. Lack of proper training for ward clerks with vague job descriptions, in some instances ward clerks functioning as aids - thus, not able to perform duties associated with those of a ward clerk.

f. Team Conferences, in some areas of the hospital, are not conducted at regularly scheduled times, which affects documentation.

RECOMMENDATIONS

1. Identify and list all medical record requirements - JCAHO, Medicare's C.O.P., PRO, Medical Staff Rules and Regulations (as shown in Appendix E and F) and any other applicable regulatory agencies' standards.

2. Certain medical record documentation requirements cited in "Policy 15, Patient Records," should be incorporated into the Medical Staff Rules and Regulations. Specific reference is made regarding time-frames for completion of history & physicals, progress notes, treatment plans, orders, and discharge summaries. This would provide the necessary input from Medical Staff officers.

3. Implement documentation evaluation tools to assure required elements are documented to facilitate patient care.

4. Conversion to non-integrated record to decrease duplication of documentation and enhance the usefulness of the record.

5. Development of a formalized outpatient medical clinic record to facilitate appropriate provision of continuity of care. Concern is raised relative to ability of the medical clinic to provide adequate follow-up of patient's medical conditions, (e.g., Lab reports are difficult to locate; prior ECG's/X-Rays not readily available for comparison, interpretation capabilities).

6. Monitor adherence to regulatory agencies' documentation requirements.

7. Evaluation of each form with the goal to combine, delete and simplify information contained therein.

8. Solicit input from each user of a specific form endeavoring to consolidate information.

9. Establish a separate multi-disciplinary Medical Record Committee of the Medical Staff with representation from medical staff leadership (psychiatric and medical physicians), Medical Records Director, Administrative liaison, Nursing and Utilization Review (others, as necessary).

10. In order to comply with regulatory /accrediting agencies th Medical Record Committee should assume at least the following functions:

    a. Determine format of complete medical record, forms to be utilized in the record, data processing use (lab slips).
    Form analysis should include:
        Need for the form
        Who will use the form
        Place form will be used in (in the record proper or flow sheet on clipboard)
        When will the form be used
        Design to facilitate use

    b. Review records for timely completion, clinical pertinence, adequacy from a quality assessment perspective, and adequacy as a medicolegal document.

    c. Review of records to assure record contains results of all tests/therapies given and reflects patient's condition and progress during hospitalization.

    d. Monitor medical record compliance to all pertinent regulatory agencies' requirements.

    e. Monitor outpatient records for all above functions.

    f. Initiate monthly Medical Record Committee quantitative and qualitative analysis functions on a representative sample.

11. Medical Record Department staff should be given the authority and responsibility to conduct orientation for new members of Medical and Ancillary Staff and provide ongoing continuing education regarding documentation practices and requirements.

12. Develop policies and procedures to accomplish the functions of qualitative and quantitative analyses in a more streamlined fashion. Specific emphasis should be placed on medical record practice standards.

13 Recommend the current practice of providing copies of records for monthly Clinical Case Conference cease immediately for medicolegal implications; this practice also represents a costly one in terms of effective employee utilization and copying costs.

14. Recommend conversion to the non-integrated record to facilitate communication among staff and enhance patient care.

    a. Conversion to the non-integrated record with the Treatment Plan being the focal point supplemented by the required Team Meetings which would create one area in the record in which to view the patient holistically - supporting segregated portions of the record would support treatment at a given point.

    b. Development of a process of conversion with target dates for completion to accompany each phase.

    c. Once departmentalization of the disciplines is accomplished, assignment of responsibility regarding acceptable documentation guidelines/professional practice standards with monitoring by the Department Manager and the Medical Record Committee will be necessary.

    d. Establishment of strong educational programs to facilitate the conversion process.

    e. Medical Record Department should have input for training of ward clerks and unit secretaries, as well as input regarding these individuals' job descriptions as they relate to medical record functions.

    f. Ward clerks should be trained to perform concurrent medical record quantitative analysis.

FLOW OF ACTIVE MEDICAL RECORDS

The committee reviewing the Flow of Active Medical Records evaluated current procedures in place to assure the timely receipt of discharged medical records following discharge, daily census reconciliation procedures, and the movement of medical records throughout the facility.

ASSESSMENT

1. Definition of authority and accountability for all record maintenance functions on inhouse patients is lacking or absent.

   a. Daily census reconciliation is handled differently by all of the nursing units. This procedure is not perceived by unit personnel as being a critical function. Staff are not sufficiently trained/oriented on census reconciliation and ward clerks are not present on all shifts/units.

   b. Medical records of discharged patients are not routinely forwarded to Medical Records upon discharge or notification of convalescent status (C.S.) termination.

   c. Reports are not filed promptly on the record or consistently in the same location within the inhouse record.

2. The medical records of inhouse patients are not consistently accompanying patients as they move throughout the facility.

   a. Patients are seen in the medical clinic and returned back to their unit while the record remains in the clinic for documentation by clinic staff.

   b. Records are removed from nursing units and taken to private offices for review/charting.

RECOMMENDATIONS

1. Develop a consistent manual census reconciliation procedure.

   Since all discharges require a physician's order, incorporate the use of the multi-copy order sheet into the discharge procedure. Forward all copies of discharge

orders to one central location responsible for processing the discharge and update the manual census. This central location should be an area that is staffed 24 hours per day. This will eliminate the inconsistency among nursing units and will allow Medical Records to be aware of all discharges the day after they occur.

2. Incorporate the use of a clinic record to document treatment performed in the medical clinic. A multi-part form (or photocopies) is suggested, with the original document filed on the patient's inhouse record and the duplicate maintained by the medical clinic. This would eliminate the need for making progress note entries regarding all lab results as clinic lab copies would be maintained in the clinic record. This would also eliminate the need for the clinic to request the medical record from the unit whenever laboratory results are received.

APPENDIX A

AMHI
Proposed Plan for Addressing Medical Record Issues

Three primary areas of concern have been identified that demand immediate attention and resolution in order for Medical Record activities to improve. The absence of any strong effective leadership for the Medical Record Department Staff and for the medical record functions in the organization has resulted in many of the current departmental problems. The lack of any accurate daily census reconciliation activities hinders work flow and accountability within the Department. Also, the record content is duplicative, difficult to follow, thus is unable to serve its main purpose for being a communication tool for patient care.

The short term goals for each problem, suggestions for process, and the medical record practitioners who have agreed to assist are noted in the following summaries.

I. Medical Record Department Function and Organization

A. Goals

1. Recommend organizational restructure and management requirements for the Medical Record Department.

2. Review the following procedures and evaluate the potential for productivity standards:
   a. Record Deficiency Monitoring
   b. Record Location/Tracking
   c. Coding/Statistical Reporting
   d. Medical Record Department Admissions Processing

3. Review transcription services in terms of the following issues:
   a. Productivity Standards
   b. Centralized versus Decentralized Transcription Services
   c. Equipment Needs

B. Process

1. Redefine job description of Medical Record Director and Medical Record Technician by 8/1/89.

2. Review and recommend appropriate changes to Department procedures and work flow by 9/1/89.

3. Review and recommend appropriate changes to Transcription procedures and work flow by 9/21/89.

C. Consortium Team Members

1. Robert Bidwell, B.S., M.A., R.R.A., Director of Medical Record Services, Central Maine Medical Center.

2. Jennifer Lohnes, B.S., R.R.A., Manager of Medical Record Department, Mercy Hospital

3. Mary Ellen Mahoney, B.S., M.S., R.R.A., Director of Medical Record Services, Maine Medical Center

4. Susan Ouellette, B.S., R.R.A., Director of Medical Records, Kennebec Valley Medical Center

II. Record Content
(Issues concerning the medical records to be addressed: Completeness, Quality, Medical Record Committee, and Development of a non-integrated medical record)

A. Goals:

1. Recommend record content assessment to determine compliance with JCAHO standards, Medicare's COP, and Medical Staff Standards by July 19, 1989.

2. Recommend assessment of all forms contained in the record:
   a) Purpose
   b) Format (for efficiency and effectiveness)
   c) Duplication of information and forms by 7/19/89.

3. Recommend Medical Record Committee be an independent committee by 8/19/89.

4. Recommend assessment of current Medical Record Committee functions by 8/16/89.
   a) Qualitative analysis functions
   b) Quantitative analysis function

5. Recommend assessment of current Medical Record Staff procedures by 8/16/89.
   a) Qualitative analysis procedures
   b) Quantitative analysis procedures

6. Recommend conversion to non-integrated records to facilitate communication among staff by 10/19/89.

B. Process:

1. List JCAHO and Medical Staff Bylaws standards and review 10 records for compliance (this will identify the problematic areas) by 7/19/89.

2. Gather all forms presently utilized in the medical record and correlate with the Medical Record Manual by 7/12/89.

3. Identify core group of individuals to serve on an independent Medical Record Committee. Representation should include: Medical Staff leadership (psychiatric and medical physicians), Medical Record Director, Administrative Liaison, Nursing Liaison, PA, Nurse Practitioner and utilization review personnel, others as the need arises by 8/19/89.

4. Develop policies and procedures and forms to satisfy the qualitative and quantitative analysis functions and implement education sessions for committee by 8/19/89.

5. Develop procedures, policies and forms to satisfy the qualitative and quantitative analyses functions and implement educational sessions for medical record staff by 8/19/89.
(NOTE: Meeting with Medical Record Staff to evaluate present evaluation process.)

6. Interview each professional discipline for feedback regarding conversion to non-integrated record by 9/16/89.

C. Consortium Team Members

1. Sharon E. King, A.A., A.R.T., C.P.Q.A., Director, Medical Review Services, Central Maine Medical Center

2. Linda Libby, A.R.T., Director of Medical Information Services Department, Mid-Maine Medical Center

III. Flow of Active Medical Records

A. Goals

1. Evaluate the timeliness of the receipt of discharged medical records in the Medical Record Department following discharge.

2. Investigate the movement/availability of medical records on patients throughout their hospitalization.

B. Process

1. Recommend changes to insure compliance of the current policy to deliver discharged records to Medical Records within 48 hours of discharge and/or death by 9/1/89.

2. Meet with key individuals within the institution to investigate and discuss daily reconciliation procedures currently in place and recommend appropriate changes by 8/1/89.

C. Consortium Team Members

1. Robert Bidwell, B.S., M.A., R.R.A., Director of Medical Record Services, Central Maine Medical Center.

2. Jennifer Lohnes, B.S., R.R.A., Manager of Medical Record Department, Mercy Hospital

3. Mary Ellen Mahoney, B.S., M.S., R.R.A., Director of Medical Record Services, Maine Medical Center

4. Susan Ouellette, B.S., R.R.A., Director of Medical Records, Kennebec Valley Medical Center

APPENDIX B

Augusta Mental Health Institute
Medical Records Department Profile

Facility Profile

AMHI is a 398 bed State psychiatric facility. The average daily census is approximately 370 with an average of approximately 100 discharges per month.

Medical Record Department Staffing

The Department is open to the public from 7:30 a.m. to 4:00 p.m., Monday through Friday and is directed by Lois Frost. Lois Frost is currently on medical leave and the Acting Director is Joan Moore. Neither the Director or Acting Director possess medical record credentials through the American Medical Record Association. There is one RRA within the Department functioning as a Medical Record Technician. The Medical Record Director reports to Richard Besson, Director of Hospital Services. The staffing in the Department is comprised of 8 FTEs performing transcription (in addition to handling court transcripts), 2 FTEs performing clerical functions, and 1 FTE coding. Two clerks in the Admission Office also report to the Director of Medical Records.

Numbering/Filing System

AMHI utilizes a dual numbering system. A unit number is assigned and utilized for billing; however, a unique new number is assigned with each subsequent hospitalization. The Department does utilize a serial unit filing system and medical record numbers are assigned by the Admitting Office (next sequential number). Since AMHI is a State institution, inactive medical records are forwarded to the State Archives and become the responsibility of the State Archivist. Within the Medical Record Department, thinned out portions of the inpatient record are maintained alphabetically until the patient is discharged. Following discharge they are processed and filed in open-shelf filing units, by the medical record number, in straight serial order. No color-coding is currently utilized.

Master Patient Index (MPI)

A new MPI card is generated with each admission. The basic information plus all past visits are recorded on the new admission/MPI card and the old card is placed in the old medical record. The MPI is maintained manually and includes inpatient visits only.

Admission/Discharge Procedure

Documents from previous admissions are pulled upon readmission and forwarded to the appropriate nursing unit. The old medical records are brought forward and assigned the new serial unit number. As patients are discharged from the facility, the Department of Evaluation is notified. Medical Records does not know that patients have been discharged unless they receive the record from the floor. Patients are routinely discharged and no one is notifying Medical Records.

Record Flow

Upon receipt of the medical record following discharge, the record is first forwarded to the Discharge Clerk. At that time, the thinned portions are merged with the discharge record and a brief analysis for missing documents is completed. The record is then forwarded to the Patient Care Coordinator (UR) and the record is reviewed by the PCC and Axis III of DSM is coded. The record is then forwarded back to the Medical Record Department and assigned to the physician extender, who is responsible for dictating a medical summary. Following completion of the Discharge Summary, the record is then forwarded to Admitting where the MPI cards are completed and the Office of Statistics is notified. The record then moves to the Discharge Clerk, followed by coding and finally back to the Patient Care Coordinator so that assigned ICD-9 codes can be entered into the computer for the billing system. The final step is the completion of the face sheet by the Medical Record Department .

Record Completion

Record deficiencies are maintained in the Department manually. Incomplete records are filed by nursing unit and a physician is given 30 days before a medical record is considered delinquent. No disciplinary action is taken for delinquent medical records. Pre-printed deficiency slips are not utilized in the Department and memos are sent to physicians notifying them of any missing signatures or incomplete documents. The Department maintains a tickler file that is a log by discharge date. The log is utilized to identify records that are incomplete for a particular physician. Incomplete/delinquent records are counted once a month and delinquency is based on 30 days from the day of discharge. It was very difficult to clearly identify the incomplete records for a given physician as a result of their tickler file being sequenced by discharge date.

Discharge analysis is performed in two steps. The initial analysis is done by the Discharge Clerk and the individual looks for the presence of certain forms and sends notices to physicians if those forms are missing. A second cursory analysis is performed again at the time that the record is coded.

Record Tracking

Record tracking is done manually through the use of a sign-out card system. Old records for all readmissions are routinely sent to the nursing units upon notification. As patients are transferred from one unit to another, the Medical Record Department is not notified of these changes and has no idea where the patients and/or the old medical records are currently located. Likewise, the Department is not notified of discharges, therefore, does not have the ability and knowledge to follow-up on records of discharged patients that are not received within the Department in a timely fashion.

Transcription

Transcription services are provided by the Medical Record Department utilizing desktop cassette units. An Admission Summary is dictated and completed within 24 hours of admission and subsequent 72 hour progress notes are also transcribed. The Medical Record Department is responsible for typing most of the transcribed reports that are found as a permanent part of the record including social assessments, physician extender notes, nursing notes, as well as typing for a patient advocate program. The Department maintains an extra copy of all dictations in the patient's record in case the original document is lost.

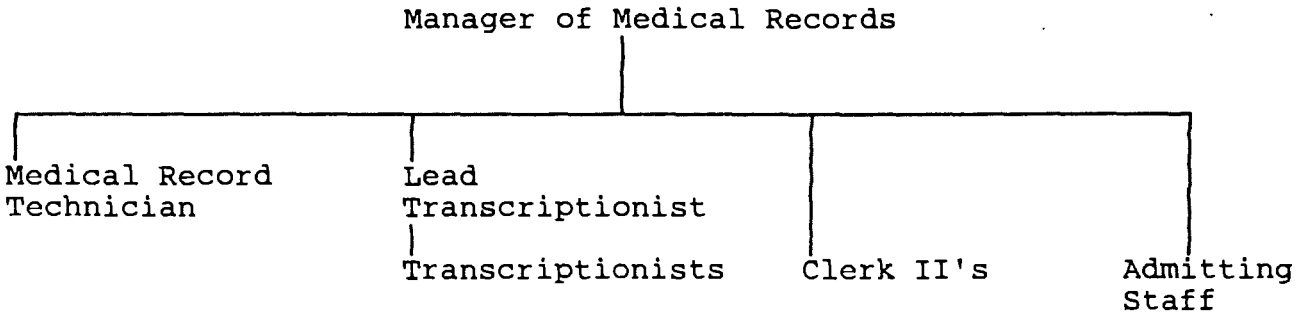
Abstracting/Coding

The Medical Record Department is responsible for coding inpatient discharges; however, no abstracting is performed. The Patient Care Coordinator (UR) also performs some of the coding, specifically Axis III of DSM coding. The Patient Care Coordinator is also responsible for entering codes into the billing system. The Billing Office requires codes within 15 days of discharge; however, the coding is not performed until the record has been completed by the appropriate physicians. Information is taken from the diagnostic sheet for the coding of medical problems.

APPENDIX C

AUGUSTA MENTAL HEALTH INSTITUTE
MEDICAL RECORDS

ORGANIZATIONAL CHART



APPENDIX D

JOB TITLE: Manager

DATE REVIEWED:_____

JOB DEFINITION

The manager of Medical Record Services will direct and maintain the operations of both the Medical Record Department and the Admission's Office. This position will manage the human, financial and material resources available in a manner that provides comprehensive, accurate and timely information on Augusta Mental Health Institute patients and the care they receive in conformity with accreditation, licensing and legal standards.

The Manager will work under the direct supervision of the Chief of Hospital Services.

QUALIFICATIONS: Certification from the American Medical Record Association as a Registered Record Administrator or an Accredited Record Technician. Must have three to five years of supervisory experience in a Medical Records Department. Strong communication and organizational skills required.

TASKS

1. Supervises daily operations of the Medical Record Department and the Admission's Office. Consistently monitors and documents staff performance to include annual performance appraisals.

2. Arranges for the hiring, training, and counseling of departmental employees. Conducts monthly meetings.

3. Demonstrates the ability to identify and resolve interpersonal conflicts constructively when dealing with department staff, medical staff and other institute personnel.

4. Insures timely and accurate provision of services through the operation of a departmental quality assurance program.

5. Sets and meets goals and objectives for the department.

6. Initiates policies and procedures for the department. Reviews and updates these at least annually.

7. Maintains ongoing fiscal awareness and budgetary limitations in the daily functioning of the departments.

8. Serves as a member of the Patient Care Evaluation and Record Committee. Participates in other committee/special task force functions, as assigned, relative to medical records and patient information systems.

9. Assures that records are reviewed for completeness and accuracy in conformance to standards as set forth by the Joint Commission on Accreditation for Healthcare Organizations, regulations associated with participation in the Medicare program and any applicable state licensing regulations.

10. Supervises the release of information from patient's medical records.

11. Teaches the Medical Record section of the basic nursing course.

12. Maintains an accurate clinical data base for use in research, reimbursement, and other statistical compilations.

13. Demonstrates current knowledge and practices in the Medical Record Profession. Assumes personal responsibility for professional development.

JOB TITLE: Medical Record Technician

JOB DEFINITION

The Medical Record Technician will assist in the management of the department. This position will maintain the statistical data base for the Institute, release patient information as authorized, serve on committees as assigned, and performs quality assurance reviews within the department.

This position will report to the Manager, Medical Record Services.

QUALIFICATIONS: Accredited Technician preferred. High school graduate plus two years Business, College, Nursing or Medical secretarial Department. Extensive knowledge of medical terminology, anatomy and physiology required.

TASKS

1. Maintains an accurate statistical data base for the institute by accurately coding and abstracting patient medical records. Keeps current on ICD-9-CM and DSM coding classification changes.

2. Insure timely and accurate completion and retrieval of patient records and information through performance of reviews as part of the departmental Quality Assurance program.

3. Releases information from patient's medical records and conformance with legal standards. Prepares abstracts of records as requested.

4. Serves as a member to the Patient Care Evaluation and Record Committee, and other committees as requested.

5. Reports cancer follow-up to the primary care provider and retrieves cancer research information.

6. Verifies discharges with charts received on a daily basis.

7. Assumes personal responsibility for professional development.

JOB TITLE: Lead Transcriptionist

DATE REVIEWED:_____

JOB DEFINITION

The Lead Transcriptionist of Medical Record Services will supervise the accurate and timely provision of transcribed reports as directed by members of the medical and ancillary staff.

The Lead Transcriptionist will work under the direct supervision of the Manager of Medical Record Services.

QUALIFICATIONS: High school graduate with 3 to 5 years experience as a medical transcriptionist

TASKS

1. Supervises the daily operations of the transcription function.
2. Assists in the selection and hiring of transcription staff.
3. Monitors the quality of transcribed reports routinely.
4. Assists in the development and monitoring of productivity standards.
5. Prepares staff schedule.
6. Acts as liaison between Medical Record Department and users of transcription services.
7. Transcribes dictated reports as necessary.

APPENDIX E

MEDICAL RECORD TEAM CONSORTIUM
AMHI REVIEW - 07/07/89

JCAHO CONTENT STANDARDS

Course of patient's medical evaluation treatment/changes during stay.

		Yes/No/Comments
I.	(MR 1.4) - Detailed and Organized to Enable:	
	A. Continuing care to be rendered.	_____
	B. Physician to determine patient's condition at any given specific time.	_____
	C. Review diagnostic/therapeutic procedures and patient's response to treatment.	_____
	D. Consultant to render opinion to exam of patient and record.	_____
	E. Another physician to assume care of patient at any time.	_____
	F. Retrieval of pertinent information required Utilization Review.	_____
	G. Retrieval of pertinent information required Quality Assurance.	_____
II.	(MR 1.5) - Unit Record is used.	_____
III.	(MR 1.6 - Information From Outside Sources Available to Reference.	_____
IV.	MR 1.7 - Standardized Format Utilized:	
	A. Approved by Medical Staff.	_____
	B. Quality Assurance (see Quality Assurance Section).	_____
V.	MR 2.1 - Medical Record Contains Following:	
	A. Identification Data:	
	Patient's Name	_____
	Address	_____
	Date of Birth	_____
	Next of Kin	_____
	Medical Record #	_____
	When not obtainable, reason recorded on MR	_____

B. Medical History:

Chief Complaint _____
Details of present illness _____
When appropriate, patient's emotional status _____
behavioral " _____
social " _____

Relevant past history _____
" social history _____
" family history _____
Inventory by body system _____
When possible, medical history obtainable from patient _____
Programs for children/adolescents:
Evaluation of developmental age factors _____
Consideration of educational needs (included as appropriate) _____
History should not include interviewer's opinion _____
Medical history done within 24 hours of admission _____
If complete history is done within 1 week PTA, durable copy may be in record if no subsequent changes or changes have been recorded with admissions. _____

C. Physical Examination:

Comprehensive current physical assessment _____
Done within 24 hours of admission _____
If complete history is done within 1 week PTA, durable copy may be in record if no subsequent changes have been recorded with admissions. _____
Signed by physician _____
For readmission within 30 days for same or related problem interval and physical exam reflecting subsequent changes may be used _____
Physical exam before surgery done _____
Statement of conclusions or impression drawn from admission history and physical exam. _____
Statement of course of action planned for patient _____

D. Physicians Orders:

Written by physician/or others with authority to do so _____
Verbal Order accepted and transcribed by qualified personnel _____
Above individuals identified by title or category _____
Medical Staff defines any category of diagnostic or therapeutic V.O. associated with any potential hazard to patient _____
Authentication within 24 hours _____

E. Evidence of appropriate informed consent:

When not obtainable, reason recorded in M.R. _____
Policy and Procedure re: informed consent _____
M.R. has informed consents for procedures/ treatments (per P & P) _____

F. Clinical observations:

Results of therapy _____
Pertinent chronological report of patient's course _____
Reflect change in condition _____
Results of treatment _____
Progress Notes made by those with clinical privileges _____

G. Reports of procedures, tests, results:

Recorded in the record and are signed _____
Reports from outside hospital may be included - Source identified _____
(Pg. 92) OR - pre-op diagnosis recorded prior to surgery _____
- OP report copy/signed _____
(Pg. 92) Path & Lab - (see Manual) _____

H. Consultations (exam of patient and M.R.): _____

I. Nursing Notes and entries by non-physicians contain:

Pertinent, meaningful observations _____

J. Autopsy done:

Provisional anatomic diagnosis recorded within 3 days _____
Complete protocol in record in 60 days _____

K. Sensitive portions of record kept elsewhere - note in record to alert authorized personnel _____

L. Conclusions at:

Termination of hospitalization _____
OR
Evaluation/Treatment _____
Provisional diagnosis or reason for admission _____
Principle and all other associates' relevant diagnosis _____

Clinical Resume _____
Significant findings _____
Treatment rendered _____
Condition of patient at discharge _____
(specific-measurable comparison with condition at admission) ("No - condition improved")
Instructions given to patient/family _____
Physical activity _____
Medication _____
Diet _____
Follow-up care _____
For pre-printed instructions given, record so indicates _____
Sample of above on file in M.R. Dept. at the time of its use _____
When appropriate, autopsy _____
Operative procedures performed _____
Final progress note for those less than 48 hours length of stay _____
Instructions to patient _____
For deaths - notes reason for admission _____
findings _____
course in hospital _____
events leading to death _____

Quality of Medical Record (timeliness, meaningfulness, authentication, legibility.

I. Entries authorized personnel: _____

Dated _____
Signed with professional discipline _____
(Use of rubber stamp) _____

II. PA's performing History and Physical Exam, signed by PA: _____

Authenticated by responsible physician _____

III. House staff/non physicians' notes, countersigned responsible physician _____

IV. Use of abbreviations (approved listing) _____

V. Typed entries _____

VI. Discharged records complete in 30 days _____

Page 5.

General observations regarding the content and quality of the medical records.

APPENDIX F

MEDICAL RECORD TEAM CONSORTIUM
AMHI REVIEW - 07/07/89

MEDICARE COP STANDARDS - PSYCHIATRIC RECORDS

		Yes/No/Comments
482.61 -	Record must document degree and intensity of treatment provided.	_____
(a)	Record contains assessment/diagnostic data - stressing psychiatric components -	_____
	- History of findings	_____
	- Treatment provided	_____
	- Patient's legal status documented	_____
	- Admitting diagnosis and inter-current diagnosis documented	_____
	- Reason(s) for admission documented	_____
	- Social Service notes include interviews with patient/family members/others	_____
	- Assessment of home plans	_____
	- Assessment of family attitudes	_____
	- Assessment of community resources	_____
	- Assessment of social history	_____
	- When indicated, complete neurological exam done	_____
(b)	Psychiatric evaluation done on each patient	_____
	- Completed within 60 hours of admission	_____
	- Includes medical history	_____
	- Documents mental status	_____
	- Notes onset of illness and circumstances leading to admission	_____
	- Describes attitude and behavior	_____
	- Estimates intellectual functioning,	_____
	- Estimates intellectual memory	_____
	- Estimates intellectual orientation	_____
	- Inventory of patient's assets in description not interpretive	_____

Yes/No/Comments

(c) Treatment Plan (T.P.) _____

- Each patient has T.P. highlights strengths and weaknesses _____
- Includes substantiated diagnosis _____
- Short Term and Long Term goals _____
- Contains specific treatment modalities _____
- Identifies responsibilities of each member of treatment team _____
- Contains documentation to justify:
  * Diagnosis _____
  * Treatment _____
  * Rehabilitation activities carried out _____
- Treatment received by patient documented to reflect that all active therapeutic efforts are included _____

(d) Progress Notes (includes):

- By M.D./D.O., Nurse, Social Worker, Psychologist, etc.) _____
- At least weekly X 1st 2 months _____
- Monthly thereafter _____
- Contain recommendations for revisions in treatment plan _____
- Reflect precise assessment of patient's proper per treatment plan and revisions thereof _____

(e) Discharge Planning and Discharge Summary

- Above must be done on each patient _____
- Reflects recapitulation of patient's hospitalization _____
- Reflects recommendations re: follow-up or after care _____
- Reflects brief summary of patient's condition on discharge _____

AUGUSTA MENTAL HEALTH INSTITUTE
AUGUSTA, MAINE

DATES OF SURVEY
DECEMBER 1-2, 1988

SURVEYORS
RAYMOND F. PATTERSON, MD
LEROY B. LAMM, MD
GEORGE B. LITTLE, JR,FACHE
PATRICIA ANN HASSEL, RN,CNA
JOAN M. GANNON, RN

ACCREDITATION DECISION: Your organization has been awarded accreditation for three years from the day following the last day of survey noted above, contingent upon compliance with the recommendations in this report preceded by the symbol (C).

CONTINGENCY: A focused survey will be scheduled within approximately six (6) months from the date of the attached letter, October 6, 1989. This visit will be conducted by a physician surveyor for two (2) days and will address only the recommendations on the following pages in the Accreditation Program for Psychiatric Facilities section preceded by the symbol (C) and relating t the following topics:

1. Direction and Staffing of Clinical Services/Departments

2. Assessment

3. Treatment Planning Process

4. Patient Rights

PRA

The written progress report for Life Safety should be in the form of a plan of correction and should include:

a. The deficiencies addressed by the plan;

b. Actions being taken to correct the deficiencies;

c. The source and availability of funding for the plan of correction; and

d. A schedule of correction.

Your organization will be notified of the date of this focused survey visit.

CONTINGENCY: A written progress report will be required within approximately three (3) months from the date of the attached letter, October 6, 1989. This report should address only the recommendations on the following pages in the Hospital Accreditation Program section preceded by the symbol (C) and relating to the following topics:

1. Medical Staff Organization (MS.3.9 and MS.3.11)

2. Life Safety (Residential Occupancies)

The written progress report for Life Safety should be in the form of a plan of correction and should include:

a. The deficiencies addressed by the plan;

b. Actions being taken to correct the deficiencies;

c. The source and availability of funding for the plan of correction; and

d. A schedule of correction.

The written progress report should be completed and sent to:

Progress Report Coordinator
Hospital Accreditation Program
Joint Commission
875 North Michigan Avenue
Chicago, Illinois 60611

CONTINGENCY: A focused survey will be scheduled within approximately six (6) months from the date of the attached letter, October 6, 1989. This visit will be conducted by a nurse surveyor and will address only the recommendations on the following pages in the Hospital Accreditation Program section preceded by the symbol (C) and relating to the following topics:

1. Nursing Process

2. Nursing Direction and Staffing

3. Monitoring and Evaluation of Nursing Services

4. Infection Control

5. Monitoring and Evaluation of Dietetic Services

6. Monitoring and Evaluation of Social Work Services

Your organization will be notified of the date of this focused survey visit.

CONTINGENCY: A focused survey will be scheduled within approximately six (6) months from the date of the attached letter, October 6, 1989. This visit will be conducted by a HAP psychiatrist surveyor and will address only the recommendations on the following pages in the Hospital Accreditation Program section preceded by the symbol (C) and relating to the following topics:

1. Clinical Privileges

2. Monitoring and Evaluation of Medical Staff/Department Care

3. Medical Record Review

4. Pharmacy and Therapeutics Review

5. Evidence of Action Taken in the Quality Assurance Program

6. Monitoring and Evaluation of Emergency Services

7. Monitoring and Evaluation of Radiology Services

8. Use of Quality Assurance Results in Competence Appraisal/Clinical Privileges

Your organization will be notified of the date of this focused survey visit.

CONTINGENCY: A written progress report will be required within approximately six (6) months from the date of the attached letter, October 6, 1989. This report should address only the recommendations on the following pages in the Hospital Accreditation Program section preceded by the symbol (C) and relating to the following topics:

1. Safety Management (General Safety and Emergency Preparedness)

2. Equipment Management (Electrically Powered Equipment)

3. Governance

4. Monitoring and Evaluation of Pharmaceutical Services

5. Monitoring and Evaluation of Rehabilitation Services

The written progress report should be completed and sent to:

Progress Report Coordinator
Hospital Accreditation Program
Joint Commission
875 North Michigan Avenue
Chicago, Illinois 60611

IMPLEMENTATION MONITORING: Some recommendations in the attached report are standards which are currently in implementation monitoring status. They are identified by the symbol (M). While these recommendations do not presently affect the accreditation decision, compliance with these standards should be pursued. Special attention will be focused on compliance with these standards during the next survey of your organization.

LABORATORY FINDINGS: Your accreditation report does not include our review of the findings from the College of American Pathologists survey of your laboratory. Your accreditation status may be affected by these results. These findings will be forwarded as soon as possible.

ADDITIONAL RECOMMENDATIONS: The attached report reflects additional recommendations for future compliance. The recommendations preceded by the symbol (+) should be given high priority and must be corrected prior to your next survey.

RECOMMENDATIONS FOR FUTURE COMPLIANCE

THE FOLLOWING RECOMMENDATIONS QUOTE STANDARDS IN THE CONSOLIDATED STANDARDS MANUAL, 1987. THE SPECIFIC STANDARDS REFERENCED ARE NOTED IN PARENTHESES FOLLOWING THE RECOMMENDATION.

WRITTEN PLAN FOR PROFESSIONAL SERVICES AND STAFF COMPOSITION

(C) 1. Within the scope of its activities, the facility has enough appropriately qualified health care professional, administrative, and support staff available to adequately assess and address the identified clinical needs of patients. (WP.2)

IT WAS NOTED THAT THE ORGANIZATION HAS 9 VACANCIES FOR NURSE II, 1 VACANCY FOR NURSE III AND 3 VACANCIES FOR NURSE IV POSITIONS.

GOVERNING BODY

(C) 2. The governing body, through the chief executive officer, develops policies and makes sufficient resources available (e.g., funds, staff, equipment, supplies, and facilities) to assure that the program is capable of providing appropriate and adequate services to patients. (GB.8)

IT WAS NOTED THAT THE ORGANIZATION HAS VACANCIES FOR 9 NURSE II POSITIONS, 1 VACANCY FOR A NURSE III POSITION AND 3 VACANCIES FOR A NURSE IV POSITION.

ASSESSMENT

(C) 3. The assessment includes, but is not necessarily limited to, physical, emotional, behavioral, social, recreational, and, when appropriate, legal, vocational, and nutritional needs. (AS.1.1)

IT WAS NOTED THAT A PATIENT'S PHYSICAL HEALTH NEED TO BE FURTHER ADDRESSED.

(C) 4. The social assessment includes a determination of the need for participation of family members or significant others in the patient's treatment. (AS.5.2)

IT WAS NOTED THAT SOCIAL ASSESSMENTS DO NOT CONSISTENTLY REFLECT THE FAMILY MEMBERS OR SIGNIFICANT OTHERS INVOLVEMENT.

(C) 5. An activities assessment of each patient is undertaken and includes information relating to the individual's current skills, talents, aptitudes, and interests. (AS.6)

IT WAS NOTED THAT ACTIVITIES ASSESSMENTS DO NOT CONSISTENTLY REFLECT A PATIENT'S SKILLS, APPTITUDES AND INTERESTS AND ARE NOT INCLUDED IN THE PATIENT'S TREATMENT PLAN.

TREATMENT PLANNING PROCESS

(C) 6. For each patient, there is a written, comprehensive, individualized treatment plan that is based on assessments of the patient's clinical needs. (TP.1)

IT WAS NOTED THAT TREATMENT PLANS ARE NOT ADEQUATELY BASED ON ASSESSMENTS. IN ADDITION, TREATMENT PLANS INADEQUATELY REFLECT THE PATIENT'S HEALTH PROBLEMS. FURTHER, TREATMENT INTERVENTIONS ARE NOT ADEQUATELY ADDRESSED AND THE OBJECTIVES OF SUCH INTERVENTIONS ARE NOT MEASURABLE.

(C) 7. Provision is made for periodic reevaluation of the patient and for revisions of the individualized treatment plan based on changes in the patient's condition. At the minimum, the treatment plan is reviewed at major key decision points in each patient's treatment course. These decision points include: (TP.1.3.2)

(C) a. the time of a major change in the patient's condition. (TP.1.3.2.1.2)

IT WAS NOTED THAT TREATMENT PLANS ARE NOT CONSISTENTLY REVISED WHEN THE PATIENT'S NEEDS OR CONDITION CHANGES.

(C) 8. The treatment plan reflects the patient's clinical needs and condition and identifies functional strengths and limitations. (TP.1.5)

IT WAS NOTED THAT TREATMENT PLANS DO NOT ADEQUATELY REFLECT THE PATIENT'S CLINICAL NEEDS AND CONDITIONS.

(C) 9. The treatment plan specifies the services necessary to meet the patient's needs. (TP.1.6)

IT WAS NOTED THAT FOR STANDARDS TP.1.6-TP.1.6.1.3: TREATMENT PLANS DO NOT CONSISTENTLY SPECIFY THE SERVICES NECESSARY TO MEET THE PATIENT'S NEEDS NOR DO THEY ADEQUATELY ADDRESS THE PATIENT'S ACTIVITIES OF DAILY LIVING SKILLS.

(C) 10. When the patient's identified needs include the development skills related to activities of daily living, the treatment team identifies the training program to be utilized, specifying (TP.1.6.1)

(C) a. the behavioral objectives of the training program. (TP.1.6.1.1)

(C) b. the methods to be used. (TP.1.6.1.2)

(C) c. the training schedule. (TP.1.6.1.3)

(C) 11. The treatment plan includes referrals for needed services that are not provided directly by the facility. (TP.1.7)

IT WAS NOTED THAT TREATMENT PLANS DO NOT CONSISTENTLY INCLUDE REFERRALS FOR NEEDED SERVICES THAT ARE NOT PROVIDED BY THE ORGANIZATION.

(C) 12. The treatment plan contains specific objectives that relate to the goals, are written in measurable terms, and include expected achievement dates. (TP.1.9)

IT WAS NOTED THAT TREATMENT OBJECTIVES ARE NOT CONSISTENTLY WRITTEN IN MEASURABLE TERMS.

(C) 13. The treatment plan delineates the specific criteria to be met for termination of treatment. (TP.1.12)

IT WAS NOTED THAT TERMINATION CRITERIA HAVE NOT BEEN ADEQUATELY DELINEATED IN THE TREATMENT PLAN.

THERAPEUTIC ENVIRONMENT

(+) 14. Good standards of personal hygiene and grooming are taught and maintained, particularly in regard to bathing, brushing teeth, caring for hair and nails, and using the toilet. (TH.16)

IT WAS NOTED THAT A NUMBER OF PATIENTS WERE OBSERVED DURING THE SURVEY TO HAVE POOR PERSONAL HYGIENE.

PATIENT RIGHTS

(C) 15. Facilities support and protect the fundamental human, civil, constitutional, and statutory rights of each patient. (PI.1)

DEFICIENCIES IN COMPLIANCE WITH STANDARD (PI.1) WERE PREVIOUSLY REPORTED.

IT WAS NOTED THAT THE ORGANIZATION HAS NOT YET ENCLOSED ALL OGF THE EXPOSED PIPES IN THE PATIENTS BEDROOMS. IN ADDITION, THE ORGANIZATION HAS NOT ADDRESSED THE EXCESSIVE USE OF RESTRAINT AND SECLUSION PROCEDURES.

REHABILITATION SERVICES

(+) 16. Activity schedules are posted in places accessible to patients and staff. (RH.5.3)

IT WAS NOTED THAT ACTIVITIES SCHEDULES ARE NOT POSTED ON THE ADMISSION, OLDER ADULT AND OVERFLOW UNITS.

(+) 17. Activity services that are included in a patient's treatment plan reflect an assessment of the patient's needs, interests, life experiences, capacities, and deficiencies. (RH.6.1)

IT WAS NOTED THAT ALTHOUGH ACTIVITIES ASSESSMENTS ARE CONDUCTED, THE RESULTS ARE NOT INTEGRATED INTO THE PATIENT'S MASTER TREATMENT PLAN.

(+) 18. Activity service staff collaborate with other professional staff in delineating goals for patients' treatment, health maintenance, and vocational adjustment. (RH.6.2)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

THE FOLLOWING RECOMMENDATIONS QUOTE STANDARDS IN THE LONG TERM CARE STANDARDS MANUAL, 1988. THE SPECIFIC STANDARDS REFERENCED ARE NOTED IN PARENTHESES FOLLOWING THE RECOMMENDATION.

QUALITY ASSURANCE

(+) 19. The quality assurance program addresses all major patient/resident care activities. (QA.2)

20. The quality and appropriateness of care are monitored and evaluated in clinical areas including: (QA.2.1)

(+) a. Patient/resident activities. (QA.2.1.1)

(+) b. Medical care. (QA.2.1.3)

IT WAS NOTED THAT ALTHOUGH IMPORTANT ASPECTS OF CARE HAVE BEEN IDENTIFIED AND INDICATORS HAVE BEEN DEVELOPED, THRESHOLDS FOR THE EVALUATION OF INDICATORS HAVE NOT BEEN ESTABLISHED. ALTHOUGH DATA IS BEING COLLECTED, MOST DATA ADDRESSES QUANTITY RATHER THAN QUALITY AND APPROPRIATENESS ISSUES.

21. The quality assurance program consists of: (QA.3.1)

a. The evaluation of (QA.3.1.3)

(+) 1. patient/resident and family comments. (QA.3.1.3.4)

(+) 2. findings from patient/resident and family/visitor councils relating to patient/resident care. (QA.3.1.3.5)

SPECIFIC REFERENCE IS MADE TO THE LACK OF EVALUATION OF THE ABOVE.

ROLES AND RESPONSIBILITIES

22. Medical Director

a. The medical director is either appointed by the administrator or designated by the organized medical staff. (RR.3.1)

1. The appointment or designation of the medical director is approved by the governing body. (RR.3.1.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF EVIDENCE THAT THE APPOINTMENT OF THE MEDICAL DIRECTOR WAS APPROVED BY THE GOVERNING BODY.

STAFF DEVELOPMENT AND EDUCATION

23. The supervising dentist provides professional auxiliary personnel with in-service education on oral health care. (SD.4)

IT WAS NOTED THAT ORAL HEALTH IN-SERVICES ARE ONLY PROVIDED BY NURSING STAFF.

PATIENT/RESIDENT RIGHTS AND QUALITY OF LIFE

(+) 24. There is a patient/resident council to provide patients/residents with a mechanism for voicing grievances and for participating in decision making. (RQ.1.2)

IT WAS NOTED THAT THE PATIENT/RESIDENT COUNCIL HAS NOT MET SINCE THE LAST QUARTER OF 1987.

CARE MANAGEMENT SYSTEM

(+) 25. The patient/resident care management system is implemented by members of an interdisciplinary team and is designed to assure coordinated participation of all appropriate health care professionals. (CM.1.3)

IT WAS NOTED THAT CARE PLANNING IS CONDUCTED BY EACH DISCIPLINE AND IS THEN REVIEWED AND UPDATED AT THE CARE PLANNING CONFERENCES. THERE IS NO INTEGRATION OF THE VARIOUS DISCIPLINES IN THE CARE PLANNING PROCESS.

(+) 26. Based on information obtained during the admission process, an interim plan of care is developed as soon as possible after admission. (CM.2.2)

IT WAS NOTED THAT INTERIM PLAN OF CARE IS THE NURSING ADMISSION NOTE. IT DOES NOT INCLUDE INTERIM GOALS FOR THE PATIENT/RESIDENT.

(+) 27. Each patient/resident has an individualized interdisciplinary plan of care. (CM.4)

(+) 28. The interdisciplinary plan of care is based on the comprehensive assessments. (CM.4.1)

29. The interdisciplinary plan of care includes: (CM.4.3)

(+) a. Identified patient/resident needs. (CM.4.3.1)

(+) b. Identified goals, which are realistic and measurable. (CM.4.3.2)

(+) c. Specification of the members of the interdisciplinary team who are responsible for working with the patient/resident to meet specific goals. (CM.4.3.4)

(+) d. The frequency with which services are to be provided and designation of which interdisciplinary team member is responsible for their provision. (CM.4.3.5)

IT WAS NOTED THAT THE MULTIDISCIPLINARY PLAN OF CARE DOES NOT INCLUDE ALL OF THE PATIENT'S/RESIDENT'S NEEDS. THIS IS DUE TO THE LACK OF INTEGRATION OF EACH DISCIPLINES CARE PLAN.

30. Interdisciplinary team members' responsibilities include: (CM.5.3)

(+) a. Development and implementation of a comprehensive, individualized plan of care that is based on the assessments of the patient/resident. (CM.5.3.2)

IT WAS NOTED THAT THE CARE PLAN DOES NOT INCLUDE ALL IDENTIFIED PATIENT'S/RESIDENT'S NEEDS.

PROVISION OF PATIENT/RESIDENT CARE

31. Social Services

a. Social services personnel provide: (PC.10.2)

(+) 1. Assistance in the development and operation of a patient/resident council. (PC.10.2.5)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A PATIENT/RESIDENT COUNCIL.

(+) 2. Assistance in the development and operation of a family/visitor council. (PC.10.2.10)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A FAMILY/VISITOR COUNCIL.

MEDICAL RECORD SERVICE

32. Each medical record contains patient/resident identification data and pertinent information on the patient's/resident's status and on the provision of and response to treatment and care. (MR.2.5)

a. The provision of and response to nursing care is documented in the medical record. (MR.2.5.8)

1. Documentation includes: (MR.2.5.8.1)

a. A summary of the patient's/resident's condition at least monthly, or more often if the patient's/resident's condition warrants, by staff on one of the nursing shifts. (MR.2.5.8.1.4)

1. The extent of the achievement of the nursing goals that are included in the interdisciplinary plan of care is contained in the summary. (MR.2.5.8.1.4.1)

IT WAS NOTED THAT NURSING SUMMARIES RARELY INCLUDE THE EXTENT OF ACHIEVEMENT OF NURSING GOALS.

THE FOLLOWING RECOMMENDATIONS QUOTE STANDARDS IN THE ACCREDITATION MANUAL FOR HOSPITALS, 1988. THE SPECIFIC STANDARDS REFERENCED ARE NOTED IN PARENTHESES FOLLOWING THE RECOMMENDATION.

DIAGNOSTIC RADIOLOGY SERVICES

(C) 33. The diagnostic radiology department/service has a planned and systematic process for the monitoring and evaluation of the quality and appropriateness of patient care services and for resolving identified problems. (DR.4.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A PLANNED AND SYSTEMATIC MONITORING AND EVALUATION PROCESS.

(+) 34. The quality and appropriateness of patient care services are monitored and evaluated in all major clinical functions of the diagnostic radiology department/service. (DR.4.2)

IT WAS NOTED THAT MONITORING AND EVALUATION ACTIVITIES ONLY ADDRESS STATISTICAL ISSUES SUCH AS THE NUMBER OF FILMS TAKEN.

35. Such monitoring and evaluation are accomplished through: (DR.4.2.1)

(C) a. routine collection in the diagnostic radiology department/service, or through the hospital's quality assurance program, of information about important aspects of diagnostic radiology or therapy services. (DR.4.2.1.1)

(C) b. periodic assessment by the diagnostic radiology department/service of the collected information in order to identify important problems in patient care services and opportunities to improve care. (DR.4.2.1.2)

IT WAS NOTED THAT THE COLLECTION AND ASSESSMENT OF INFORMATION ONLY ADDRESSES STATISTICAL ISSUES, RATHER THAN CLINICAL ASPECTS OF CARE.

36. When important problems in patient care services or opportunities to improve care are identified: (DR.4.3)

(C) a. actions are taken. (DR.4.3.1)

(C) b. the effectiveness of the actions taken is evaluated. (DR.4.3.2)

(C) 37. The findings from the conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (DR.4.4)

IT WAS NOTED THAT THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN ONLY ADDRESS STATISTICAL ISSUES, RATHER THAN CLINICAL ASPECTS OF CARE.

(C) 38. As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of monitoring, evaluation, and problem-solving activities in the diagnostic radiology department/service is evaluated. (DR.4.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

(C) 39. When an outside source(s) provides diagnostic radiology services, or when there is no designated diagnostic radiology department/service, the quality and appropriateness of patient care services provided are monitored and evaluated, and identified problems are resolved. (DR.4.7)

SPECIFIC REFERENCE IS MADE TO THE LACK OF EVIDENCE OF PLANNED AND SYSTEMATIC MONITORING AND EVALUATION OF THE APPROPRIATENESS OF PATIENT REFERRALS TO THE OUTSIDE SOURCE(S).

DIETETIC SERVICES

40. Such monitoring and evaluation are accomplished through: (DT.7.2.1)

(C) a. periodic assessment by the dietetic department/service of the collected information in order to identify important problems in patient care services and opportunities to improve care. (DT.7.2.1.2)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF A PERIODIC ASSESSMENT OF THE COLLECTED INFORMATION.

41. When important problems in patient care services or opportunities to improve care are identified: (DT.7.3)

(C) a. actions are taken. (DT.7.3.1)

(C) b. the effectiveness of the actions is evaluated. (DT.7.3.2)

(C) 42. The findings from and conclusions of the monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (DT.7.4)

IT WAS NOTED THAT THE ACTIONS TAKEN AND FOLLOW-UP ACTIONS TAKEN WHEN PROBLEMS ARE IDENTIFIED ARE NOT DOCUMENTED.

EMERGENCY SERVICES

(+) 43. Emergency patient care is guided by written policies and procedures. (ER.5)

IT WAS NOTED THAT THE ORGANIZATION HAS NOT FORMALIZED WRITTEN POLICIES ADDRESSING EMERGENCY PATIENT CARE WITH THE EXCEPTION OF A PARAGRAPH WHICH LISTS SOME CONDITIONS WHICH A PATIENT SHOULD BE TRANSFERRED TO THE COMMUNITY HOSPITAL.

(C) 44. When an outside source(s) provides emergency services, or when there is no designated emergency department/service, the quality and appropriateness of patient care provided are monitored and evaluated, and identified problems are resolved. (ER.9.7)

SPECIFIC REFERENCE IS MADE TO MINIMAL EVIDENCE OF PLANNED AND SYSTEMATIC MONITORING AND EVALUATION OF THE APPROPRIATENESS OF PATIENT REFERRALS TO THE OUTSIDE SOURCE(S). IN ADDITION, ALTHOUGH PROBLEMS HAVE BEEN IDENTIFIED, THERE IS A LACK OF DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

GOVERNING BODY

45. The bylaws specify: (GB.1.2)

a. the requirement for the establishment of auxiliary organizations, if applicable. (GB.1.2.7)

IT WAS NOTED THAT THE GOVERNING BODY BYLAWS DO NOT ADDRESS AUXILIARY ORGANIZATIONS.

46. Any auxiliary organizations and individual volunteers delineate their purpose and function for approval by the governing body. (GB.1.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

47. A record of governing body proceedings is maintained. (GB.1.7)

IT WAS NOTED THAT GOVERNING BODY MEETINGS WERE NOT DOCUMENTED UNTIL JANUARY, 1988.

(+) 48. The governing body acts on recommendations concerning medical staff appointments, reappointments, terminations of appointments, and the granting or revision of clinical privileges within a reasonable period of time, as specified in the bylaws of the medical staff. (GB.1.13)

IT WAS NOTED THAT THE GOVERNING BODY BYLAWS DO NOT SPECIFY THE PERIOD OF TIME THAT APPOINTMENTS OR REAPPOINTMENTS TO THE MEDICAL STAFF ARE GRANTED. IN PRACTICE, ALL REAPPOINTMENTS ARE DONE ON THE PRACTITIONER'S ANNIVERSARY DATE.

49. The governing body requires a process or processes designed to assure that all individuals who provide patient care services, but who are not subject to the medical staff privilege delineation process, are competent to provide such services. (GB.1.15)

(C) a. The quality of patient care services provided by these individuals is reviewed as part of the hospital's quality assurance program. (GB.1.15.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

50. All members of the governing body understand and fulfill their responsibilities. (GB.3)

a. All new members of the governing body participate in an orientation program. (GB.3.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

INFECTION CONTROL

51. A basic element(s) of the infection control program include(s): (IC.1.2)

(C) a. a practical system for reporting, evaluating, and maintaining records of infections among patients and personnel. (IC.1.2.2)

IT WAS NOTED THAT A SYSTEM FOR REPORTING, EVALUATING AND MAINTAINING RECORDS OF INFECTIONS AMONG PATIENTS AND PERSONNEL HAS ONLY BEEN IMPLEMENTED FOR 10 MONTHS PRIOR TO SURVEY. POST SURVEY INFORMATION: THE INFECTION CONTROL COMMITTEE HAS BEEN REVISED AND A PRACTICAL SYSTEM FOR REPORTING, EVALUATING AND MAINTAINING RECORDS OF INFECTIONS AMONG PATIENTS AND PERSONNEL IS INADEQUATELY IMPLEMENTED.

b. participation in the content and scope of the employee health program. (IC.1.2.7)

IT WAS NOTED THAT THE PRESENT EMPLOYEE HEALTH PROGRAM ONLY REQUIRES A TB TEST AND A HEALTH HISTORY OF EACH EMPLOYEE. THIS PROGRAM HAS NOT BEEN REVIEWED BY THE INFECTION CONTROL COMMITTEE AND THERE HAS BEEN NO ONGOING COLLECTION AND REVIEW OF DATA.

(C) c. coordination with the medical staff on action relative to the findings from the regular evaluation of the clinical use of drugs. (IC.1.2.9)

SPECIFIC REFERENCE IS MADE TO THE LACK OF COORDINATION WITH THE MEDICAL STAFF AND THERE IS MINIMAL REVIEW OF DRUGS.

52. An effective hospitalwide infection control program includes elements that may be implemented to varying degrees depending on the hospital and the services provided. (IC.1.3)

(C) a. These elements include: (IC.1.3.1)

(C) 1. the institution of antibiotic susceptibility/resistance trend studies as appropriate. (IC.1.3.1.4)

(C) 2. consultation regarding the purchase of all equipment and supplies used for sterilization, disinfection, and decontamination purposes. (IC.1.3.1.5)

(C) 3. the periodic review of cleaning procedures, agents, and schedules in use throughout the hospital, and consultation regarding any major change in cleaning products or techniques. (IC.1.3.1.6)

(C) 4. the monitoring of all findings from any patient care quality assessment activities that relate to infection control. (IC.1.3.1.7)

IT WAS NOTED THAT FOR STANDARDS IC.1.3.1, IC.1.3.1.4-IC.1.3.1.7: THESE ACTIVITIES HAVE NOT BEEN ADDRESSED.

53. The infection control committee determines the type of surveillance and reporting programs to be used. (IC.2.5)

(C) a. The committee recommends corrective action based on records and reports of infections and infection potential among patients and hospital personnel. (IC.2.5.3)

IT WAS NOTED THAT ALTHOUGH CORRECTIVE ACTIONS HAVE BEEN DOCUMENTED BY THE INFECTION CONTROL NURSE FOR THE 10 MONTHS PRIOR TO SURVEY, THESE ACTIONS WERE NOT REFLECTED IN THE INFECTION CONTROL COMMITTEE MINUTES. IN ADDITION, THE MINUTES ADDRESSED A PROBLEM REGARDING THE LACK OF DOCUMENTATION OF WHAT IS BEING DONE WHEN POSITIVE CULTURES ARE IDENTIFIED IN URINALYSIS TESTS. FURTHER, THERE WAS A LACK OF DOCUMENTATION THAT THESE POSITIVE CULTURES WERE BEING TREATED.

54. In assessing the effectiveness of the hospital infection control program, the infection control committee reviews: (IC.2.10)

(C) a. the results of any antimicrobial susceptibility/resistance trend studies. (IC.2.10.3)

SPECIFIC REFERENCE IS MADE TO THE LACK OF IMPLEMENTATION.

(C) b. proposals and protocols for all special infection control studies to be conducted throughout the hospital, and any subsequent findings. (IC.2.10.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF IMPLEMENTATION.

55. There are specific written infection control policies and procedures for all services throughout the hospital. (IC.3)

a. The written policies and procedures are developed in cooperation with: (IC.3.3)

1. the dietetic department/service. (IC.3.3.5)

IT WAS NOTED THAT THE DIETETIC POLICY DOES NOT ADDRESS THE COMMUNITY KITCHEN ON THE FORENSIC UNIT WHERE PATIENTS MAY COOK FOR EACH OTHER.

2. the pharmaceutical department/service. (IC.3.3.12)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A POLICY THAT ADDRESSES THE PHARMACEUTICAL SERVICE.

3. the radiology department/service. (IC.3.3.13)

4. the respiratory care department/service. (IC.3.3.14)

SPECIFIC REFERENCE IS MADE TO THE LACK OF SUCH POLICIES.

5. the rehabilitation service. (IC.3.3.15)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A POLICY THAT ADDRESSES PHYSICAL THERAPY.

6. the support services, including central services, housekeeping, laundry, and engineering and maintenance. (IC.3.3.17)

SPECIFIC REFERENCE IS MADE TO THE LACK OF POLICIES FOR ENGINEERING AND MAINTENANCE SERVICES.

7. the surgical suite: (IC.3.3.18)

a. Specific policies and procedures relate to protective clothing and drapes, sterilization techniques, management of septic cases, routine cleaning techniques, and handling of materials. (IC.3.3.18.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF POLICIES THAT ADDRESS THE MEDICAL CLINICS WERE PATIENT EXAMS ARE CONDUCTED.

(C) 56. Specific written guidelines are available for all personnel involved with procedures that are commonly used in patient care and known to be associated with nosocomial infection potential. (IC.3.4)

a. Example(s) of such procedures include: (IC.3.4.1)

(C) 1. the use of thermometers. (IC.3.4.1.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A POLICY THAT ADDRESSES THERMOMETERS.

(C) 57. There are written guidelines for the selection, storage, handling, use, and disposition of disposable items. (IC.3.5)

SPECIFIC REFERENCE IS MADE TO THE LACK OF WRITTEN GUIDELINES.

58. Central services is provided with adequate direction, staffing, and facilities to perform all required functions. (IC.4)

a. There are written policies and procedures for the decontamination and sterilization activities performed in central services and elsewhere in the hospital, and for related requirements. (IC.4.5)

1. These policies and procedures relate to: (IC.4.5.1)

a. the recall and disposal or reprocessing of outdated sterile supplies. (IC.4.5.1.7)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A WRITTEN POLICY AND PROCEDURE ADDRESSING THE RECALL AND DISPOSAL OF OUTDATED STERILE SUPPLIES.

59. Steam and hot-air sterilizers are tested with live bacterial spores at least weekly. (IC.4.9)

IT WAS NOTED THAT BIOLOGICAL TESTING OF HOT AIR STERILIZERS ARE NOT TESTED FOR SEVERAL PERIODS UP TO 14 DAYS IN THE YEAR PRIOR TO SURVEY.

(+) 60. The housekeeping service is provided with adequate direction, staffing, and facilities to perform all required functions. (IC.5)

IT WAS NOTED THAT HOUSEKEEPING STAFF ARE NOT SCHEDULED FOR WEEKENDS. IT WAS NOTED THAT NURSING SERVICES PERFORMS HOUSEKEEPING DUTIES ON THE WEEKENDS.

a. To guide personnel in providing a hygienic environment for patients and staff, departmental procedures are developed for: (IC.5.5)

1. the maintenance of liaison with the infection control committee to determine appropriate action based on the results of any microbiological evaluations performed. (IC.5.5.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

61. There is an adequate supply of clean linen that is handled and stored in such a way as to minimize contamination from surface contact or airborne deposition. (IC.6.3)

IT WAS NOTED THAT CLEAN LINEN ARE UNPROTECTED WHILE STORED IN PATIENT CORRIDORS.

62. Soiled linen is collected in such a manner as to minimize microbial dissemination into the environment. (IC.6.4)

IT WAS NOTED THAT SEVERAL SOILED LINEN HAMPERS WERE OBSERVED TO BE NEXT TO UNPROTECTED CLEAN LINEN.

MANAGEMENT AND ADMINISTRATIVE SERVICES

63. The chief executive officer, through the management and administrative staff, provides for personnel policies and practices that pertain to: (MA.1.5)

a. a periodic performance evaluation, based on a job description, of each employee. (MA.1.5.5)

IT WAS NOTED THAT PERFORMANCE EVALUATIONS ARE NOT BASED ON JOB DESCRIPTIONS.

MEDICAL RECORD SERVICES

(+) 64. Inpatient medical records include: (MR.2.2)

(+) a. the report of the physical examination. (MR.2.2.3)

(+) 1. The report reflects a comprehensive current physical assessment. (MR.2.2.3.1)

IT WAS NOTED THAT PELVIC AND RECTAL EXAMS WERE NOT CONDUCTED OR DEFERRED IN 4 OF 11 RECORDS REVIEWED. IN ADDITION, THERE WAS A LACK OF DOCUMENTATION OF THE REASON FOR NOT CONDUCTING A PELVIC AND RECTAL EXAM.

(+) b. progress notes made by the medical staff. (MR.2.2.9)

IT WAS NOTED THAT THERE IS MINIMAL DOCUMENTATION OF THE PATIENT'S PHYSICAL PROBLEMS.

(+) c. conclusions at termination of hospitalization. (MR.2.2.15)

(+) 1. The clinical resume concisely recapitulates the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, as pertinent. (MR.2.2.15.3)

(+) a. Consideration is given to instructions relating to physical activity, medication, diet, and follow-up care. (MR.2.2.15.3.1)

IT WAS NOTED THAT ALTHOUGH CLINICAL RESUMES ADDRESS THE PATIENT'S MEDICATIONS, THERE IS A LACK OF DOCUMENTATION OF THE INSTRUCTIONS GIVEN TO THE PATIENT REGARDING THE MEDICATIONS AND THE PATIENT'S ACTIVITY LEVEL.

MEDICAL STAFF

(+) 65. Medical staff bylaws include provisions for: (MS.2.4)

(+) a. fair-hearing and appellate review mechanisms, which may differ for medical staff members and other individuals holding clinical privileges and for applicants for such membership or privileges. (MS.2.4.2)

IT WAS NOTED THAT THERE IS NO FAIR HEARING AND APPELLATE REVIEW MECHANISM.

(+) b. mechanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's medical staff membership and/or clinical privileges. (MS.2.4.3)

IT WAS NOTED THAT THERE ARE NO MECHANISMS FOR CORRECTIVE ACTION AND INDICATIONS FOR AUTOMATIC AND SUMMARY SUSPENSION OF AN INDIVIDUAL'S MEDICAL STAFF MEMBERSHIP AND/OR CLINICAL PRIVILEGES.

(C) 66. The written policies assure appropriate physician involvement in and approval of the multidisciplinary treatment plan. (MS.2.6.4.1)

IT WAS NOTED THAT THE WRITTEN POLICIES DO NOT REQUIRE APPROPRIATE INVOLVEMENT OF THE PHYSICIAN IN THE MULTIDISCIPLINARY TREATMENT PLANNING PROCESS.

(C) 67. Each clinical department or major clinical service (or medical staff, for a nondepartmentalized medical staff) holds monthly meetings to consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. (MS.3.7)

IT WAS NOTED THAT ALTHOUGH THE MEDICAL STAFF MEETS EACH WEEK, THEY MAINLY ADDRESS ADMINISTRATIVE ISSUES.

(C) a. A record that includes the resultant conclusions, recommendations, and actions taken is maintained. (MS.3.7.2)

IT WAS NOTED THAT THERE IS INADEQUATE DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

(C) 68. Responsibilities of department chairmen are specified in the medical staff bylaws and rules and regulations. (MS.3.9)

IT WAS NOTED THAT THE RESPONSIBILITIES OF THE MEDICAL STAFF AND/OR THE CLINICAL DIRECTOR'S ARE NOT SPECIFIED IN THE MEDICAL STAFF BYLAWS, RULES AND REGULATIONS.

(C) 69. There is a mechanism to assure the same level of quality of patient care by all individuals with delineated clinical privileges, within medical staff departments, across departments/services, and between members and nonmembers of the medical staff who have delineated clinical privileges. (MS.3.11)

SPECIFIC REFERENCE IS MADE TO THE LACK OF SUCH A MECHANISM.

70. Professional criteria specified in the medical staff bylaws and uniformly applied to all applicants for delineated clinical privileges constitute the basis for granting clinical privileges. (MS.4.2.2)

(C) a. The criteria include, at the least, evidence of current licensure, relevant training and/or experience, current competence, and health status. (MS.4.2.2.2)

IT WAS NOTED THAT A PRACTITIONER'S CURRENT COMPETENCE AND RELEVANT TRAINING ARE NOT ADDRESSED IN THE PRIVILEGING PROCESS.

71. Privileges are related to: (MS.4.2.7.3.3)

(C) a. an individual's documented experience in categories of treatment areas or procedures. (MS.4.2.7.3.3.1)

(C) b. the results of treatment. (MS.4.2.7.3.3.2)

(C) 72. When privilege delineation is based primarily on experience, the individual's credentials record reflects the specific experience and successful results that form the basis for the granting of privileges. (MS.4.2.7.3.4)

IT WAS NOTED THAT ALL PRIVILEGES ARE GENERAL FOR MEDICAL/PSYCHIATRIC CARE AND THERE IS A CHECKLIST FOR SPECIAL MODALITIES. THESE PRIVILEGES ARE NOT RELATED TO THE PRACTITIONER'S EXPERIENCES OR THE RESULTS OF TREATMENT.

(M) 73. The reappraisal includes information concerning the individual's professional performance, judgment, and clinical/technical skills, as indicated by the results of quality assurance activities. (MS.5.3.1)

IT WAS NOTED THAT QUALITY ASSURANCE FINDINGS ARE NOT CONSISTENTLY USED IN THE REAPPOINTMENT/REPRIVILEGING PROCESS.

74. <u>Monitoring and Evaluation of the Quality and Appropriateness of Patient Care Provided by All Individuals with Clinical Privileges</u>

(+) a. Departmental or medical staff monitoring and evaluation encompass all major clinical activities of the department. (MS.6.1.1.2)

IT WAS NOTED THAT MONITORING AND EVALUATION ACTIVITIES MAINLY ADDRESS STATISTICAL ISSUES, RATHER THAN CLINICAL ASPECTS OF CARE.

b. Departmental or medical staff monitoring and evaluation include: (MS.6.1.1.3)

(C) 1. the routine collection of information about important aspects of patient care provided in the department and about the clinical performance of its members. (MS.6.1.1.3.1)

(C) 2. the periodic assessment of this information to identify opportunities to improve care and to identify important problems in patient care. (MS.6.1.1.3.2)

IT WAS NOTED THAT ONLY STATISTICAL INFORMATION IS COLLECTED AND THIS INFORMATION HAS NOT BEEN ADEQUATELY ASSESSED.

c. When important problems in patient care and clinical performance or opportunities to improve care are identified: (MS.6.1.1.4)

(C) 1. actions are taken; and (MS.6.1.1.4.1)

(C) 2. the effectiveness of the actions taken is evaluated. (MS.6.1.1.4.2)

(C) d. The findings from and conclusions of monitoring, evaluating, and problem-solving activities are documented and reported monthly. (MS.6.1.1.5)

SPECIFIC REFERENCE IS MADE TO INADEQUATE DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

75. Drug Usage Evaluation

(M) a. Drug usage evaluation is performed by the medical staff as a criteria-based, ongoing, planned and systematic process for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs to help assure that they are provided appropriately, safely, and effectively. (MS.6.1.3.1)

IT WAS NOTED THAT ALTHOUGH THE ORGANIZATION CONDUCTS A DIFFERENT DRUG STUDY EACH MONTH, THE PROPHYLACTIC, THERAPEUTIC AND EMPERIC USE OF DRUGS IS NOT ADEQUATELY ADDRESSED AND THERE IS A LACK OF DOCUMENTATION OF THE OPPORTUNITIES TO IMPROVE CARE.

(M) 1. This process includes the routine collection and assessment of information in order to identify opportunities to improve the use of drugs and to resolve problems in their use. (MS.6.1.3.1.1)

(M) b. There is ongoing monitoring and evaluation of selected drugs that are chosen because: (MS.6.1.3.2)

(M) 1. based on clinical experience, it is known or suspected that the drug causes adverse reactions or interacts with another drug (or drugs) in a manner that presents a significant health risk. (MS.6.1.3.2.1)

IT WAS NOTED THAT LITHIUM HAS NOT BEEN REVIEWED EVEN THOUGH IT IS THE HIGHEST RISK AND HIGHEST VOLUME DRUG USED.

c. The process for monitoring and evaluating the use of drugs: (MS.6.1.3.3)

(M) 1. is performed by the medical staff in cooperation with, as required, the pharmaceutical department/service, the nursing department/service, management and administrative staff, and other departments/services and individuals. (MS.6.1.3.3.1)

IT WAS NOTED THAT THE STUDIES ARE CONDUCTED BY THE PHARMACIST WITH REPORTS GOING TO THE CLINICAL DIRECTORS AND MINIMAL OR NO INVOLVEMENT OF OTHER SERVICES.

(M) d. Written reports of the findings, conclusions, recommendations, actions taken, and results of actions taken are maintained and reported at least quarterly through channels established by the medical staff. (MS.6.1.3.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

76. The Medical Record Review Function

(C) a. Written reports of conclusions, recommendations, actions taken, and the results of actions are maintained. (MS.6.1.4.4)

SPECIFIC REFERENCE IS MADE TO INADEQUATE DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN. FOR EXAMPLE, DOCUMENTATION OFTEN ONLY STATED "REPORTED TO ADMINISTRATION" OR "CONTINUE TO MONITOR" WITHOUT EVIDENCE OF FOLLOW-UP ACTIONS.

77. The Pharmacy and Therapeutics Function

a. The pharmacy and therapeutics monitoring function includes: (MS.6.1.6.2)

(C) 1. the definition and review of all significant untoward drug reactions. (MS.6.1.6.2.4)

IT WAS NOTED THAT A DEFINITION OF UNTOWARD DRUG REACTIONS WAS DEVELOPED 3 MONTHS PRIOR TO SURVEY. IT WAS NOTED THAT 9 UNTOWARD DRUG REACTIONS HAVE BEEN REPORTED BUT HAVE NOT BEEN REVIEWED BY THE PHARMACY AND THERAPEUTICS FUNCTION.

NURSING SERVICES

78. The nursing department/service is organized to assure that nursing management functions are effectively fulfilled. (NR.3.3)

a. Nursing management functions include: (NR.3.3.1)

(C) 1. reviewing and approving policies and procedures that relate to the qualifications and employment of nursing department/service members. (NR.3.3.1.1)

IT WAS NOTED THAT NURSING MANAGEMENT DO NOT REVIEW POLICIES RELATED TO THE QUALIFICATIONS OF EMPLOYEES.

2. establishing standards of nursing care and mechanisms for evaluating such care. (NR.3.3.1.2)

IT WAS NOTED THAT ALTHOUGH STANDARDS OF CARE HAVE BEEN DEVELOPED, THEY HAVE NOT YET BEEN UTILIZED TO EVALUATE CARE.

79. Job descriptions for each position classification of registered nurses and other nursing personnel specify standards of performance and delineate the functions, responsibilities, and specific qualifications of each classification. (NR.3.7)

80. Job descriptions are reviewed periodically and revised as needed to reflect current job requirements. (NR.3.7.2)

IT WAS NOTED THAT JOB DESCRIPTIONS DO NOT IDENTIFY ALL OF THE RESPONSIBILITIES OF A PATICULAR POSITION AND ARE NOT EVALUATED ON AN ANNUAL BASIS. IN ADDITION, EACH UNIT DIRECTOR DEVELOPS THEIR OWN JOB DESCRIPTIONS WITHOUT COORDINATION WITH THE NURSING ADMINISTRATOR.

81. A written evaluation of the performance of registered nurses and other nursing personnel is made at the end of the probationary period and at a defined interval thereafter. (NR.3.8)

(C) a. The evaluation is criteria based and relates to the standards of performance specified in the individual's job description. (NR.3.8.1)

IT WAS NOTED THAT PERFORMANCE EVALUATIONS ARE NOT CRITERIA BASED.

(C) 82. Nursing department/service assignments in the provision of nursing care are commensurate with the qualifications of nursing personnel and are designed to meet the nursing care needs of patients. (NR.4)

(C) 83. A sufficient number of qualified registered nurses are on duty at all times to give patients the nursing care that requires the judgment and specialized skills of a registered nurse. (NR.4.1)

IT WAS NOTED THAT THERE IS INSUFFICIENT REGISTERED NURSING STAFF. FOR EXAMPLE, 3 WEEKS OF STAFFING WERE REVIEWED WHICH COMPRISED OF 168 SHIFTS. 18 OF 168 SHIFTS REVIEWED THE WEEK OF AUGUST 2, 1987 LACKED REGISTERED NURSE COVERAGE, 33 OF 168 SHIFTS REVIEWED THE WEEK OF DECEMBER 27, 1987 LACKED REGISTERED NURSE COVERAGE AND 30 OF 168 SHIFTS REVIEWED THE WEEK OF OCTOBER 2, 1988 LACKED REGISTERED NURSE COVERAGE AS PER THE ORGANIZATION'S STAFFING PLAN. POST INTERVIEW INFORMATION: THE ORGANIZATION HAS BEEN ALLOCATED A LARGE AMOUNT OF MONEY IN ORDER TO HIRE NURSING STAFF. VACANCIES STAILL EXIST BUT THE ORGANIZATION IS TRYING TO FILL THE VACANCIES.

(C) 84. Nursing personnel staffing also is sufficient to assure prompt recognition of any untoward change in a patient's condition and to facilitate appropriate intervention by the nursing, medical, or hospital staffs. (NR.4.2)

IT WAS NOTED THAT THERE IS INSUFFICIENT NURSE STAFFING TO ASSURE PROMPT RECOGNITION OF UNTOWARD CHANGES IN THE PATIENT'S CONDITION. STAFFING ON THE UNITS MAINLY COMPRISES OF MENTAL HEALTH WORKERS WHO ARE NOT BEING SUPERVISED BY A REGISTERED NURSE ACCORDING TO THE ORGANIZATIONS OWN POLICY.

85. To assure quality nursing care and a safe patient environment, nursing personnel staffing and assignment are based on: (NR.4.3)

(C) a. A registered nurse plans, supervises, and evaluates the nursing care of each patient. (NR.4.3.1)

IT WAS NOTED THAT THERE IS ONE REGISTERED NURSE SUPERVISOR ON EACH SHIFT TO COVER 350 PATIENTS IN 9 UNITS AND 3 SEPARATE BUILDINGS. REGISTERED NURSES ARE SUPPOSED TO BE SUPERVISING MENTAL HEALTH WORKERS AND THE ADMINISTRATION OF MEDICATIONS BY THE MENTAL HEALTH WORKERS. THIS POLICY IS NOT BEING FOLLOWED.

(C) b. The patient care assignment is commensurate with the qualifications of each nursing staff member, the identified nursing needs of the patient, and the prescribed medical regimen. (NR.4.3.4)

IT WAS NOTED THAT THE PATIENT ASSIGNMENT SYSTEM DOES NOT COMMENSURATE WITH THE QUALIFICATIONS OF EACH NURSING STAFF MEMBERS AND THE IDENTIFIED NEEDS OF THE PATIENTS. THERE ARE ACUTELY ILL PATIENTS WHO ARE TAKING CARDIAC, HYPERTENSIVE AND PSYCHOTROPIC MEDICATIONS. THESE PATIENTS ARE ADMINISTERED THESE MEDICATIONS AND MONITORED BY MENTAL HEALTH WORKERS WHO ARE NOT BEING SUPERVISED BY A REGISTERED NURSE OR A PHYSICIAN AS SPECIFIED IN THE ORGANIZATION'S OWN POLICY.

(C) 86. The nursing department/service defines, implements, and maintains a system for determining patient requirements for nursing care on the basis of demonstrated patient needs, appropriate nursing intervention, and priority for care. (NR.4.4)

IT WAS NOTED THAT THE ORGANIZATION DEVELOPED AN ACUITY SYSTEM SIX MONTHS PRIOR TO SURVEY AND THE NEW SYSTEM DETERMINED THAT THE ORGANIZATION WAS UNDERSTAFFED BY 54.6 REGISTERED NURSE FULL TIME EQUIVILENTS AND 42.9 NONREGISTERED NURSING EQUIVILENTS.

(C) 87. Specific nursing personnel staffing for each nursing care unit, including, as appropriate, the surgical suite, obstetrical suite, ambulatory care department/service, and emergency department/service, are commensurate with the patient care requirements, staff expertise, unit geography, availability of support services, and method of patient care delivery. (NR.4.4.1)

IT WAS NOTED THAT NURSING STAFF ARE REQUIRED TO DO MANY NON-NURSING FUNCTIONS SUCH AS HOUSEKEEPING ON THE WEEKENDS, NURSING STAFF FILL IN FOR DIETARY WHEN THEY ARE SHORT STAFFED AND REGISTERED NURSES ARE RETRIEVING ALL OF THE QUALITY ASSURANCE DATA FOR ALL DISCIPLINES.

(C) 88. Individualized, goal-directed nursing care is provided to patients through the use of the nursing process. (NR.5)

(C) 89. The nursing process (assessment, planning, intervention, evaluation) is documented for each hospitalized patient from admission through discharge. (NR.5.1)

IT WAS NOTED THAT THE NURSING PROCESS IS ONLY EVIDENT AT THE TIME OF ADMISSION, AFTER ADMISSION THE NURSING PROCESS IS NOT ADEQUATELY DOCUMENTED.

(C) 90. Each patient's nursing needs are assessed by a registered nurse at the time of admission or within the period established by nursing department/service policy. (NR.5.2)

IT WAS NOTED THAT A REGISTERED NURSE DOES NOT ASSESS A PATIENT'S NURSING NEEDS IN APPROXIMATELY 50 PERCENT OF THE 30 RECORDS REVIEWED.

(C) 91. A registered nurse plans each patient's nursing care. (NR.5.3)

IT WAS NOTED THAT REGISTERED NURSES ONLY PLAN EACH PATIENTS INITIAL NURSING CARE WITH MINIMAL DOCUMENTATION THAT THEY PLAN SUBSEQUENT NURSING CARE.

a. Whenever possible, nursing goals are mutually set with the patient and/or family. (NR.5.3.1)

IT WAS NOTED THAT NURSING GOALS ARE NOT MUTUALLY SET WITH THE PATIENT AND/OR FAMILY IN 75 PERCENT OF THE 30 RECORDS REVIEWED.

(C) b. Nursing goals are based on the nursing assessment and are realistic, measurable, and consistent with the therapy prescribed by the responsible medical practitioner. (NR.5.3.2)

IT WAS NOTED THAT NURSING GOALS WERE NOT WRITTEN IN MEASURABLE TERMS AND WERE NOT REALISTIC IN APPROXIMATELY 50 PERCENT OF THE 30 RECORDS REVIEWED.

92. Patient education and patient/family knowledge of self-care are given special consideration in the nursing plan. (NR.5.4)

IT WAS NOTED THAT PATIENT EDUCATION WAS NOT ADDRESSED IN 90 PERCENT OF THE 30 RECORDS REVIEWED.

93. The plan of care is documented and reflects current standards of nursing practice. (NR.5.5)

(C) a. As appropriate, such measures include physiological, psychosocial, and environmental factors; patient/family education; patient discharge planning. (NR.5.5.2)

IT WAS NOTED THAT A PATIENT'S PHYSIOLOGICAL NEEDS WERE NOT ADDRESSED IN 50 PERCENT OF THE 30 RECORDS REVIEWED, PATIENT/FAMILY EDUCATION IS NOT ADDRESSED IN 90 PERCENT OF THE 30 RECORDS REVIEWED, INFECTION CONTROL ISSUES WERE NOT ADDRESSED IN 90 PERCENT OF THE 30 RECORDS REVIEWED AND DISCHARGE PLANNING NEEDS WERE NOT ADDRESSED IN 75 PERCENT OF THE 30 RECORDS REVIEWED.

(C) b. The scope of the plan is determined by the anticipated needs of the patient and is revised as the needs of the patient change. (NR.5.5.3)

IT WAS NOTED THAT THE SCOPE OF THE CARE PLAN IS NOT REVISED WHEN THE PATIENT'S NEEDS CHANGED IN 50 PERCENT OF THE 30 RECORDS REVIEWED. FOR EXAMPLE, 12 OF THE 30 RECORDS REVIEWED PATIENT'S EXPERIENCED HYPERTENSIVE EPISODES, EDEMA OF THE FEET, CELLULITIS, AND EXTREME BEHAVIOR PROBLEMS WHICH REQUIRED 5 POINT RESTRAINTS. IN ADDITION, ONE PATIENT HAD TB WITHOUT A CLEAR DETERMINATION AS TO THE STATUS OR NEED FOR ISOLATION.

(C) 94. Documentation of nursing care is pertinent and concise and reflects patient status. (NR.5.6)

IT WAS NOTED THAT NURSING DOCUMENTATION DOES NOT CONSISTENTLY REFLECT THE PATIENT'S STATUS IN 50 PERCENT OF THE 30 RECORDS REVIEWED.

(C) a. Nursing documentation addresses the patient's needs, problems, capabilities, and limitations. (NR.5.6.1)

(C) b. Nursing intervention and patient response are noted. (NR.5.6.2)

IT WAS NOTED THAT DAILY HYGIENE AND ORAL CARE ARE NOT DOCUMENTED. IN ADDITION, NURSING INTERVENTIONS ARE NOT CONSISTENTLY DOCUMENTED.

c. When a patient is transferred within or discharged from the hospital, a nurse notes the patient's status in this medical record. (NR.5.6.3)

IT WAS NOTED THAT THE PATIENT'S STATUS AT DISCHARGE WAS ONLY DOCUMENTED IN 1 OF 3 CLOSED RECORDS REVIEWED.

d. As appropriate, patients who are discharged from the hospital requiring nursing care receive instructions and individualized counseling prior to discharge. (NR.5.6.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION IN ALL 3 RECORDS REVIEWED.

1. Evidence of the instructions and the patient's or family's understanding of these instructions is noted in the patient's medical record. (NR.5.6.4.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

(+) 95. Nursing department/service policies and procedures relate to: (NR.7.2)

(+) a. the assignment of nursing care consistent with patient needs, as determined by the nursing process. (NR.7.2.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF SUCH A POLICY.

(+) b. medication administration. (NR.7.2.3)

SPECIFIC REFERENCE IS MADE TO THE LACK OF SUCH A POLICY.

(+) c. the role of the nursing staff in patient and family education. (NR.7.2.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF SUCH A POLICY.

(+) d. the maintenance of required records, reports, and statistical information. (NR.7.2.7)

IT WAS NOTED THAT THESE ACTIVITIES ARE NOT ADDRESSED IN AA POLICY.

96. Additional policies and procedures are usually required for units in which special care is provided. (NR.7.3)

IT WAS NOTED THAT NURSING STAFF CONDUCT RESPIRATORY THERAPY BUT THE POLICY REGARDING OXYGEN ADMINISTRATION IS INCOMPLETE AND THERE IS NO POLICY ADDRESSING IPPB TREATMENTS WHICH ARE OCCASIONALLY DONE BY NURSING STAFF.

(+) 97. The quality and appropriateness of patient care are monitored and evaluated in all major clinical functions of the nursing department/service. (NR.8.2)

IT WAS NOTED THAT MAINLY MANAGEMENT FUNCTIONS ARE MONITORED AND EVALUATED, RATHER THAN CLINICAL ASPECTS OF CARE.

98. Such monitoring and evaluation are accomplished through: (NR.8.2.1)

(C) a. routine collection in the nursing department/service, or through the hospital's quality assurance program, of information about important aspects of nursing care. (NR.8.2.1.1)

(C) b. periodic assessment by the nursing department/service of collected information in order to identify important problems in patient care and opportunities to improve care. (NR.8.2.1.2)

IT WAS NOTED THAT THE INFORMATION COLLECTED AND ASSESSED MAINLY RELATE TO ADMINISTRATIVE ISSUES.

99. When important problems in patient care or opportunities to improve care are identified: (NR.8.3)

(C) a. actions are taken; and (NR.8.3.1)

(C) b. the effectiveness of the actions taken is evaluated. (NR.8.3.2)

(C) 100. The findings from and conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (NR.8.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OR INADEQUATE DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

(C) 101. As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities in the nursing department/service is evaluated. (NR.8.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

PHARMACEUTICAL SERVICES

102. The director of the pharmaceutical department/service is responsible for: (PH.3.3)

(+) a. assuring the monitoring and evaluation, with medical staff input, of the quality and appropriateness of patient services provided by the pharmaceutical department/service. (PH.3.3.12)

(+) b. participating in those aspects of the hospital's overall quality assurance program that relate to drug utilization and effectiveness. (PH.3.3.13)

SPECIFIC REFERENCE IS MADE TO MINIMAL DOCUMENTATION.

103. Written policies and procedures include the following: (PH.5.2)

(+) a. Medication errors and adverse drug reactions are reported immediately in accordance with written procedures. (PH.5.2.6)

IT WAS NOTED THAT ALTHOUGH SEVERAL CASES OF ADVERSE DRUG REACTIONS HAVE BEEN REPORTED SINCE THIS POLICY WAS INSTITUTED A FEW MONTHS PRIOR TO SURVEY, THERE IS A LACK OF DOCUMENTATION OF AN INVESTIGATION AND REVIEW OF THESE INCIDENTS.

104. When important problems in patient care services or opportunities to improve care are identified: (PH.6.3)

(C) a. actions are taken; and (PH.6.3.1)

(C) b. the effectiveness of the actions taken is evaluated. (PH.6.3.2)

(C) 105. The findings from and conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (PH.6.4)

SPECIFIC REFERENCE IS MADE TO INADEQUATE DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN. IN ADDITION, FOLLOW-UP ACTIONS ARE NOT DOCUMENTED.

(C) 106. As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities in the pharmaceutical department/service is evaluated. (PH.6.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

PHYSICAL REHABILITATION SERVICES

107. In the organization of the physical rehabilitation service or services: (RH.1.1)

(+) a. A sufficient number of qualified, competent professional and support personnel are available to meet the objectives of the service and the needs the of patient population. (RH.1.1.8)

SPECIFIC REFERENCE IS MADE TO INSUFFICIENT STAFF COVERAGE BY PHYSICAL THERAPISTS.

108. In the process of providing for any physical rehabilitation service to patients: (RH.1.2)

a. A treatment plan is developed based on the functional assessment and evaluation of the patient, unless he is being referred to a single service as an outpatient. (RH.1.2.3)

(+) 1. The patient and the family participate as appropriate in the development and implementation of the treatment plan. (RH.1.2.3.1)

IT WAS NOTED THAT FAMILY MEMBERS ARE RARELY INVOLVED IN THE THE DEVELOPMENT AND IMPLEMENTATION OF THE PATIENT'S TREATMENT PLAN.

109. Such monitoring and evaluation are accomplished through: (RH.4.2.1)

(C) a. routine collection in the comprehensive physical rehabilitation program or unit or rehabilitation service(s), or through the hospital's quality assurance program, of information in order to identify important problems in patient care and opportunities to improve care. (RH.4.2.1.1)

(C) b. periodic assessment by the comprehensive physical rehabilitation program or unit or by the rehabilitation service(s) of collected information in order to identify important problems in patient care and opportunities to improve care. (RH.4.2.1.2)

IT WAS NOTED THAT THERE IS MINIMAL DOCUMENTATION OF THE ROUTINE COLLECTION AND PERIODIC ASSESSMENT OF PATIENT CARE INFORMATION.

110. When important problems in patient care or opportunities to improve care are identified: (RH.4.3)

(C) a. actions are taken; and (RH.4.3.1)

(C) b. the effectiveness of the actions taken is evaluated. (RH.4.3.2)

(C) 111. The findings from and conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (RH.4.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

(C) 112. As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities in the comprehensive physical rehabilitation program or unit or in the rehabilitation service(s) is evaluated. (RH.4.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

PLANT, TECHNOLOGY, AND SAFETY MANAGEMENT

113. Building

(C) a. Buildings in which patients are housed overnight or receive treatment are in compliance with the provisions of the 1981 edition of the Life Safety Code of the National Fire Protection Association (NFPA). (PL.1.1)

The Life Safety Code recommendations contained in this report are based upon a survey technique of sampling. Where a specific reference is indicated, that is where the surveyor noted a problem. It is expected that the organization, as a part of its Life Safety Management program, will conduct a self-survey to ascertain that all areas of the physical plant are in compliance with the specific Life Safety Code requirement.

1. Residential Occupancies

(C) a. There are two remote approved exits on each floor. (NFPA 101, 1981: 20-2.1.1, 2.1.3) [RS.1A]

IT WAS NOTED THAT THERE IS ONLY ONE STAIRWELL IN THE BURLEIGH ANNEX AND THE NORTON HOUSE BUILDINGS.

114. General Safety

(C) a. The hospital has a system that is designed to provide a safe environment for patients, personnel, and visitors and that is designed to monitor that environment. (PL.3)

IT WAS NOTED THAT THERE ARE PIPES HANGING FROM THE CEILINGS THROUGHOUT THE BUILDINGS WHICH ARE UNPROTECTED AND PROVIDE A HAZARD IN THAT TWO SUICIDES HAVE BEEN SUCCESSFUL BECAUSE OF THESE PIPES. POST INTERVIEW INFORMATION: THE ORGANIZATION IS STILL IN THE PROCESS OF ENCLOSING PIPES.

b. The safety system addresses: (PL.3.1)

(C) 1. the promotion and maintenance of an ongoing, hospitalwide hazard surveillance program to detect and report all safety hazards related to patients, visitors, and personnel. (PL.3.1.2)

(C) a. This hazard surveillance program includes a policy for responding to medical-device recalls and hazard notices from government agencies and manufacturers. (PL.3.1.2.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ONGOING HAZARD SURVEILLANCE PROGRAM EXCEPT FOR AN INCIDENT REPORTING SYSTEM.

(C) 2. methods for monitoring the results of the safety program (see Standard PL.3, Required Characteristic PL.3.2, of the "Plant, Technology, and Safety Management" chapter of the Accreditation Manual for Hospitals) and for analyzing the program at least annually. (PL.3.1.5)

(C) a. To determine the safety program's effectiveness, the analysis includes a review all of pertinent records and reports. (PL.3.1.5.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

(C) c. The conclusions, recommendations, and actions of the safety committee are reported at least quarterly to the administrative, medical, and nursing staffs and others as appropriate. (PL.3.5.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

(C) d. There is evidence of information exchange and consultation between the safety committee and the various safety programs (for example, safety programs for engineering and maintenance, housekeeping, laboratory, nursing, and dietetic services), the infection control committee, the hospitalwide quality assurance function, and other standing committees. (PL.3.7)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

(C) e. There is evidence that the conclusions, recommendations, and actions of the safety committee are evaluated by the appropriate administrative directors of the areas affected and that proper action is documented in subsequent safety committee minutes. (PL.3.8)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

115. Education

a. The hospital has an organized safety education program. (PL.4)

1. There is evidence that the education programs are analyzed at least annually to determine their effectiveness. (PL.4.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

116. Emergency Preparedness

a. The role of the hospital in communitywide disaster plans is identified in the emergency preparedness program. (PL.5.3)

b. The emergency preparedness program addresses hospital preparedness, including space utilization, supplies, communication systems, security, and utilities. (PL.5.4)

(C) c. The emergency preparedness program addresses staff preparedness, including staffing requirements and the designation of roles and functions, particularly in terms of capabilities and limitations. (PL.5.5)

(C) d. The emergency preparedness program addresses patient management, including modified schedules, criteria for the cessation of nonessential services, and patient transfer determinations, particularly in terms of discharge and relocation. (PL.5.6)

IT WAS NOTED THAT FOR STANDARDS PL.5.3-PL.5.6: THE EMERGENCY PREPAREDNESS PROGRAM DOES NOT ADEQUATELY ADDRESS THESE ACTIVITIES.

(C) e. The emergency preparedness program is implemented, evaluated, and documented semiannually. (PL.5.7)

(C) 1. Each implementation (whether a drill or an actual emergency) exercises emergency preparedness plan elements related to hospital preparedness, staff preparedness, and patient management; at least one implementation includes an influx of patients from outside the hospital. (PL.5.7.1)

IT WAS NOTED THAT ONLY ONE DISASTER DRILL HAS BEEN CONDUCTED.

f. It is recommended that on each work shift the hospital have appropriately trained personnel responsible for assisting with the implementation of the fire plan and the activation of the nonautomatic components of the fire safety systems. (PL.5.8.1)

(C) g. The fire plan is implemented at least quarterly for each work shift of hospital personnel in each patient-occupied building. (PL.5.8.1.1)

(C) 1. Documentation of the implementation of the plan includes, at a minimum, problems identified during implementation, corrective actions taken, and staff participation. (PL.5.8.1.1.1)

IT WAS NOTED THAT FOR STANDARDS PL.5.8.1-PL.5.8.1.1.1: THE ORGANIZATION HAS NOT CONDUCTED FIRE DRILLS ON EACH SHIFT IN ALL BUILDINGS. IT WAS NOTED THAT LESS THAN 50 PERCENT OF THE REQUIRED DRILLS HAVE BEEN CONDUCTED.

h. The emergency preparedness program is evaluated annually and is updated as needed. (PL.5.10)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

117. Communication

(+) a. Appropriate maintenance for all equipment included in the communication systems is provided. (PL.8.2)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

(+) b. In those parts of the communication system where an equipment failure can have life-threatening consequences, the hospital has procedures for implementing an alternative means of communication. (PL.8.3.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

118. Electrically Powered Equipment

(C) a. The hospital has a program designed to assure that non-patient-care, electrically powered, line-operated equipment is electrically safe. (PL.10)

IT WAS NOTED THAT FOR STANDARDS PL.10-PL.10.4: THERE IS A LACK OF DOCUMENTATION OF AN ELECTRICALLY POWERED EQUIPMENT PROGRAM.

(C) b. There is a policy that identifies types of non-patient-care equipment that may pose an electrical hazard during intended use. (PL.10.1)

(C) c. Non-patient-care equipment identified by the policy is inspected prior to initial use and at intervals to determine electrical safety. (PL.10.2)

(C) 1. The intervals are determined by the requirements of the equipment. (PL.10.2.1)

(C) d. Documentation of inspections and appropriate corrective actions is maintained. (PL.10.3)

e. The safety committee develops and implements policies for the use and control of personal electrical equipment. (PL.10.4)

119. Electrical Distribution

(+) a. There is a program of preventive maintenance and periodic inspection designed to assure that the electrical distribution system operates safely and reliably. (PL.11.1)

1. Inspections and corrective actions are documented. (PL.11.1.1)

(C) b. periodic assessment by the social work department/service of the collected information in order to identify important problems in patient care services and opportunities to improve care. (SO.5.2.1.2)

IT WAS NOTED THAT INSUFFICIENT INFORMATION IS COLLECTED AND ASSESSED.

125. When important problems in patient care services or opportunities to improve care are identified: (SO.5.3)

(C) a. actions are taken. (SO.5.3.1)

(C) b. the effectiveness of the actions taken is evaluated. (SO.5.3.2)

(C) 126. The findings from and conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (SO.5.4)

SPECIFIC REFERENCE IS MADE TO MINIMAL DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

(C) 127. As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities in the social work department/service is evaluated. (SO.5.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

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SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF A PREVENTATIVE MAINTENANCE PROGRAM.

2. In identifying components of the electrical distribution system to be included in the program, consideration is given to the reliability of receptacles, electrical feeds, and transformers. (PL.11.2)

IT WAS NOTED THAT ELECTRICAL PANELS ARE NOT TESTED.

(+) b. There is a current set of documents that indicate the distribution of and controls for partial or complete shutdown of each electrical system. (PL.11.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

120. Safety Devices and Practices

a. In toilet and bathing areas serving patients, there are grab bars and similar safety devices. (PL.19.2)

IT WAS NOTED THAT THERE ARE NO GRAB BARS OR A CALL SYSTEM IN THE PATIENT TOILETS IN THE X-RAY AREA.

QUALITY ASSURANCE

(C) 121. There is a written plan for the quality assurance program that describes the program's objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities. (QA.1.3)

IT WAS NOTED THAT THE WRITTEN PLAN FOR QUALITY ASSURANCE IS DATED THE DAY BEFORE THE SURVEY. THEREFORE, THERE HAS BEEN INSUFFICIENT TIME FOR IMPLEMENTATION.

SOCIAL WORK SERVICES

(+) 122. Social work services are provided by a sufficient number of qualified personnel. (SO.1.9)

SPECIFIC REFERENCE IS MADE TO INSUFFICIENT STAFF COVERAGE BY SOCIAL WORKERS.

123. Education programs for social work department/service personnel are based, at least in part, on the findings from the monitoring and evaluation of the social work services provided. (SO.2.3.2)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

124. Such monitoring and evaluation are accomplished through: (SO.5.2.1)

(C) a. routine collection in the social work department/service, or through the hospital's quality assurance program, of information about important aspects of social work services. (SO.5.2.1.1)

MEMORANDUM

TO : William J. Thompson, Interim Superintendent AMHI

FROM : The Primary Care Study Group

SUBJECT: Primary Medical Care at AMHI

DATE : 09-12-89

A study group consisting of representatives from the hospitals in the consortium presently advising the Augusta Mental Health Institute (AMHI) was convened to address the following question:

How well is AMHI organized to meet its primary health care needs?

Procedure:

A preliminary meeting was held at AMHI and the charge of the committee as well as the general structure and function of the Augusta Mental Health Institute were reviewed. Arrangements were made to tour the facility and review several medical records. Basic demographic data including admissions, discharges, length of stay, patient characteristics and medical needs were also reviewed. After this, one day was spent interviewing individuals employed at AMHI. This included two physician extenders (P.A.'s), two primary care physicians, the psychiatrist working on the admission unit, the unit directors, Vera Gillis who works in nursing, and two representative from the patient advocate office. This report has been formulated following these interviews.

This report must, by necessity, be limited in its scope and is meant only to address the primary medical care needs at AHMI. To better interpret our recommendations, it is important to understand certain recent trends at AMHI. Until very recently, the number of admissions has been climbing. This has resulted in increased numbers of medical patients and the workload for all at the institute has subsequently increased. It is also likely that the number of patients admitted and evaluated with medical problems has increased. This is in part due to an increasing number of patients with geriatric problems. In addition, the institution recently lost JCAH accreditation and has been publicly scrutinized. Several patient deaths have been extensively investigated, morale has been low, and staffing has been barely adequate.

There have been several responses to the aforementioned difficulties and our understanding is that improvements have already been implemented. The difficulties arising from the high census, high admissions and low staffing have begun to be addressed. The Legislature has helped by granting new positions to the institution. The Bureau of Mental Health and Retardation has allocated special funding to be used to help divert patients from AMHI to other psychiatric facilities within the State. This has eased some of the pressure since the admission rate to AMHI has dropped from highs of greater than 120 patients a month to an average of about 60 patients per month at this time. Clearly, these are short-term answers and long-term solutions are being planned. Our recommendations are based on the assumption that the patient population and admission rates will stabilize with an average number of admissions approximating 60 per month. If these conditions do not hold true, then increases in medical staff will be needed in order to maximize

and ensure good medical care.

CONCLUSIONS AND RECOMMENDATIONS:

1) There is need for more aggressive leadership within the institution.

There should be a clinical director to oversee the overall health needs of the patient population and there should be a medical director to oversee the medical care. The clinical director should be a dynamic individual, able to integrate both psychiatric and medical care, and ideally would be board certified in psychiatry and internal medicine or family practice. This individual should have administrative capabilities and be a "people person" who can look for solutions to problems. The medical director also needs good administrative abilities and should report to the clinical director. It is important that both these individuals be interested in continuing education. If the clinical director does not have a strong primary care background, then the medical director's position becomes even more important. Clearly, the medical director and clinical director must be compatible and be able to communicate effectively.

2) The nursing administration should be reorganized and a nursing administrator position should be created. This individual should work closely with the clinical and medical director to establish standards of care.

Primary health care is vitally dependent on good and thorough nursing care. Therefore, there needs to be lines of communication between nursing and physicians. This could be better achieved by developing a nursing administration with direct lines of responsibility for the nursing department.

3) The number of primary care physicians should be increased.

Increasing the number of medical doctors would help to provide continuity of care. We feel that five primary care physicians will be needed to care for the medical needs of the patients admitted to AMHI. Medical evaluations should be available 24 hours a day. This will require the physicians to develop an on-call schedule for off hours and weekends. The off-hours coverage should either be on site or within 1/2 hour of the hospital so that quick response time is possible. In the future, if the workload or the acuity of the medical problems increases, it will be necessary to have 24 hour a day onsite coverage. The night time P.A.'s should not be on-call without easily available medical backup. Psychiatric on-call from home should also be available to the covering P.A.'s.

4) The Medical Service needs to be reorganized.

Daily rounds with an attempt to integrate medical and psychiatric care should be encouraged. These rounds would ideally occur in the separate units of the facility. They should involve individuals from nursing, the medical departments, including both physicians and physician extenders as well as psychiatrists. This could provide the framework for meaningful discussions between all caregivers responsible for each patient. To provide medical care in each of

the units would require providing rooms for examinations that are well equipped for basic medical care. The clinic would still function and be available for routine follow-up examinations and any other specialized problems. As part of this reorganization, more efficient charting systems, medication lists and problems lists should be developed for the medical charts.

5) Within the framework of a reorganized medical service, continuity of care and primary preventive medical care should be encouraged.

Patients presently have a yearly physical, but little is provided beyond this for preventive care. Patients from AMHI require close observation and follow-up. This is especially true on the "chronic ward". To provide appropriate follow-up, medical records will need to keep information centralized and easily available to the physicians and nurses so that health maintenance screens can be done.

6) Emergency medical care in off hours needs to be strengthened.

This would ideally be best accomplished by establishing better lines of communication between the Augusta Mental Health Institute and the Kennebec Valley Medical Center. The primary care physicians at AMHI should be qualified to be credentialed at Kennebec Valley Medical Center. The physicians could have admitting privileges so that they could follow their patients after admission for acute problems. For the same reasons, arrangements can be made to have lab work and x-rays available during off hours on an as needed basis. This could possibly be arranged by contract with Kennebec Valley Medical Center.

7) A physician directed quality assurance program needs to be developed.

Quality assurance is the key to providing quality medical care and is a requirement by JCAH and most other reviewers. Physicians need to be reviewing physician charts and actions within the hospital. Presently, physicians are only minimally involved and allow the nurses to do most of the quality assurance review. This is not acceptable to JCAH and should not be acceptable to the medical staff. As part of quality review, doctors privileges should be reviewed by a quality assurance and credentials committee and privileges should be granted using these reviews every two years.

8) Until a more structured quality assurance program is in place and functioning properly, outside peer review and quality assurance should continue.

9) There needs to be better integration of the psychiatric and medical care and this should be reflected within the charts.

This could be accomplished by establishing better communication between these disciplines and utilizing combined team conferences. Presently, the psychiatrist orders psychotropic medicines, but complications and follow-up is provided by the primary care physicians. Patient care is thus fragmented and continuity is lacking. Medical records should be changed so that pertinent information can be transmitted and retrieved easily and caregivers

can readily identify problems. To provide more continuity of care, there needs to be a sign-out system for patients to the on-call physician that is formalized and mandatory so that problems in the various units can be addressed and understood prior to physicians leaving for the day. Likewise, a system of formalized intake rounds in the morning should continue.

10) There needs to be improved relationships with the community hospitals.

Guidelines for admissions to AMHI must be developed and implemented and transmitted to the referring community hospitals. There must be sharing of information between institutions. Medical records from other institutions need to be readily available and present on transfer of patients. One method of doing this would be to use a FAX machine. Internal records also need to be easily available for the physicians at AMHI and computerization of the system would improve the availability of past medical records and problem lists. Statistically, 77% of the admissions to AMHI occur in the off hours. Most of these occur early in the morning. The reasons for this should be thoroughly investigated and attempts made to increase the number of patients admitted in day time hours. It will, though, be necessary for patients to be admitted throughout all shifts and the hospital should endeavor to provide quality medical care on a continuous basis.

11) Continued medical education and staff development is clearly needed.

This could involve support and sharing of information with other state psychiatric institutions. Continuing education is needed throughout the system and should involve mental health workers, nurses, ancillary support staff, primary care physicians, and psychiatrists (ie: all members of the health care team). State psychiatric patients often present with very difficult and demanding medical problems and, it is, therefore, mandatory that well trained, competent individuals be available. Inservice education, especially in the recognition of acute medical problems should be stressed.

12) If the number of admissions increase, then the psychiatrists should be available during off hours to help screen patients and determine the appropriateness of admission to AMHI.

At the current admission level, "one or two patients at night", it does not seem necessary to have a psychiatrist present on the grounds, but if the admission rate doubles, as it has in the past, and admissions increase to between four and ten patients per night, then psychiatric, in-house, coverage should be appropriate. Presently, only physician extenders are in the institute at night. It is essential that both psychiatric and medical back-up be available.

13) A medical environment dedicated to quality health care delivery must be established and maintained.

To recruit and retain new doctors, institutional support for research would be very important. To this end, it would be

advantageous to network with the residency programs in Portland for psychiatry and in Augusta with the Maine Dartmouth Family Practice Residency for primary care. In this manner, primary care and psychiatric care could develop in a teaching atmosphere and provide for increased opportunities to recruit and retain interested and active medical staff.

14) New medical equipment should be obtained.

It is apparent that much of the medical equipment available is outdated and when medical staff is increased new equipment will be necessary. This could be best accomplished by creating a primary care medical team to evaluate present equipment availability and necessary and desired needs.

15) An ethics committee should be established.

Difficult socio-medical issues such as "do not resuscitate" orders need to be addressed and continuously monitored. Restraining of patients and the need for consent for procedures are other issues an ethics committee could address.

16) Better access to specialty physicians is needed.

These could include, but not be limited to, physicians trained in gerontology, geriatric psychiatric care, pediatrics and child psychiatry and other primary specialties as needed. These relationships could be contractual with physicians in the community.

We hope that the recommendations in this report will provide a broad and useful set of guidelines that will help in the development of quality primary medical care at the Augusta Mental Health Institute. Due to the time constraints necessary to complete this project, these recommendations are not meant to be exhaustive. More study of the problem would be useful. We would like to stress that the medical care needs at AMHI are complicated and solutions will not come quickly. It would be helpful to have a "cooling off period" in which changes can be implemented and AMHI is not under such stringent public scrutiny. We feel the problems can be solved, but will need the staff at AMHI to be given the time and resources to implement these suggestions. We realize that many changes have already been made at AMHI. When the facility has a new superintendent, we expect more changes will be likely.

We would like to take this opportunity to thank all those at AMHI that helped us and made our visit fruitful. We found all individuals to be open, cooperative and pleasant. We all learned a great deal about AMHI. We hope you find our comments useful.

Respectfully submitted,

Stephen D. Sears M.D.

Stephen Sears, M.D., MPH
Kennebec Valley Medical Center
Chairman-Primary Care Study Group

Dermott Killian, M.D.
Mercy Hospital

Thomas E. McDermott, M.D.
Mid-Maine Medical Center

Walter Peterlein, M.D.
Central Maine Medical Center

John Randall, M.D.
Maine Medical Center

SS/bad

Maine Department of Mental Health and Mental Retardation
Augusta Mental Health Institute

P.O. Box 724, Augusta, Maine 04330 (207) 289-7200 - TTY (207) 289-2000

JOHN R. McKERNAN, JR.
Governor

SUSAN B. PARKER
Commissioner

June 15, 1989

Susan B. Parker, Commissioner
Department of Mental Health and Mental Retardation
State Office Building, Room 400
State House Station #40
Augusta, Maine 04333

Thru: William B. Deal, M.D., Chairman, Health Consortium, Inc.
C/o Maine Medical Center
Portland, Maine 04101

Subject: Interim Report No. 1 - May 24, through June 15, 1989

Dear Commissioner Parker,

During the above mentioned period, I have visited all departments and patient units at AMHI. I have met with a large number of employees on all shifts, individually and in groups. When I've asked "What, in your opinion, is the one thing that needs to be changed?", the most frequent responses were:

a) Increased staffing
b) Improved compensation, and
c) Improvement in therapeutic environment.

Taken as generalizations and based upon personal observations, I agree.

It is clear that in-depth studies will be required to validate the specifics of each issue. Only then can an overall action place be developed.

Let me review the specific items and actions taken on each of the above issues:

Issue: Increased Staffing

Action: In order to meet certain staffing needs, a request for 86 new or expanded positions have been requested in Part II. An explanation of these positions is attached as Appendix "A".

Issue: Increased Compensation

Action: The Institute and Department are recommending significant increases to the compensation of physicians (both psychiatrists and primary care specialists) in Part II.

Immediate action is required to address the pay for two other categories of employees: Physician Assistants/Extenders and the Superintendent.

The P.A. issue has been under review for sometime and has reached a critical point. If one looks at responsibility and comparibility, the level of compensation of this category of employee needs to be increased to approximately $45,000 per annum.

The compensation level for the Superintendent is not realistic. The "Gaver-Holland Report" states on Page 5 that "A qualified and experienced mental health professional with managerial, administrative and leadership capabilities is essential." At the current level of compensation, it is clear that we will not be able to recruit and retain an individual who possesses those qualifications. The compensation level for this position should be in the $90,000 to $100,000 range. (I also recommend that title be changed to reflect the Chief Executive Officer role. This change should coincide with your appointment of the new Superintendent).

Issue: Improved Therapeutic Environment

Action: $700,000 has been requested in the Part II Budget. A copy of this request is attached as Appendix "B".

A brief walk through the facility would convince the most casual observer that much of the equipment and physical plant is in need of repair and/or replacement. An in-depth study should be commissioned to identify the needs and the costs for corrective action.

I have reviewed the "Gaver-Holland Report" and have taken the following actions to address four specific issues they have identified.

Issue #1: Administrative Organization:

The current (October 1988) Administrative Organizational Chart is, at best, confusing and is not reflective of the actual organization alignment. Various surveyors from accrediting and certifying agencies have identified this as a major issue that must be corrected.

Action:

a) The Interim Superintendent will, with some input from staff, develop a new administrative organization using a more logical grouping of activities. Completion Date: July 21, 1989

b. As part of this reorganization, special emphasis is being placed on the lack of an organized Nursing Department. A consulting group of senior nursing executives is being formed by the Consortium. This group will work with the AMHI nurse managers to develop a nursing department organizational plan. See Appendix "C". Completion Date: August 1, 1989

Issue #2: Basic Nursing Staffing Levels

There is no documented logic process to justify the minimum staffing required to provide for a basic level of patient safety and some minimal therapeutic interaction.

Action:

A Nursing Staffing Consulting Group is being formed by the Consortium and will be working with certain members of the AMHI Nursing Staff; the basic staffing needs will be fully documented. Completion Date: August 18, 1989.

Issue #3: Medical Records

There is a multitude of sub-issues in the Medical Records area that are not limited to the activities in the Medical Record Room.

Action:

I have met with three Medical Records Administrators from the Consortium. They have agreed to establish a task force to review the current medical records "system" at AMHI and make recommendations relative to a system, equipment and staffing. Completion Date: To be announced by June 30, 1989.

Issue #4: Planning

There has been no long-range planning at AMHI.

Action :

I have met with the Reorganization Committee. This committee will be focused and designated as the Augusta Mental Health Institute Strategic Planning Committee in order for AMHI to become more flexible in the way that we deliver care as our role/mission changes. The members of the committee will need to fully understand the long-range plans of the Department, as well as the specific role AMHI will play, as these goals become a reality. In the near future, I will be asking you to appoint a representative of the Department to be a full member of this committee. Completion Date: This is a standing committee.

I have concluded that, while there is much that needs to be done at AMHI, I believe that the basic ingredients for change are present. The employees are serious, hard-working and fully accept the need for change. The Executive and Legislative branches of State Government have demonstrated their willingness to provide the resources to resolve the issues.

It is going to take several years to bring AMHI up to the standards of the 1990's. It is going to be achieved one issue at a time. Some of the changes will be painful for some staff. Some of the changes will require short and long-term increases in Augusta Mental Health Institute's financial resources. Some of the issues will require changes in State-wide systems, at least as they impact on Augusta Mental Health Institute and the provision of mental health care.

I have seen a willingness to make these changes and that makes me optimistic about the future of the Augusta Mental Health Institute.

Respectfully Submitted,

William J. Thompson
Interim Superintendent

AUGUSTA MENTAL HEALTH INSTITUTE PART II STAFFING PROPOSAL

CLASS	#	DEPLOYMENT	DIRECT SERVICE IMPACT	DHS WARDS SERVED	JCAHO/MEDICARE/MEDICIAD AND QHR REFERENCE	COST FY 90	COST FY 91
MHW I	36	SRU 7-3, 3-11 NH 7-3, 3-11	16 positions will address direct care needs of patients on the Nursing Home and Senior Rehab. Units, and will permit direct care staff to take needed vacations, as well as reducing mandated overtime, which will boost morale and enhance patient care. On the Nursing Home, there is insufficient staff to turn and ambulate patients, release restraints, as well as toileting and feeding. Of the 70 patients: Incontinence = 55 Feeeding Assistance = 35 Non-ambulatory = 27 Special Skin Care = 24 Patients are fed in dayroom due to insufficient staff to more non-ambulatory patients and to supervise dining room. Several patients had to stop attending GROW Workshop due to insufficient staffing. 7-3 staffing is priority.	NH (17) SRU (11)	QHR referenced severe direct care needs on NH. Medicaid has placed NH in "termination mode" for inadequate 1:1 interaction, inability to consistently release restraints in a timely fashion and ambulate patient while out of restraint. On Senior Rehab. Unit, Medicare/ Medicaid increase the minimum direct care staffing over previous approved level.	632,736	664,373
APPENDIX [A]		(16) Float Pool - All shift on Psychiatric Service	16 of these 36 MHW's will be assigned to our 10 person float pool. Beyond covering for acuities, (1:1's COR's) staff still receive specific unit-based training depending on skills & interests. This will permit more focused treatment activity. Priority will be given to 3-11 & 11-7 shifts. This additional staffing will significantly reduce overtime & permit regularly assigned staff to remain on their designated areas, enhancing quality of care.	17 Public Wards on Psych. Service.	QHR cited high overtime; need to compensate for MHW's doing non-direct care.		

AUGUSTA MENTAL HEALTH INSTITUTE PART II STAFFING PROPOSAL

CLASS	#	DEPLOYMENT	DIRECT SERVICE IMPACT	DHS WARDS SERVED	JCAHO/MEDICARE/MEDICIAD AND QHR REFERENCE	COST FY 90	COST FY 91
MHW I cont.		(4) Alternative Living Program (ALP) 3-11, 11-7	These 4 positions will reduce floating, enhance continutity of care, and allow for 24 hour supervision of the half-way houses..	2 Public Wards in ALP.			
Nurse II	14		These positions will provide direct coverage, as well as supervision of LPN's and MHW's on:		Medicare calls for a nurse on each program every shift. QHR page 8 notes absence of evidence of nuring process. QHR pg.	$322,565 (Effective	429,562 9/4/89)
		7-3, 3-11	(2) Adult Treatment Program	26 public	10 notes low nursing care		
		7-3	(1) Young Adult Treatment Prog.	wards will	hours on YATP, ATP. Need to		
		7-3	(1) Medical Clinic	be	staff for acuity and allow for		
		11-7 (float)	(1) Admissions Unit	affected.	RN oversight of med. techs.		
		11-7	(2) Forensic Treatment Unit (FTU)		JCAHO notes they expressed concern		
		11-7	(1) Greenlaw Nursing Home		over inadequate nursing super-		
		3-11, 11-7	(2) Older Adult Treatment Prog.		vision of med. techs. Licenses		
		7-3 (weekend relief)	(4) Adolescent Unit		being stretched. On N.H., use of psychotropic drugs requires RN supervision.		
Nurse III	4	7-3, 3-11 (12) 11-7	3 positions will allow for a head nurse on each shift on FTU, overseeing provision of delivery of direct patient care.		Standards of nursing care and assure nursing process.	$ 98,961 (Effective	131,427 9/4/89)
		7-3	One position will provide much needed continuity of licensed coverage in our Alternative Living Program.	4 Public Wards	QHR Pg. 8 and JCAHO TNA #20 -25 reference lack of nursing process and assessment of nursing needs.		

AUGUSTA MENTAL HEALTH INSTITUTE PART II STAFFING PROPOSAL

CLASS	#	DEPLOYMENT	DIRECT SERVICE IMPACT	DHS WARDS SERVED	JCAHO/MEDICARE/MEDICIAD AND QHR REFERENCE	COST FY 90	COST FY 91
LPN	7	(2) 7-3, 3-11, 11-7	4 positions will provide relief coverage on each floor of the nusing home as well as weekend coverage 2 positions will cover weekends. 1 position will assist with direct medical care in our overburdened clinic.	11 All DHS wards	Increased medical issues, licensed coverage.	$131,611 (effective 8-6-89)	159,689
NURSE IV	3		These positions will provide on-ward training in areas of therapeutic patient interventions and medical records documentation for RN/LPN/MHW's. Also implementation of nursing standards of care.	17	QHR (pg. 11 - 12) references lack of psychiatric nursing training. Also QHR pg. 8 notes that standards of nursing care are not being utilized in the planning of patient care and lack of nursing process.	$ 91,377 (Effective 8/6/89)	$110,872
NURSE I	1	7-3	This position will provide direct patient care in the medical clinic.	All Public Wards	Medicaid has acknowledged the high number of medically ill patients.	$25,529 (effective 8/6/89)	28,812
PERSONNEL SPECIALIST	1	7-3	This position will assist in processing new positions and will substantailly enhance the Worker's Compensation Prog., which at AMHI primarily impacts direct care staff.			$23,612 (effective 7/17/89	26,859

NOTE: The Medical Unit portion of this request had already been scaled down. We will likely lose our Medical Unit Director if further compromise is made.

AUGUSTA MENTAL HEALTH INSTITUTE PART II STAFFING PROPOSAL

CLASS	#	DEPLOYMENT	DIRECT SERVICE IMPACT	DHS WARDS SERVED	JCAHO/MEDICARE/MEDICIAD AND QHR REFERENCE	COST FY 90	COST FY 91
PHYS. III	3		One of these positions would provide primary medical care. Our patients increasingly present with medical problems in addition to their psychiatric difficulties. The other postions would augment our capacity to provide psychiatric oversight and to reduce excessive patient loads.		Medicare has noted lack of physician involvement in providing direction to treatment planning and supervision of physician extenders. QHR (p. 4) notes admission pressures, complexity of the patient mix. QHR (p. 13) References a physician resigning in part due to admissions pressures.	$ 210,869	221,414
CUST. WORKER I	12		These positions would allow for both cleaning patient care areas as well as maintaining the environment on weekends and holidays. Weekend housekeeping, in particular, would relieve nursing staff from having to perform custodial duties.	All DHS Wards would benefit	Improvements anticipated to the therapeutic environment (e.g. carpeting) will heighten the need for an expanding housekeeping capacity.	$ 192,092	201,697
HOUSE-KEEPER I	1		This position would provide supervision to expanded custodial worker complement, in order to maximize performance officiency.			$ 17,637	18,520
REG. DIETICIAN	1		This postion would provide much needed support in patient counseling and monitoring of the many special diets. We currently have only 1 Dietician for our entire patient population.			$ 23,797.	24,987

AUGUSTA MENTAL HEALTH INS 'UTE PART II STAFFING PROPOSAL
OTHER PEI NEL ACTIONS

CLASS # DEPLOYMENT	DIRECT SERVICE IMPACT	DHS WARDS SERVED	JCAHO/MEDICARE/MEDICIAD AND QHR REFERENCE	COST FY 90	COST FY 91
Conversion of 500 hour Nurse II to full-time	This action would allow for a full-time CNA instructor, and also would supplement our Infection Control Program.		JCAHO referenced insufficient infection control oversight. The CNA program has been expanded and additional instructional time is essential. CNA training is critical in view of our need for direct care staff to be able to adequately observe patients (under the direction of licensed nursing) for signs/symptoms of medical problems.	$ 30,413	31,934
Increase 24 hour Nurse III to 40 hours	This action will permit an appropriate level of medication instruction as well as providing CPR training, and refresher training in the use of emergency life support equipment.	All DHS Wards impacted	Currently, we have to pull staff from direct-care service to supplement the much-needed training opportunities. QHR (p. 11-12) references need for continuing education at all levels, and notes that programs should be integrated with needs indentified through the QA Process which is true of the emergency life support training.	$ 16,270	17,084
Convert seasonal Nurse IV to full-time Psychiatric Therapy Instructor.	This action will allow continuing of training in Intro. to Mental Health for new hires who provide direct-care to patients. Currently we have a 3-month gap in this training due to seasonal positions. This is a master's level position which is necessary for maintaining our cooperative program with UMA.	All DHS Wards impacted.	As stated above.	$ 11,400	11,970
			TOTALS	1,828,600	2,079,200

APPENDIX |B|

STATE OF MAINE

Inter-Departmental Memorandum Date May 29, 1989

To Ric Hanley, Asst. Superintendent Dept. Augusta Mental Health

From Richard Besson, Hospital Services Dept. Augusta Mental Health

Subject Additional Support Services Staffing

This memo is a follow up of our meeting on March 22, 1989, on the above subject. Prior to venturing into the material that follows I feel it is important to make a disclaimer to the effect that these are reasonable requests and do not include more than I can justifiably feel are required to do a good, not excellent, job here at Augusta Mental Health. As this material is reviewed you will find common denominators in many of the areas. These being the Joint Commission on Accreditation of Hospital Organization's requirements which have evolved into a program requiring considerably more documentation, data collection, quality assurance emphasis and a need by the Institution to have a safe and healthy environment for our patients and staff.

The following material is a result of individual meetings on March 22, 1989. I will outline the specific needs, i.e., staffing, equipment and then I will summarize the requirements and/or justification by department.

SAFETY COMPLIANCE:

Staffing: Occupational Health Specialist or other appropriate classification. Clerk Typist II.
All other requirements: $1,200.00
Capital Equipment: Professional Computer, $2,000.00
Justification: The additional staffing requirement is needed due to the Joint Commission on Accreditation of Hospital Organizations reporting requirements, specifically investigation of patient accidents, employee industrial accidents, analysis of information to identify trends and adverse situations. There is an ever increasing need for training by the Safety Compliance Officer which is being met at the expense of other duties. As of this writing the Safety Compliance Officer has duties lined up as follows: Employee Incident Investigation, the Disaster Plan requiring revision, Chemical I.D. Law throughout the Institution, Patient Incident Investigation, Hazardous Waste Policies and Procedures and follow up of safety issues in our G.R.O.W. Department. Augusta Mental Health has 1 Safety Officer to patrol and supervise 608,000 square feet of living space plus assure the safety of almost 800 staff and almost 400 patients. This is a monumental task that 1 person cannot keep pace with the ever changing environment.

BUSINESS OFFICE/WAREHOUSE/BOUTIQUE/MAILROOM:

Staffing: Laborer II
All other requirements: 0
Capital Equipment: 0
Justification: There exists a need within these departments for a continuum of service. This continuum is an ever increasing problem. We have a condition whereby the absence of a person from our warehouse, our boutique or mailroom necessitates the movement of personnel from department to department to continue services. Now that the warehouse has 2 staff it is impossible for deliveries to be made when one person is absent, although planning and organizing will compensate for expected absences it is the last minute, unforseen that create a major problem and directly effect the quality of patient care due to the availability of needed supplies. This position would also be used for data entry purposes in the Business Office when we are able to bill patients for outside services.

ENGINEERING/MAINTENANCE:

Staffing: 2 Maintenance Mechanics
All other requirements: 0
Capital Equipment: 0

ELECTRICAL:
Staffing: 1 Electrician
All other requirements: $2,000.00
Capital Equipment: 0

PAINTERS:

Staffing: 1 Painter
All other requirements: $1,000.00
Capital Equipment: 0

Justification: Due to current priority projects the Maintenance Department is able to accomplish approximately 60% of preventative maintenance requirement for the Institution. Even without these priority projects, it is felt that our PM Program would be at an 80% level and if this were to be reached we would be doing well. Preventative Maintenance can save the Institution considerable dollars, inconvenience and increase the quality of care to our patients through the services we provide. We must also add to our Preventative Maintenance Program additional patient care equipment. This would include items such as hospital beds in the Nursing Home and wheelchairs and any other equipment that deals with the quality of patient care. Our fire alarm system which includes our smoke detectors and sprinkler system is currently maintained through a contract which costs a minimum of $10,000.00 to $12,000.00 per year. What I propose is to hire an Electrician with an electronics back ground to be trained in the maintenance of our smoke detector system which deals directly with patient safety. Although this would not be a full-time job for an Electrician we have more than enough preventative maintenance and repairs for an Electrician to fill up his time. I am requesting a Painter due to the general condition of the Institution and the exit comments at the summation on March 16, which indicated a gross lack of a healthy living environment, i.e., a sterile environment, no color to activate sensory preceptions.

One additional comment on the need for Maintenance Mechanics is the pending recommendation on ventilating and air conditioning throughout the Institution which will require additional services by our staff.

HOUSEKEEPING:

Staffing: 12 Custodial Worker Is, 1 Housekeeper I
All other requirements: $5,000.00
Capital Equipment: 0
Justification: With the addition of this staff, housekeeping would be able to clean all patient areas Monday through Friday and be able to maintain the environment on weekends and holidays. The addition of a Housekeeper is necessary to supervise this staff due to past experience of unexperienced personnel in lost/work inefficiencies. This would also relieve Mental Health Workers and other nursing staff from performing custodial work. In addition, the environment as it relates to housekeeping will be the full responsibility of our Executive Housekeeper and his staff.

LAUNDRY:

Staffing: 1/2 Laundry Worker I
All other requirements: 0
Capital Equipment: 0
Justification: The current patient population and the accuity plus the advent of the Senior Rehab Unit have greatly contributed to the work load of the Laundry. We are using pre-release personnel to the best of our ability, the only problem with this is the reliability of having pre-release staff. What I propose is a 1/2 time laundry worker position to work the earlier days in the week to allow a catch up from the weekend accumulation of linen.

MEDICAL RECORDS:

Staffing: 3 Clerk Typist IIs
All other requirements: 0
Capital Equipment: Personal Computer, $2,000.00
Justification: With the addition of positions, psychologist and P.A.s, it is necessary to add a minimum of 3 Clerk Typist IIs. We are also involved in Quality Assurance Tracking, example, H.I.V. Testing Records not to mention other ongoing requests from the Clinical Director and outside personnel.

SWITCHBOARD:

Staffing: Clerk Typist II
All other requirements: 0
Capital Equipment: 0
Justification: An ongoing problem exists whereby Switchboard Operators during the day must be releived by my secretary which causes work here to back up. Switchboard Operators do not have the opportunity to attend mandatory training. Work is not being done on a timely basis.

AMHI

Proposed Plan for Addressing Nursing Issues

Two primary areas of concern have been identified that demand immediate attention and resolution in order for the nursing care activities to improve. The absence of any clear structure and organization for nursing services, and similarly, no established methodology or rationale for determining staffing requirements are the problems demanding immediate attention.

The short term goals for each problem, suggestions for process, and the nurses with related expertise who have agreed to assist are noted in the following summaries.

I. Nursing Structure and Organization

A. Goals:

1. Recommend structure and organization for nursing services by August 1, 1989.

2. Recommend generic definitions of the various nursing roles.

3. Define qualifications for each nursing role.

4. Explore options for implementation of changes with Interim Superintendent.

B. Process:

1. Gather data about current operational systems - formal and informal.

2. Review proposed organization plan prepared by AMHI staff.

3. Engage staff in active process of defining plan which is acceptable and will provide clear lines of authority, accountability and communication.

4. Use various methodologies including retreat as deemed appropriate to achieve goals.

C. Nurse Experts:

1. Alice Cirillo, R.N, B.S.N., Director of Medical Nursing - Maine Medical Center.

2. Patricia Hutchinson, R.N., B.S.N., M.Ed, Director of Health Education Services, Kennebec Valley Medical Center.

Nurse Experts - Continued:

3. Linda Pearson, R.N., M.Ed Nursing, Director of Nursing Resources, Maine Medical Center.

II. Staffing Requirements

A. Goals:

1. Define core elements of the nursing care program for this patient population.

2. Recommend plan for determining number and level of staff needed for nursing care.

3. Support recommended plan with rationale that encompasses principles used in defining staffing requirements.

B. Process:

1. Review the relevant literature regarding determination of staffing requirements for this patient population.

2. Review all regulatory and professional standards for clarity of expectations and quality measures.

3. Contact similar facilities to explore their staffing methodologies and rationale.

4. Use various methodologies including consultation as appropriate to achieve goals.

C. Nurse Experts:

1. Carol Cosand, R.N., M.S.N., Manager Nursing Management and Information Systems, Maine Medical Center.

2. Katherine Guilbault, R.N., M.S.N., Assistant Vice President for Nursing, Central Maine Medical Center.

3. Carol Niziolek, R.N., M.S.N., Administrator for Nursing, Mercy Hospital.

These two groups will begin their assignment as soon as authorized and each will address their respective issue within the defined time frame. It may be necessary for the two groups to meet periodically to assure congruency in their developing recommendations. Coordination of the nursing committees work will be provided by Judith T. Stone, R.N., M.S.N., Vice President for Nursing, Maine Medical Center.

The Interim Superintendent will be kept informed of progress by a designated team leader from each group.

Stone North Building:	87,000 sq. ft.
Carpeting (4,800 yards)	41,605.
Wallpaper	15,000.
Painting	9,000.
Suspended Ceiling	43,500.
Sound Buffers	-0-
Furniture:	
Beds (40 ea.)	18,000.
Side chairs (60 ea.)	2,885.
Wardrobes (45 ea.)	24,750.
Sofa (15 ea.)	6,824.
End tables (10 ea.)	2,280.
Cocktail tables (12 ea.)	2,736.
Lighting:	
200 lights at $1.64 ea.	328.
Pictures:	
45 pictures at $30. ea.	1,350.
Plants:	
45 assorted plants at $25 ea.	1,125.
	$169,383.
Stone South Building:	79,000 sq. ft.
Carpeting (4,300 yards)	41,605.
Wallpaper	13,500.
Painting	8,000.
Suspended Ceiling	39,500.
Sound Buffers	-0-
Furniture:	
Beds (40 ea.)	18,000.
Side chairs (60 ea.)	2,885.
Wardrobes (45 ea.)	24,750.
Sofa (15 ea.)	6,824.
End tables (10 ea.)	2,280.
Cocktail tables (12 ea.)	2,736.
Lighting:	
400 lights at $1.64 ea.	656.
Pictures:	
45 pictures at $30. ea.	1,125.
Plants:	
45 assorted plants at $25 ea.	1,350
	163,211

Marquardt Building:	60,149 sq. ft.	
Carpeting (3,342 yards)		35,000.
Wallpaper		10,125.
Painting		6,500.
Suspended Ceiling		45,112.
Sound Buffers		-0-
Furniture:		
Beds (50 ea.)		22,500.
Side chairs (60 ea.)		2,885.
Wardrobes (50 ea.)		27,500.
Sofa (15 ea.)		6,824.
End tables (20 ea.)		4,560.
Cocktail tables (12 ea.)		2,736.
Lighting:		
500 lights at $1.64 ea.		820.
Pictures:		
45 pictures at $30. ea.		1,350.
Plants:		
45 assorted plants at $25 ea.		1,125.
		167,037.
Greenlaw Building:	49,311 sq. ft.	
Carpeting (2,740 yards)		20,000.
Wallpaper		8,000.
Painting		5,000.
Suspended Ceiling		24,656.
Sound Buffers		-0-
Furniture:		
Wardrobes (50 ea.)		18,950.
Electric Hi/Low beds (40 ea.)		48,000.
End tables (20 ea.)		4,560.
Recliner Geri Chairs (20 ea.)		10,00.
Lighting:		
200 lights at $1.64 ea.		328.
Pictures:		
45 pictures at $30. ea.		1,350.
Plants:		
45 assorted plants at $25 ea.		1,125.
		$ 141,969.

Summary of Estimated Costs:

Stone North	$169,383.
Stone South	163,211.
Greenlaw	141,969.
Marquardt	167,037.
Pipe Enclosure	50,000.
Equipment	8,400.
	$700,000.

Maine Department of Mental Health and Mental Retardation
Augusta Mental Health Institute

P.O. Box 724, Augusta, Maine 04330 (207) 289-7200 · TTY (207) 289-2000

JOHN R. McKERNAN, JR.
Governor

SUSAN B. PARKER
Commissioner

August 1, 1989

Susan B. Parker, Commissioner
Department of Mental Health and Mental Retardation
State Office Building, Room 400
State House Station #40
Augusta, Maine 04333

Thru: William B. Deal, M.D.
Chairman, Health Consortium, Inc.
c/o Maine Medical Center
Portland, Maine 04101

Subject: Interim Report No. 2 - June 16 through July 31, 1989

Dear Commissioner Parker,

This is the second of four reports and covers a period that has proven to be a busy one.

Along with the day to day duties of the Superintendent, I have been able to meet with the Maine Commission on Mental Health. I firmly believe that it will be of critical importance that frequent communications between AMHI and its various constituancies be initiated and improved (this will be a major role for the AMHI Superintendent as the mission of the community providers is expanded).

I have concluded that, as a part of the continuing analysis of AMHI operations, it would be beneficial to add three additional areas to those already under review. These areas are:

a. Primary Medical Care
b. Food and Nutrition Services
c. Housekeeping Services.

Issue: How well is AMHI organized to meet the primary healthcare needs of its 300+ residents.

Action: A study group of five primary care physicians has been formed by the Consortium. They will meet during August and submit their report on September 9, 1989 (Appendix "A").

Issue: Review how food and nutrition services are delivered at AMHI.

Action: Early in July, I spoke with Mr. Anthony Alebrio, Eastern Regional Vice President of Marriott Corporation's Healthcare Division to find out if his company would, at no charge, review the overall food service operation at AMHI. He agreed, and on July 18 and 19, 1989, Mr. Ted Kinkle, RD, Regional Vice President, Ms. Peri Bridges, RD, Human Resources Director, Marriott Healthcare Services - East and Mr. Martin Smith, Food Service Director, Hale Hospital, visited AMHI. They met the various staff, observed food preparation and delivery, reviewed staffing as well as the general administration of the department. Dan Spofford, RD, of the Department of Mental Health and Mental Retardation also participated in the review. Completion Date: Mr. Kinkle expects his report will be submitted on or about August 21, 1989.

Issue: Review the delivery of Housekeeping Services.

Action: Mr. Mike Faucher, Area Manager for Servicemaster was asked if his company would review, at no cost, the Housekeeping Program at AMHI. Mr. Faucher has received approval for this study, with actual review taking place early in August and a report to be submitted before the end of the month.

I have made it clear to the representatives of both Marriott and Servicemaster that we are not looking for contract proposals for their services.

The following is an update on the previously identified issues:

Increased Staffing:

Appendicies B1 and B2 shows the status of March 19, 1989 (81 positions) and June 30, 1989 (85 positions) staffing authorizations. The positions still vacant on the March 19th list are reflective of the continuing shortages in these professions.

Improved Therapeutic Environment:

I am including, as Appendix "C", Dick Besson's plan of correction and time-table to complete these changes. I must point out that the $100,000 funding to cover certain pipes, that Dick mentions, is being provided by the Office of Risk Management, Department of Administration. Commissioner Morrison and his staff have been quick to recognize and respond to our need. Ron Martel was very effective in presenting our position on this issue.

Administrative Organization:

A new administrative organizational chart has been developed (Appendix "D") This organizational plan:

a) Reduces the span of control of the Superintendent to a more reasonable number,

b) Provides for a more logical grouping of clinical and administrative services/functions.

c) Promotes collegial leadership in each area. This should result in improved clinical treatment, timely allocation of professional resources based on programmatic needs and will ultimately enhance the recruitment and retention potential in areas of very limited professional resources.

d) Gives testimony to the critical role that Quality Assurance Program plays at AMHI.

There are still many details to be worked out before the plan can be fully implemented.

Nursing Organization and Staffing:

Work on the Nursing Organization and Staffing reports is progressing. The reports will be submitted as a two-part document on August 18, 1989.

Medical Records:

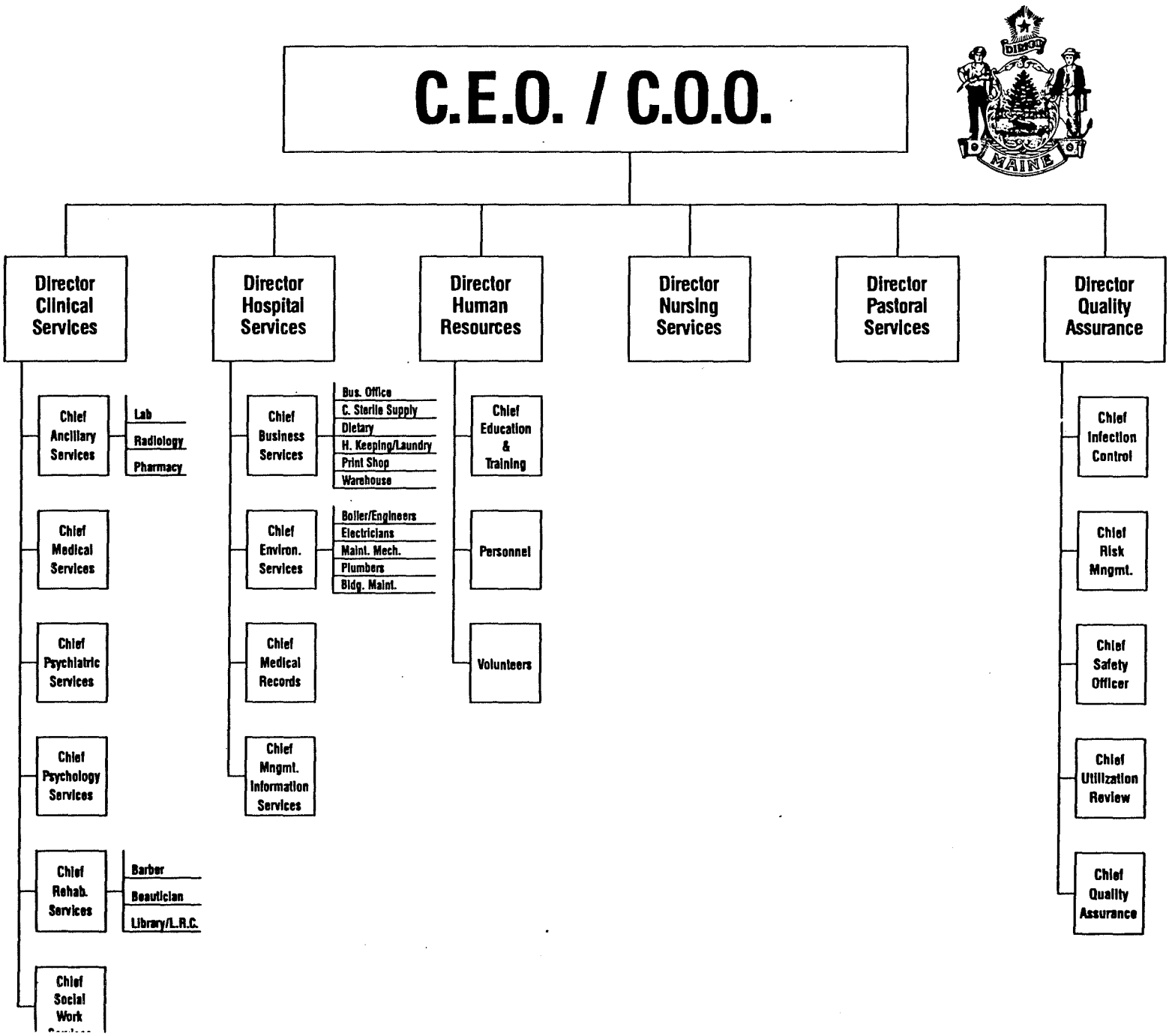
The Medical Records Group continues to meet. Their work is progressing on schedule. We have invited a representative from the Archives Office to meet with the group as the discuss records retention issues.

I continue to be very impressed with the sincerity and dedication of the AMHI Staff and their receptivity to change. I would not want any of the above initiatives to be taken as a reflection of lack of their competence.

Respectfully Submitted,

William J. Thompson
Interim Superintendent

AUGUSTA MENTA HEALTH INSTITUTE
PROPOSED ADMINISTRATIVE ORGANIZATION



Maine Department of Mental Health and Mental Retardation
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JOHN R. McKERNAN, JR.
Governor

SUSAN B. PARKER
Commissioner

September 1, 1989

Susan B. Parker, Commissioner
Department of Mental Health and Mental Retardation
State Office Building, Room 400
State House Station #40
Augusta, Maine 04333

Thru: William B. Deal, M.D.
Chairman, Health Consortium, Inc.
c/o Maine Medical Center
Portland, Maine 04101

Subject: Interim Report No. 3. August 1, - 31, 1989

Dear Commissioner Parker,

During the period of this report I have taken the first steps to implement the administrative reorganization of AMHI. Three (3) of the operational studies that we have commissioned have been completed and written reports submitted. The completed studies covered:

1. Nursing Structure and Organization/Staffing
2. Food and Nutrition Services
3. Housekeeping Services

A copy of each study is attached as an appendix to this report.

1. Nursing Structure and Organization/Staffing (Appendix 1)

I have provided Vera Gillis, R.N., Nursing Services, Marion Carroll, R.N., Unit Director, Vada Rose, R.N., Unit Director and Marilyn Dennis, R.N., Unit Director, a copy of this study. These managers will meet with members of the Consortium's Special Nursing Task Force on September 6th to review the report and clarify any special issues.

It should be noted that the report recommends the establishment of a Department of Nursing. This outlines the structure within which we can clearly define and establish responsibility for all nursing care provided to our patients. Once the nursing organizational structure is in place, it will be the responsibility of the Director of Nursing and the Associate Directors to insure that the nursing staff at all levels is held accountable for the quantity, but most importantly, the quality of that care.

The staffing section indicates that staffing authorizations provide for favorable overall staff-to-patient ratios, although some adjustments to individual unit staffing patterns may be necessary.

A transitional organization chart has been provided as well as two lists of specific recommendations. One list relates to structure and organization (thirteen recommendations) the other pertains to staffing issues (twelve recommendations).

We will need to review the current role and responsibilities of Mental Health Workers IV, V, VI and make the necessary modifications in their respective roles and responsibilities to fit within the new structure.

2. Food and Nutrition Services (Appendix 2) The Marriott report contains several key comments:

   a. In general, the overall staffing authorization is adequate.
   b. There is an identified need for a third Registered Clinical Dietician and a second Clinical Dietetic Technician.
   c. Depending on how the food delivery system is organized, there is the potential for increased efficiency. Salary savings should be utilized to fund the additional Registered Dietician and the Dietetic Technician positions.
   d. Emphasis should be placed on the clinical aspects of the Food and Nutrition Service.
   e. In the near future, there will be a need to replace much of the basic major equipment in the department.

3. Housekeeping Services (Appendix 3)

   The Servicemaster report on the Housekeeping Department was in general very complimentary. Among their suggestions are:

   a. The Housekeeping Department is in dire need of "state of the art" equipment. This would enhance the quality of work as well as improve efficiency. There is also a clear requirement for more "basic" housekeeping equipment.
   b. Staffing appears to be adequate.
   c. Coverage should be extended to the evening shift. This would help the patient care areas and certain tasks could be scheduled for that shift.
   d. Standardized work rates and written work schedules should be developed.

The two remaining reports - Medical Records and Primary Medical Care - are due early in September and will be covered in my final report.

Respectfully Submitted,

William J. Thompson
Interim Superintendent

SPECIAL NURSING TASK FORCE

FINAL REPORT

AUGUST 18, 1989

CONTENTS

CONTRIBUTORS

Judith T. Stone, RN, MS - Coordinator
Vice President for Nursing
Maine Medical Center

Committee on Structure & Organization

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Assistant Vice President for Nursing
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In May, 1989, AMHI Acting Superintendent, William Thompson, invited nurse representatives from the coalition hospitals to meet with him and discuss two areas of principal concern to the institution regarding nursing. The concerns were: (1) the structure and organization of nursing, and (2) the nurse staffing requirements for patient care. The nurse representatives were presented these problems and asked how they might help AMHI in addressing them.

From that meeting a proposal (Appendix A) was developed for Mr. Thompson which identified specific objectives, a time line and nurses with needed expertise who would participate. The proposal was accepted and the special nursing committees began their work.

In the proposal for addressing the nursing issues, process steps were identified. These have been followed with the exception of the retreat. It is believed that a retreat might still be beneficial to lay the foundation for critical future change.

The first step in the process was for the two committees, the committee coordinator and the nursing leadership of AMHI to meet and discuss the proposed study and to outline how each group might proceed. Specific information elements needed were identified, facilities were toured and current systems were explored through communication with staff. This step was focused on establishing constructive work relationships with the AMHI staff.

The next phase of the review included data gathering for the committees. Similar processes were adopted for both work groups. These included review of relevant literature, focused interviews with members of AMHI nursing staff, and phone consult with a nurse consultant* recommended by the Joint Commission for Accreditation of Health Organizations (JCAHO).

Once the data collection was completed, the committees held work sessions to assimilate these findings and begin to formulate recommendations. It was determined that the preliminary findings and recommendations should be subject to some testing prior to drafting a report. The committee chairmen met with the committee coordinator and verified that their information, while collected through separate means, was consistent and their developing views were complementary. A session was then held with the Consultant for Nursing and the Unit Directors and/or their designee to share the assessment and developing recommendations. Their input and reactions were invited and a positive, constructive exchange ensued.

The committee coordinator and the committees met again for integration of their efforts and the report was drafted for submission to the Superintendent.

*Ms. Sylvia Blount, RN, CEO, Vacaville Prison, California, consultant recommended by the Joint Commission for Accreditation of Health Organizations, who was successful in achieving accreditation of California State Hospitals.

DISCUSSION AND GENERAL FINDINGS

It is important to identify that the recommendations in this report represent only a beginning. The work that needs to be done is long term and developmental in nature, however, a new foundation has to be laid and a framework developed that will support continued enhancement of not only nursing services, but all the institutional factors that influence patient care.

There are general findings of significance that influence this report. First, the absence of a clear care model in most areas of the hospital proves to be a major obstacle for planning. The care model should be the basis for structure and for staffing. Without it, the projections lack the program focus it must have. It has been the committee's conviction that their recommendations would provide sufficient resources to support a clinical care program, however, it is expected that modification to their proposals would naturally flow from a clear therapeutic program in the future. In addressing the care of AMHI patients, decisions need to be made about a number of items: (1) the rationale for clustering of patients, (2) the therapeutic initiatives to be offered, (3) the quality of life aspect of the hospital experience, and (4) the connections between the hospital and other community based mental health services.

Another major concern is the need for the nursing recommendations to be congruent with the institution's plans. The nursing organization and structure must fit the hospital organization so that there will be ease of communication, role clarity and minimal question regarding accountability. Similarly, the staffing plan must be based on assumptions that are consistent with the institution's view.

The final concern is how the recommendations will be translated to the AMHI community and what strategies will be employed to support personnel during a necessarily difficult time.

It has been stressed by the committees throughout their work that their efforts have concentrated on <u>what</u> needed to be done, not <u>who</u> should do it. There has been no attempt to assess the performance of any of AMHI's present staff. The work has been exclusively system analysis and the recommendations represent the committees' best thinking for system improvement.

The reality is that the recommendations, if implemented, have various implications for many of the staff. Because the changes will be so far-reaching, it is imperative that a systematic plan be developed for communication, education and, whenever possible, participation.

The Committee on Nursing Structure and Organization has completed the assessment phase of this project and we have developed a series of recommendations for short- and long-term reorganization and development of nursing services at the Augusta Mental Health Institute. These recommendations are in a developmental phase and may still require further definition and refining; particularly in consultation with the Acting Superintendent and nursing staff members at AMHI.

Definitions and qualifications for each nursing role have been addressed in general terms but this area is one which requires further study by this committee and will also await, in part, reorganization of nursing services. General recommendations in the area of definition of nursing roles are found later in this report.

ASSESSMENT

1. There is no defined nursing service. Nursing services are integrated with a number of other professional services in a decentralized organizational model.

   The decentralized model has failed to support development of standards of nursing care or development of clinical skill or professional accountability in nursing staff.

2. There is no mechanism for development or evaluation of standards of nursing care.

   The lack of defined structure and fragmenting of responsibility has created a situation in which the time and energy of nursing staff are primarily directed to organizational maintenance as opposed to development, delivery and evaluation of nursing services.

3. There is confusion and dissension as to the mission of AMHI as a whole.

   a. This confusion, combined with the lack of clear organizational structure, has resulted in lack of defined programs for the treatment or maintenance of specific patient populations.

   b. The above factors have led to poor definition of criteria for patient placement which further compounds problems in developing standards of nursing care. Many units combine patients with such a variety of needs as to render attempts at planned care approaches almost impossible.

4. There is minimal involvement of medical staff in development or evaluation of either programs of care and treatment or individual treatment plans. This is reflective of the lack of organizational mission and structure defined in prior assessment statements.

   This lack of consistent interaction with medical colleagues significantly hinders efforts to develop nursing care standards and treatment modalities.

5. Definition of authority and accountability for all aspects of nursing service is lacking or absent.

   a. Roles of registered nurses, licensed practical nurses and mental health workers are so blurred as to render a lack of professional accountability for practice.

   b. Functions of each role are fragmented to the point of inefficiency and lack of accountability for the intended outcome of any given function.

   c. This lack of definition and accountability permeates both patient care functions and management functions.

   d. The ratio of mental health workers to registered professional nurses further compounds this problem by forcing the investment of professional nursing responsibility in the mental health worker's role.

6. The role of the patient advocate(s) is not clearly defined or focused on enhancement of patient rights, appropriate contribution to definition of standards of care, or contribution to individual treatment plans and interventions as necessary.

7. There is a lack of support services in general and particularly in evening, night and weekend shifts. This leads to investment of nursing resources in the provision of such support services as housekeeping, dietary and others.

8. The lack of organizational structure and role definition has contributed to an inability to develop an appropriate, effective employee evaluation system.

   a. Lack of a sound evaluation system inhibits development of accountability in individuals.

   b. Lack of an evaluation system which enhances professional growth inhibits retention of professional staff.

9. There is a lack of knowledge and skill in both the areas of nursing care and management functions which seriously inhibits efforts to improve nursing services at AMHI.

   a. Registered professional nursing staff lack up-to-date knowledge and skills in both general and psychiatric nursing.

b. Mental health workers at all levels receive only marginal preparation for responsibilities and much of this through job experience rather than through planned education with evaluation of outcomes.

c. All roles vested with management functions receive little or no preparation or development for this responsibility.

10. The redefinition of both care giving and management roles and functions is rendered especially difficult by the interplay of existing labor union contracts and civil service systems.

RECOMMENDATIONS

1. Create a Department of Nursing led by a qualified Director of Nursing (see attached organizational chart).

   a. Creation of a Department of Nursing would impose restructuring of other professional services which currently report through the positions of Unit Directors.

   b. Definition of educational and experience requirements for nursing positions (as defined in attached materials) would support development of clinical management skills.

   c. The primary management role for Nursing needs to be a confidential position which is independent from any union affiliation.

2. Place the Nursing Department in the total organizational structure in a direct relationship to the Superintendent (see attached organizational chart).

   This would enhance the abilities of both the Director of Nursing and the Superintendent in achieving the necessary reforms in patient care and organization at AMHI.

3. Redefine the registered professional nurse role at the unit level to enhance direct care functions and professional accountability.

   Revise ratio of RN to mental health worker as suggested by Staffing Committee.

4. Redefine the mental health worker role to enhance patient care functions and more clearly define responsibility.

   a. Evaluate current Mental Health Worker I, II and III roles in relationship to functions and responsibility with focus on direct patient care.

   b. Evaluate current Mental Health Worker IV, V and VI roles with focus on definition of responsibility in areas of material resource management, security and case management services through a Department of Social Work.

5. Create of three positions, responsible to the Director of Nursing, which would carry responsibility for development and management of psychiatric services, extended care services and management services.

   a. The specific unit of service will need further definition as the organization evolves, but some specifics appear on the attached organizational chart.

   b. These positions would be occupied by RN's qualified as described in the attached materials. The Director of Nursing must appoint to these positions as they are key in supporting and developing nursing services.

6. A plan for definition and placement of patient populations must be created and acted upon promptly.

   a. Criteria for definition and placement of patient populations based on potential treatment modalities and nursing needs of patients will better enable all professional staff to develop and carry out therapeutic programs.

   b. Placement of patient populations in this manner will facilitate maximal use of nursing resources.

7. Structure nursing units with defined patient populations and nursing staff assigned according to patients' nursing needs. Each nursing unit should be managed by a Head Nurse who is a Registered Nurse with appropriate education and experience.

   a. Each Head Nurse should have responsibility for the management of resources and standard of care in a nursing unit.

   b. These responsibilities would include selection of nursing staff, assignment of nursing staff to a work schedule, disciplinary action, budget development and control, staff development and program development in conjunction with other professional disciplines.

8. Staffing patterns for nursing units must be developed and managed at the unit level.

   a. This accountability rests with the Head Nurse and is a critical element of optimal use of resources.

   b. Control of staffing at the unit level increases staff cohesiveness and commitment to patient care, thereby supporting both staff retention and quality patient care.

9. The centralized staffing function should consist primarily of a group of nursing staff, both Registered Nurses and Mental Health Workers, who have been hired to fill vacancies in unit staffing patterns on a shift by shift basis.

   a. This would minimize the reassignment of nursing staff from one unit to another, thereby allowing development of unit-based programs.

b. Nursing staff hired to this "float pool" would be working in this model by choice and, therefore, maintain broader skills and better morale. This should improve "sick calls" and overtime.

c. Consideration should be given to development of a sub group of RN's who maintain high skills in physical assessment and general nursing. These nurses should respond to all calls for assessment of patients with acute physical illness. These nurses should not be based on a unit or assigned psychiatric nursing responsibilities.

10. The function of coordinating the materials and ancillary services needed to support nursing services should be defined and developed in a group of positions assigned to supporting nursing services in this manner.

a. These positions should report to the Assistant Director of Nursing for Management Services and work collaboratively with Head Nurses to ensure that necessary materials and ancillary services were focused on patient care units.

b. These positions would assist in budget development for supplies and capital items.

c. These positions should be available on evenings, nights and weekends as well as week days to support nursing administration in the maintenance of a safe and effective care environment.

d. Creation of these positions would assist nursing administration in focusing direct care givers on patient care and in maintaining a safe and effective care environment.

11. Ancillary services of all types must be addressed if nursing service is to maintain a safe and therapeutic environment and meet standards of regulatory bodies.

a. Availability of such services as housekeeping, dietary, maintenance and others on all shifts is essential.

b. Adequate secretarial/clerical support to nursing services from the unit level on through the Director level is essential if such functions as documentation, education and communication are to be addressed.

12. A concentrated, organized staff development effort must be initiated and supported if above recommendations are to be implemented effectively.

a. Education in clinical nursing knowledge and skills, directed to specific patient populations, is needed for both nurses and mental health workers.

b. Management development and education is essential for all positions vested with management responsibilities.

c. Career development tracts for both RN's and Mental Health Workers should be reassessed and redefined as the organization develops over the next two years.

d. Use of clinical nurse specialists to broaden and enhance psychiatric nursing skills is recommended.

e. A temporary position, responsible to the Director of Nursing, responsible for developing and implementing a management development program is recommended. This position should be eliminated in two to three years, once sound management practices supportive of the redefined nursing department were implemented.

f. Current Staff Development positions need study and redefinition.

13. Each Assistant Director of Nursing (three) should be assigned a staff support position on a temporary basis to carry out projects necessary to the reorganization and development of nursing services over the next two to four years.

a. The qualifications of these positions should vary, depending on the needs of that part of the organization assigned to the Assistant Director.

b. The amount of work necessary to create an effective nursing services necessitates such temporary support if progress is to be made.

INITIAL RECOMMENDATIONS ON QUALIFICATIONS FOR NURSING POSITIONS

I. Director, Nursing Services

Responsible for the planning and implementation of nursing services through definition of care standards, definition of resource requirements and administration of nursing personnel.

Reports to the Superintendent and works collaboratively with other administrative and clinical positions to define and support services of AMHI.

Qualifications

1. Licensed as a Registered Professional Nurse in the State of Maine.

2. Master's degree in either Nursing Administration or Psychiatric Nursing.

3. A minimum of ten years' experience in nursing with progressive experience in nursing administration. Recent experience in a psychiatric setting preferred.

4. Demonstrated leadership and interpersonal skills.

5. Demonstrated knowledge of psychiatric services.

II. Assistant Director of Nursing (Three)

Responsible for the planning and implementation of a defined group of nursing services through development of appropriate positions and programs.

Reports to the Director of Nursing and works collaboratively with other administrative and clinical positions to define and develop nursing services within a specific area.

Qualifications

1. Licensed as a Registered Professional Nurse in the State of Maine.

2. Bachelor's Degree in Nursing required, Master's Degree in Nursing strongly preferred.

3. Minimum of seven years of experience in nursing with progressive experience in nursing administration.

4. Experience related to specific area of assignment necessary.

5. Demonstrated leadership and interpersonal skills.

III. Head Nurse

Responsible for the development and implementation of nursing services to a specified patient population. Plans and implements staffing patterns, develops staff to meet patient care needs, plans and implements budget to support defined program and works collaboratively with other disciplines and services to develop standards and programs.

Reports to an Assistant Director of Nursing.

Qualifications

1. Licensed as a Registered Professional Nurse in the State of Maine.

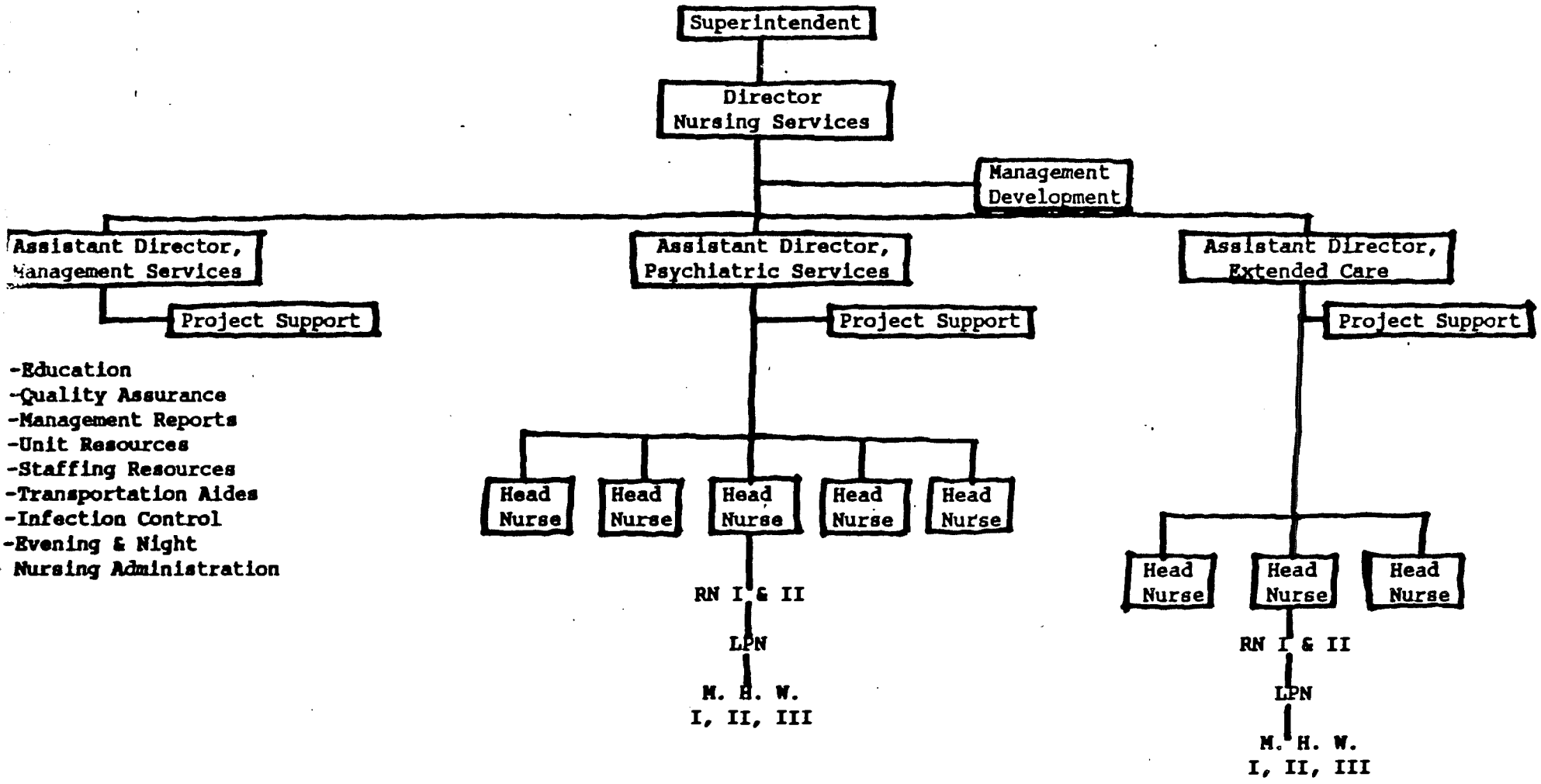
2. Bachelor's Degree in Nursing strongly preferred.

3. Minimum of five years of progressive nursing experience with at least three years in related clinical practice.

4. Progressive management responsibility preferred.

5. Demonstrated leadership and interpersonal skills.

AUGUSTA MENTAL HEALTH INSTITUTE
NURSING SERVICES
TRANSITIONAL ORGANIZATIONAL CHART
2 - 4 YEARS



REPORT ON STAFFING REQUIREMENTS

The Committee to evaluate the staffing requirements for the nursing units at the Augusta Mental Health Institute had three objectives:

I To define the core elements of therapeutic care delivered by the nursing staff for the patient population.

II To recommend a plan for determining the number and skill mix of staff required for nursing care.

III To support these recommendations with a rationale which encompasses principles used to define staffing requirements.

The Committee's assessments and recommendations are outlined according to the above objectives. For the purpose of this report, staffing is the process of determining and providing the acceptable number and mix of nursing personnel to produce a desired level of care to meet the patient's demand for care (Rowland, 1986).

OBJECTIVE I

Define the core elements of therapeutic care delivered by nursing staff for the patient population. The data base included:

I. Interviews with the Consultant for Nursing and Unit Directors.

II Interviews with nursing staff selected at random.

III Unit observations

ASSESSMENT

A. Nursing Care and Practice Model

The therapeutic care provided by the nursing staff appears to be custodial and crisis oriented. The major emphasis of the nursing care is patient safety and defusing escalating behavior in order to prevent an assaultive incident. These are important aspects of psychiatric care for all patients, however, safety and nonviolent crisis intervention are usually approached in the broader context of therapeutic treatment.

The practice model or delivery system utilized to provide patient care seems to be a hybrid of functional and team nursing. This approach has a strong emphasis on tasks and fragments care. Functional and team nursing minimizes continuity of care, blurs the accountability for care and forfeits the evaluation of care outcomes. There is minimal evidence that the Professional Nurse is planning and evaluating care.

Most units do not have a therapeutic treatment program. There is little evidence of large and small group work focused on corrective change that is continuous. This observation also applies to the nursing home units. It is our observation that nursing staff in these units are providing basic physical care to patients. Consequently, the milieu structure is

provided by people, rather than through a therapeutic program. This dependency on staff for structure generates the felt need that more staff is required to do the job. This approach leaves the milieu loose, and the patient population vulnerable to regression.

A therapeutic program provides for patient and staff safety, allows for maintenance of functional status, contains the patient's anxieties, and allows for corrective change. We also noted that the physical environment interferes with the planning and implementation of care; thus increasing the perception that more staff is required to deliver that care. For example, the units are not designed to keep the patient population visible and accessible to staff.

It appears that the Adolescent Treatment Unit has a therapeutic program which provides treatment on an ongoing basis. The milieu is structured and the care delivery system seems to be a modification of primary nursing. The care of the patient appears to be planned and evaluated by a professional team.

B. CONSTANT OBSERVATIONS AND ONE TO ONE INTERVENTION

Nursing interventions such as constant observation and one to one were reviewed because these interventions effect unit staffing on each shift. It is not clear if adequate assessment to initiate and terminate one to one status is conducted by the Professional Nurse. One to one seems to be utilized as an on going intervention rather than an approach reserved for active suicidal ideation and acute care situations.

During the month of June 1989, 8% of the total patient population was placed on one to one status across several units (Table I). This approach to patient care demands a high utilization of staff. We also noted a cluster of patients in the same units who required one to one care over several days. Regression frequently occurs with a lack of structure and therapeutic program.

The procedures for constant observation and one to one lack clarification and distinction about how they differ and when they could be implemented. For example, the supervision procedure for suicide precaution, one to one and constant observation are very similar and describe minimal differentiation.

C. PATIENT ESCORT AND SUPPORT SERVICES

Presently, many units schedule several patient escorts each day for on campus appointments. These appointments are often lengthy and remove care providers from the units. It was reported that staff are required to escort patients in order to communicate information about the patients. This is an example of poor staff utilization and a more efficient escort and communication system is required.

A variety of non-nursing functions such as cleaning floors and toilets, managing linen, preparing food and clerical activities were reported to be delegated to nursing staff. This is another indication of poor staff utilization and a lack of support from other ancillary departments.

RECOMMENDATIONS

. DEVELOPMENT OF THERAPEUTIC PROGRAMS

Each unit needs to develop a therapeutic program which provides structure to the milieu. A lack of therapeutic structure results in patient regression, acting out and increased need for one to one intervention. The Adolescent Treatment Unit has a structured milieu and care planned by a professional team. We suggest that the Adolescent Unit conduct a program evaluation in an effort to evaluate quality and appropriateness of care provided to this particular population. Once evaluated, this program can be used as a model to develop other therapeutic programs. Development of therapeutic programs could begin immediately.

. DEVELOP A PROFESSIONAL PRACTICE MODEL

Develop a professional practice model which provides for continuity of care and accountability for care outcomes. This approach would require a higher ratio of Professional Nurses to nonprofessional care staff. The Adolescent Unit can serve as a model of modified primary nursing. This approach establishes accountability and continuity in the plan of care with those providing the direct care. Successful implementation of a professional practice model could occur after the transition in leadership and the establishment of a Department of Nursing.

. EVALUATE CONSTANT OBSERVATION AND ONE TO ONE INTERVENTIONS

A review of these procedures with clarification about how and when to implement them is necessary. More specific criteria for implementation is needed to insure uniform application. The emphasis should be on patient assessment conducted by the Professional Nurse. We suggest minimum use of constant observation and utilization of one to one for acute care needs. There is a subgroup of patients who make self-destructive gestures such as wrist scratching, hand and head banging, who regress with one to one intervention. The use of the quiet room, frequent checks and behavioral approaches are more effective with this patient population. Concern about milieu structure is critical and has an impact on the utilization of one to one intervention. We suggest that seclusion with frequent checks be implemented for the patient who is assaultative. The evaluation of these procedures can be immediate.

. A MORE EFFICIENT SYSTEM FOR PATIENT ESCORT AND SUPPORT SERVICES

We suggest that patients who have on campus privileges, use them to their appointments unescorted. We suggest unit appointments for therapy, social work and unit rounds by clinic staff for those patients restricted to the unit. This would allow care providers to remain with the larger group of patients who need care and a better utilization of the assigned staff. This would also provide a better mechanism of communication about the patient needs.

Ancillary support services provided by the appropriate personnel need to be in place and functioning daily. Professionals need to be free of non-nursing functions in order to provide therapeutic care to the patients.

OBJECTIVES II & III

Recommend a plan for determining the number and level of staff needed for nursing care and support these recommendations with a rationale which encompasses principles used to define staffing requirements. The data base included:

I Interviews with the Consultant for Nursing.

II Interviews with Unit Directors and Staffing Coordinator.

III Interviews with a random selection of nursing staff.

IV Review of acuity tool (Appendix A) sick time, overtime, float record (Appendix B), position control report (Appendix C), minimum staffing plan (Appendix D), ICF survey report (Appendix E).

ASSESSMENT

A. STAFFING METHODOLOGY

The present staffing methodology is based upon the capacity census, the usual number of staff expected, with some attention to safety of the patient environment. For example, the total FTE's on duty in June sometimes matched the daily minimum plan, sometimes matched the needs specified by the acuity tool, and some units had no match at all. This indicates a lack of structure and methodology for daily staffing (Table II and III).

The time schedule for each unit is planned by two central staffing coordinators. These coordinators plan and augment daily schedules. A float system is utilized to provide staff coverage to those units with sick calls and additional staffing needs for one to one care. This means that units which have adequate staff coverage for a given shift are at risk to lose a care provider to a unit in need of help. We suspect that this approach to fill staffing needs has created the problem of excessive sick time and overtime usage and contributes to low morale.

During the month of June a total of 9.3 FTE's per day reported out sick. A total 18.5 FTE's per day worked overtime. Also in June a total of 8 FTE's per day were floated to other units (Table II). The float system also creates problems with continuity of care because care providers are "floated" to units where they do not know the patient and have difficulty providing individualized care.

The Psychiatric Patient Classification and Nursing Care Hours report is currently utilized by most units to collect data about patient acuity, census and staff compliments per shift (Appendix A). However, these data were not used to guide staffing decisions. Upon review of the classification data and use of RN's I, II, III, LPN's and MHW's I, II, III

for direct care, we conclude that some units are understaffed such as Stone South Middle and Stone North Upper, while other units are overstaffed such as Stone North Upper, Stone North Middle, Forensic and Forensic Treatment (Table III). Table three also illustrates that the total budget positions are nearly adequate to meet the acuity needs of patients for the capacity census. If actual census surpasses capacity, additional worked hours in overtime might be necessary.

Overall the units are overstaffed for the average census but adequately staffed for capacity census. There is, however, a 10% vacancy in budget positions. This vacancy rate leaves the nursing staff feeling short staffed. These data differ from the Quality Health Report (QHR) and we suggest that the data sources used were different.

A review of the classification data and the staff currently available indicates that current staff to patient ratios meet the standard as applied at Trenton New Jersey State Hospital and McLean Hospital in Belmont, Massachusetts and exceeds the standard at a California State Hospital (Table IV). There are some confounding variables which skew the present staffing plan. Excessive use of one to one intervention along with a high degree of role diffusion makes the present core staffing plan feel inadequate.

The nursing home units could explore a more comprehensive classification system. We suggest that this area develop a classification tool which would capture the actual acuity needs of those patients. The ICF Survey Report represents minimum staffing versus staff needed to meet patient's needs (Appendix E). We note that these units seem under staffed and do require a higher ratio of professional to non professional staff. We also suggest a program evaluation to ascertain the need for Occupational therapy, Physical Therapy and further development of recreational activities.

ROLE DIFFUSION AND ROLE BLURRING

Upon review, we find a budgeted ratio of 1:7 Professional Nurses to Mental Health Workers and Licensed Practical Nurses and an actual ratio of 1:10 due to vacancies (Table V). This appears to be out of balance compared with McLean Hospital and indicates a need for more professional nurses.

There are many staff, professional and non professional, who perform clinical and administrative functions that belong to the purview of a nurse manager. Consequently, this role diffusion has blurred the line of accountability at the unit level and has removed care providers from direct care activities. This blurring of accountability also contributes to inadequate decisions about staffing and inadequate management of sick time and overtime usage. We agree with the Quality Health Report (QHR) which recommends reallocation of professional nurse and Mental Health Worker positions to direct care FTE's.

RECOMMENDATIONS

UNIT BASED SCHEDULING

Facilitate time planning at the unit level because those individuals have the local specific knowledge about the patients and the care they require. This could be implemented immediately and would increase morale and unit accountability.

Explore flexible staff schedules that would meet individual unit needs. This could lead to a more efficient use of staff and enhance recruitment and retention.

Examine the high utilization of sick time and overtime. Establish clear authorization of sick time and overtime at the unit level and establish policies to effectively manage it.

Improve distribution of staff to all shifts. A fuller staff compliment to evening and night shifts is needed. There is a strong tendency to heavily schedule the day shift and leave the evening and night shifts light. These decisions should be based upon the patient acuity and skill mix of staff required not solely upon staff's desire to work the day shift.

Reallocate of FTE's from units identified as overstaffed to the units identified as understaffed. This could be implemented immediately.

CENTRAL FLOAT POOL

Develop the use of the central float pool. This pool includes individuals who elect to be assigned to nursing units in need of staff. It is well documented in the health care literature that "floating" staff from units impacts morale and is viewed negatively. The central float pool is a more cost effective approach and may help decrease sick time.

Expand the pool to include professional Nurses and Licensed Practical Nurses.

Utilize one Staffing Coordinator to manage the Central Float Pool and assign staff to units in need of help. The nursing home units are self contained and could cover their staffing needs.

PATIENT CLASSIFICATION TOOL

Continue the utilization of the present classification tool and establish content validity and interrater reliability. The use of a classification tool demonstrates movement away from a census focused model of staffing. This is positive because a classification system can better predict the patient's nursing care needs, staffing needs and budgetary parameters.

Acquire consultation to educate and assist staff with a full understanding and application of this tool. The notion that a computer system is required to capture this data is erroneous. The Staffing Coordinator would be an appropriate individual to tabulate

this data. This can be accomplished immediately. Computer support could be pursued after a classification system is in place.

DEVELOP DATA MANAGEMENT SYSTEMS

A more efficient system to collect and interpret pertinent data is needed. Present systems do not handle data diligently and accurately. We suggest a more accurate documentation, filing and trending system to be established. Assistance is also needed for the accurate interpretation and application of this information. These efforts can be accomplished without automation. Computer support should not be pursued until a data management reporting system is in place.

CLARIFY ROLES AND JOB DESCRIPTIONS

Clarification of roles according to professional competency is needed. This would contribute to the better utilization of current staff.

The skill mix should be adjusted to reflect a 1:3 ratio of Professional to Non Professional staff in all units except Alternative Living Program and the nursing home units (Table VI).

We recommend additional staff changes in the following areas:

I. A ratio of 1:6 Professional to Non Professional for Alternative Living Program.

II. Determine the staff ratio for the nursing home units as part of the development of a classification system.

III. Increase RN II positions, MHW II and MHW III positions and decrease MHW I positions to improve skill mix of staff and to ease into the transition period.

IV. Consider reallocation of MHW FTE's to Registered Nurse FTE's based on attrition.

SUMMARY OF RECOMMENDATIONS

STRUCTURE AND ORGANIZATION

1. Create a Department of Nursing led by a qualified Director of Nursing.

2. Place the Nursing Department within the total organizational structure in a direct relationship to the Superintendent.

3. Redefine the Registered Professional Nurse role at the unit level to enhance direct care functions and professional accountability.

4. Redefine the Mental Health Worker role to enhance patient care functions and more clearly define responsibility.

5. Create three positions, responsible to the Director of Nursing, which would carry responsibility for development and management of psychiatric services, extended care services and management services.

6. A plan for definition and placement of patient populations must be created and acted upon promptly.

7. Structure nursing units with defined patient populations and nursing staff assigned according to patients' nursing needs. Each nursing unit should be managed by a Head Nurse who is a Registered Nurse with appropriate education and experience.

8. Staffing patterns for nursing units must be developed and managed at the unit level.

9. The centralized staffing function should consist primarily of a group of nursing staff, both Registered Nurses and Mental Health Workers, who have been hired to fill vacancies in unit staffing patterns on a shift by shift basis.

10. The function of coordinating the materials and ancillary services needed to support nursing services should be defined and developed in a group of positions assigned to supporting nursing services in this manner.

11. Ancillary services of all types must be addressed if nursing service is to maintain a safe and therapeutic environment and meet standards of regulatory bodies.

12. A concentrated, organized staff development effort must be initiated and supported if above recommendations are to be implemented effectively.

13. Each Assistant Director of Nursing (three) should be assigned a staff support position on a temporary basis to carry out projects necessary to the reorganization and development of Nursing Services over the next two to four years.

SUMMARY OF RECOMMENDATIONS

STAFFING

1. Each unit needs to develop a therapeutic program which provides structure to the milieu.

2. Develop a professional practice model which provides for continuity of care and accountability for care outcomes.

3. Evaluate constant observation and one to one interventions.

4. Develop a more efficient system for patient escort and support services.

5. Establish unit based scheduling.

6. Continue the use of the central float pool, staffed with individuals who elect to be assigned to nursing units in need of staff.

7. Continue the utilization of the present classification tool and establish content validity and interrater reliability.

8. Acquire consultation to educate and assist staff with a full understanding and application of this tool.

9. Develop data management systems to collect and interpret pertinent data.

10. Clarify roles and job descriptions.

11. Increase RN II, MHW II and MHW III and decrease MHW I to improve skill mix of staff and to ease into the transition period.

12. Consider reallocation of Mental Health Worker FTE's to Registered Nurse FTE's based on attrition.

TABLE I

Number and Percent of Patients on 1 to 1 Observation PER DAY

On AMHI Psychiatric Units

UNIT	AVERAGE CENSUS	NUMBER OF PATIENTS ON 1:1 OBSERVATION	% OF PATIENTS 1:1 OBSERVATIONS
SNL Admit	18.7	6.0	32%
SSU Adult Tx	44.8	1.4	3%
SSM Young Adult#	44.8	2.7	6%
SNU Pre Discharge	25.4	1.1	4%
SNM Older Adult	46.0	1.0	2%
Adolescent	12.8	3.8	30%
Alternative Living	No data	No data	No data
Forensic	7.1	1.0	14%
Forensic Tx*	23.0	1.0	3%
TOTAL	222.6	18.0	8%

Source: AMHI Patient Acuity Records, June 1989

* Forensic Tx had 10 patients on pass, thus 23 patients on unit.
# Stone South Middle - no data available, estimate made.

TABLE II

AVERAGE PER DAY: FTEs Scheduled vs. FTEs Actual on Duty - AMHI Psychiatric Units

JUNE 1989

UNIT NAME	CAPACITY CENSUS	ACTUAL CENSUS	ACUITY FTEs CAP CEN	FTEs DAILY PLAN	FTEs SCHEDULED PER DAY	FTEs SICK PER DAY	FTEs OVERTIME PER DAY	FTEs FLOATED IN PER DAY	FTEs FLOATED OUT PER DAY	TOTAL FTEs ON DUTY	ACUITY FTEs AVER CEN
SNL Admit	30.0	18.7	31.0	23.0	25.1	1.0	2.8	0.4	0.8	26.1	19.0
SSU Ad. Tx	45.0	‡ 44.8	25.0	17.0	23.2	1.7	1.7	1.3	0.8	23.7	24.5
SSM Y. Ad.	45.0	* 44.8	* 35.0	17.0	30.6	1.2	1.9	1.1	0.6	33.0	* 34.4
SNU Pre Disch	45.0	25.4	29.0	10.0	18.6	1.5	0.6	0.4	2.4	15.7	16.4
SNM Older Ad.	40.0	46.0	27.0	17.0	28.1	1.5	2.4	0.4	2.5	26.9	31.0
Adolescent	20.0	12.8	20.0	17.0	22.4	0.9	3.5	0.6	0.3	25.3	12.5
Altern. Liv.	40.0	no data	12.0	12.0	22.0	0.3	1.3	0.1	0.3	22.8	* 12.0
Forensic	8.0	7.1	9.0	6.0	10.3	0.5	1.4	0.3	0.4	11.1	7.9
Forensic Tx	25.0	‡ 23.0	18.0	12.0	1.9	0.7	2.9	0.6	0.7	21.2	16.6
TOTALS	293.0	222.6	206.0	131.0	199.4	9.3	18.5	5.2	8.0	205.8	174.3

Sources: Sick/Overtime Report, June 1989 for Sick, Overtime, Float-In, Float out
"Position Control Report", June 1989 for Capcity Census
AMHI Patient Acuity Records, June 1989 for average census, acuity plans, FTE scheduled.

Formula: Hours per month ÷ 30 = hours per day. Hours per day ÷ 8 = FTEs per day

‡FTU - 10 patients on Pass, thus 23 average census
SSU - 16 patients on Pass for Community placement. Thus 44.8 on unit.

* SSM - no data available, estimate made

ALP

TABLE III
AVAILABLE STAFF, BUDGETED STAFF, STAFF BY ACUITY
REPORTED IN FTE's
AMHI PSYCHIATRIC UNITS

UNIT	CAPACITY CENSUS	STAFF AVAILABLE	BUDGETED POSITIONS	POSITIONS BY ACUITY	DAILY 24 HR MIN. PLAN	DAILY 24 HR BY ACUITY
SNL Admit	30.0	41.1	44.0	42.8	23.0	31.0
SSU Ad. Tx	45.0	39.0	41.0	34.6	17.0	25.0
SSM Y. Ad.	45.0	34.5	38.0	est 48.2 no data	17.0	est 35.0 no data
SNU Pre Di	45.0	33.0	35.0	40.6	10.0	29.0
SNM Older	40.0	34.3	41.0	37.8	17.0	27.0
Adolescent	20.0	23.6	27.0	27.4	17.0	20.0
Altern. Li	40.0	26.0	27.0	used 27.0 no data	12.0	used 12.0 no data
Forensic	8.0	12.0	16.0	12.6	6.0	9.0
Forensic T	25.0	22.5	26.0	25.2	12.0	18.0
TOTALS	293.0	266.0	295.0	296.2	131.0	206.0

*All figures are based on paid hours. 1 FTE = 40 hrs/week or 2080 hrs/yr.

Sources:
Capacity census from "Position Control Report", June 30, 1989
Staff available from "Position Control Report". Only RN, MHW I, II, III and LPN used.
Budgeted positions from "Position Control Report". Only RN, MHW I, II, III and LPN used.
Acuity from June 1989 Acuity Records.
(HPPD × Census) ÷ 8 = FTE/Day. × 1.4 = Budget
Daily Minimum Plan from Staffing Office
Daily Acuity from average HPPD calculated from June 1989 AMHI records.

TABLE IV
RATIO OF STAFF TO PATIENTS*

AMHI PSYCHIATRIC UNITS

UNIT NAME	UNIT TYPE	CAP CENSUS	AMHI STAFF AVAIL DAY	EVE	NOC	AMHI BY ACUITY DAY	EVE	NOC	CALIFORNIA DAY	EVE	NOC	TRENTON & McLEAN DAY	EVE	NOC
SNL	Admit	30.0	1-3	1-3	1-5	1-3	1-3	1-6	1-6	1-6	1-12	1-4	1-4	1-7
SSU	Ad. Tx	45.0	1-4	1-4	1-8	1-5	1-5	1-9	1-6	1-6	1-12	1-4	1-4	1-7
SSM	Y. Ad.	45.0	1-5	1-5	1-9	1-3	1-3	1-6	1-6	1-6	1-12	1-4	1-4	1-7
SNU	Pre Disch	40.0	1-4	1-4	1-9	1-4	1-4	1-7	1-8	1-8	1-18	1-4	1-4	1-7
SNM	Older Ad.	40.0	1-4	1-4	1-8	1-4	1-4	1-8	1-6	1-6	1-12	1-4	1-4	1-7
Adolescent		20.0	1-3	1-3	1-6	1-3	1-3	1-5	1-6	1-6	1-12	1-4	1-4	1-7
Altern. Liv.		40.0	1-5	1-5	1-11	NO ACUITY AVAIL			1-8	1-8	1-18	---	---	---
Forensic		8.0	1-3	1-3	1-4	1-3	1-3	1-4	1-8	1-8	1-18	---	---	---
Forensic Tx		25.0	1-4	1-4	1-8	1-4	1-4	1-7	1-8	1-8	1-18	---	---	---
AVERAGE		293.0	1-4	1-4	1-8	1-4	1-4	1-7	1-7	1-7	1-15	1-4	1-4	1-7

*Ratios all based on capacity census.

Formulas: 1. Number of Full time Equivalent Staff Available ÷ 1.4 = Number of staff available daily.
2. No. staff avail x 40% = No. for Days. (40% for Eves) (20% for Nocs) Census ÷ No. = ratio.

California figures reported per telephone consult. Trenton and McLean calculated from materials received: Total Census ÷ No. staff planned = ratio.

TABLE V

Ratio of Professional to Non-Professional Staff*

On AMHI Psychiatric Units

UNIT	BUDGETED POSITIONS	FILLED POSITIONS
SNL Admit	1 RN to 2.4 LPN/MHW	1 RN to 3.3 LPN/MHW
SSU Adult Tx	1 RN to 4.8 LPN/MHW	1 RN to 6.8 LPN/MHW
SSM Young Adult	1 RN to 4.4 LPN/MHW	1 RN to 6.6 LPN/MHW
SNU Pre Discharge	1 RN to 3.4 LPN/MHW	1 RN to 3.7 LPN/MHW
SNM Older Adult	1 RN to 3.1 LPN/MHW	1 RN to 5.2 LPN/MHW
Adolescent	1 RN to 4.4 LPN/MHW	1 RN to 5.5 LPN/MHW
Alternative Living	1 RN to 12.5 LPN/MHW	1 RN to 25.0 LPN/MHW
Forensic	1 RN to 3.0 LPN/MHW	1 RN to 11.0 LPN/MHW
Forensic Tx	1 RN to 7.6 LPN/MHW	1 RN to 21.5 LPN/MHW
AVERAGE	1 RN to 5.1 LPN/MHW	1 RN to 9.8 LPN/MHW

*Only RNs I, II, III, LPNs and MHWs I, II, III used.

Note: Ratio at McLean is 1 RN to 1.1 non professional staff

Sources: AMHI "Position Control Report", June 30, 1989

TABLE VI

IMPROVING RATIO OF PROFESSIONAL TO NON-PROFESSIONAL STAFF ON AMHI PSYCHIATRIC UNITS

(RN I, II, IIIs, LPNs and MHW I, II, IIIs)

		BUDGETED STAFFING						SUGGESTED STAFFING						ADJUSTMENTS				
UNIT	NAME	BUDGETED POSITIONS	RN	LPN	MHW I	MHW II	MHW III	TOTAL	RN	LPN	MHW I	MHW II	MHW III	TOTAL	RN	LPN	MHW I	MHW II	MHW III
SNL	Admit	1 to 2.4	13	4	9	13	5	44.0	13.0	4.0	9.0	13.0	5.0	44.0	NONE	NONE	NONE	NONE	NONE
SSU	Ad, Tx	1 to 4.8	7	4	17	10	3	41.0	9.0	4.0	8.6	10.0	3.0	34.6	+ 2.0	0	- 8.4	0	0
SSM	Y. Ad.	1 to 4.4	7	3	16	9	3	38.0	12.0	3.0	12.2	16.0	5.0	48.2	+ 5.0	0	- 3.8	+ 7.0	+2.0
SNU	Pre Disch	1 to 3.4	8	1	14	9	3	35.0	10.2	1.0	10.0	14.4	5.0	40.6	+ 2.2	0	- 4.0	+ 5.4	+2.0
SNM	Older Ad.	1 to 3.1	10	4	16	8	3	41.0	9.6	4.0	9.0	12.2	3.0	37.8	- 0.5	0	- 7.0	+ 4.2	0
Adolescent		1 to 4.4	5	2	11	6	3	27.0	7.0	2.0	7.0	8.4	3.0	27.4	+ 2.0	0	- 4.0	+ 2.4	0
Altern. Liv.		1 to 12.5	2	0	12	9	4	27.0	4.0	0.0	8.0	11.0	4.0	27.0	+ 2.0	0	- 4.0	+ 2.0	0
Forensic		1 to 3.0	4	0	7	4	1	16.0	4.0	0.0	2.6	5.0	1.0	12.6	0	0	- 4.4	+ 1.0	0
Forensic Tx		1 to 7.6	3	2	10	9	2	26.0	6.2	2.0	6.0	9.0	2.0	25.2	+ 3.3	0	- 4.0	0	0
Float Pool		0 to 28.0	0	0	28	0	0	28.0	7.0	0.0	10.0	11.0	0.0	28.0	+ 7.0	0	-18.0	+11.00	0
TOTAL		1 TO 7.0	59	20	140	77	27	323.0	82.0	20.0	82.4	110.0	31.0	325.4	+23.0	0	-57.6	+33.0	+4.0

Rationale:

1. Aim for a ratio of 1 RN to 3 non-professional nursing staff, except for ALP.
   Aim for a ratio fo 1 RN to 6 for ALP.
2. Increase RN II positions only for now
3. Reduce MHW I positions. Increase MHW II and III positions to minimize impact of changes on staff
4. Ratio of MHW I to MHW II positions is suggested as 1 to 1.2 - 1.5
5. Adjustments based on ratios and on patient acuity data for total FTEs.
6. Formula: Total FTEs ÷ 4 = No. RNs.
   Total FTEs minus RNs, LPNs, MHW IIIs = No. MHW Is and IIs.

FIGURE 1

Psychiatric Patient Classification and Nursing Care Hours Report

Page ___ of ___ Unit _____ Date _____
Signature _____ Time _____

	7-3	3-11	11-7
Census			
RN			
LVN			
NL			
Nsg. Hrs.			
Total Nsg. Hrs.			

Comments: _____

Bed	Name
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	

Level 1 (7-12)
Level 2 (13-18)
Level 3 (19-24)
Level 4 (25+)

Do Not Use This Space

Total Hours Required: _____

Nursing Care Activities	Acuity	Bed 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
I. THERAPEUTIC INTERACTION 1 to 1	4																
New Admission	3																
Frequent	2																
Routine	1																
II. MEDICATIONS I.V. fluid and/or medication	4																
Meds. infrequently/ PRN meds/side effects	3																
New medication	2																
Routine medication	1																
No medication	0																
III. PHYSICAL PROBLEMS Bed care or isolation	4																
Secondary physical problems, moderate extra care	3																
Secondary physical problems, minimal extra care	2																
Routine care	1																
IV. DIET/NUTRITION Hand or tube feeding	4																
Urge. supervise dining 1:1	3																
Supervised group dining	2																
Routine supervised dining	1																
V. HYGIENE Complete care	4																
Direct assistance	3																
Needs urging, supervision	2																
Self-care	1																
VI. ACTIVITIES/ PRIVILEGES Restricted to unit	3																
Staff attended pass	2																
Unattended pass	1																
VII. RISK Suicidal (level 3), elopement, or assaultive, high	4																
Suicidal (level 2), elopement, or assaultive, moderate	3																
Suicidal (level 1), elopement, or assaultive, minimal	2																
No overt risk	1																
VIII. TEACHING/ PLANNING Requires 1:1 with patient/family	4																
Discharge	3																
Requires group teaching	2																
Routine	1																
IX. OTHER Seclusion or restraints	4																
ECT	3																
Accompanied campus appointments	3																
Extra lab tests	2																
Accompanied to school	2																
Care plan update	1																
	Total Points																
	Acuity Level																
	Bed	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

APPENDIX B

AMHI Sick, Overtime and Float Record

Psychiatric Units

June, 1989

UNIT NAME	SICK TIME HRS	OVERTIME HOURS	FLT TO HOURS	FLT FROM HOURS
SNL Admit	251	664	112	200
SSU Ad. Tx	409	400	320	192
SSM Y. Ad.	296.5	456	256	144
SNU Pre Disch	355	152	112	568
SNM Older Ad.	348	568	112	596
Adolescent	222	848.25	152	64
Altern. Liv.	64	320	24	72
Forensic	112	336	80	96
Forensic Tx	176	688	144	168.25
Float Pool	80	160	0	0
N.S.	16	0	0	0
TOTAL Hrs/Mo.	2329	4592.25	1312	2100.50
TOTAL Hrs/Day	77.63	153.08	43.73	70.02

Formula: $\frac{\text{Total Hours/Mo}}{\text{30 Days}}$ = Total Hrs/Day

APPENDIX C
AMHI Position Control Report*
In Full-Time Equivalents (FTE's)

Ward	Positions	Budgeted FTE's	Actual FTE's
Nursing Office	RN IV	5.0	2.0
	RN II	1.0	1.0
	Infection Control	1.8	1.8
	Medication Instructor	0.3	0.3
	Staff Development	1.0	1.0
	Pt. Care Coordinator	1.0	1.0
	Staffing Coordinator	2.0	2.0 (1 Psych; 1 Nsg. Home)
	Coordinator for Nursing	1.0	1.0
	Patient Funds	1.0	1.0
	MHW V	1.0	1.0
	Totals	15.1	12.1
	Vacancies = 20%		
Float Pool	RN III	0.4	0.4
	RN I	1.0	1.0
	MHW (? level)	27.0	25.0
	Totals	28.4	26.4
	Vacancies = 7%		
SNL	Unit Director	0.2	0.2
	Clinical Nsg. Specialist	1.0	1.0
	RN IV	1.0	1.0
	RN III	6.0	5.5
	RN II	7.0	4.6
	LPN	4.0	3.0
	MHW V	1.0	1.0
	MHW III	5.0	5.0
	MHW II	13.0	13.0
	MHW I	1.0	1.0
	Ward Clerk	1.0	1.0
	Totals	48.2	44.3
	Vacancies = 8%		

*From materials prepared by AMHI staff, June 30, 1989. (One FTE = 40 hrs/week)

Appendix C - Continued (2 of 5)

Ward	Positions	Budgeted FTE's	Actual FTE's
SSU (Adult Treatment)	Unit Director	0.2	0.2
	RN III	3.0	3.0
	RN II	4.0	2.0
	LPN	4.0	4.0
	MHW VI	0.5	0.5
	MHW IV	2.0	2.0
	MHW III	3.0	3.0
	MHW II	10.0	10.0
	MHW I	17.0	17.0
	Ward Clerk	1.0	1.0
	Totals	44.7	42.7
	Vacancies = 4%		
SSM Young Adult	Unit Director	0.2	0.2
	RN III	4.0	4.0
	RN II	3.0	0.5
	LPN	3.0	3.0
	MHW VI	0.5	0.5
	MHW IV	1.0	1.0
	MHW III	3.0	3.0
	MHW II	9.0	9.0
	MHW I	16.0	15.0
	Ward Clerk	1.0	1.0
	Totals	40.7	37.2
	Vacancies = 8%		
SNU (Pre Discharge)	Unit Director	0.3	0.3
	RN III	3.0	3.0
	RN II	4.0	3.0
	RN I	1.0	1.0
	LPN	1.0	1.0
	MHW VI	1.0	1.0
	MHW IV	2.0	2.0
	MHW III	3.0	3.0
	MHW II	9.0	9.0
	MHW I	14.0	14.0
	Ward Clerk	1.0	1.0
	Totals	39.3	38.3
	Vacancies = 2%		

Ward	Positions	Budgeted FTE's	Actual FTE's
SNM (Older Adult)	Unit Director	0.4	0.4
	RN III	4.0	4.0
	RN II	5.0	0.0
	RN I	1.0	1.0
	LPN	4.0	2.2
	MHW VI	1.0	1.0
	MHW IV	2.0	2.0
	MHW III	16.0	16.0
	MHW II	8.0	7.0
	MHW I	16.0	16.0
	Ward Clerk	1.0	1.0
	Totals	58.4	50.6
	Vacancies = 13%		
Adolescent	Unit Director	1.0	1.0
	RN III	2.0	2.0
	RN II	3.0	1.6
	LPN	2.0	2.0
	MHW IV	1.0	1.0
	MHW III	3.0	3.0
	MHW II	6.0	6.0
	MHW I	11.0	9.0
	Totals	29.0	25.6
	Vacancies = 12%		
Alternative Living Program	Unit Director	0.3	0.3
	RN III	1.0	0.0
	RN II	1.0	1.0
	MHW V	1.0	1.0
	MHW III	4.0	4.0
	MHW II	9.0	9.0
	MHW I	12.0	12.0
	Totals	28.3	27.3
	Vacancies = 3%		

Appendix C - Continued (4 of 5)

Ward	Positions	Budgeted FTE's	Actual FTE's
Forensic	Unit Director	0.2	0.2
	RN III	1.0	0.0
	RN II	3.0	1.0
	MHW VI	0.5	0.5
	MHW V	0.5	0.5
	MHW III	1.0	1.0
	MHW II	4.0	3.0
	MHW I	7.0	7.0
	Totals	17.2	13.2
	Vacancies = 23%		
Forensic Treatment	Unit Director	0.2	0.2
	RN III	3.0	1.0
	LPN	2.0	2.0
	MHW VI	0.5	0.5
	MHW V	0.5	0.5
	MHW IV	2.0	2.0
	MHW III	2.0	2.0
	MHW II	9.0	8.5
	MHW I	10.0	9.0
	Ward Clerk	1.0	1.0
	Totals	30.2	26.7
	Vacancies = 12%		
Clinics	Unit Director	0.25	0.25
	RN III	1.0	1.0
	RN II	3.0	2.0
	RN I	1.0	0.0
	LPN	2.0	1.0
	Totals	7.25	4.25
	Vacancies = 41%		
Senior Rehab	Unit Director	0.25	0.25
	RN III	3.0	3.0
	RN II	4.0	3.0
	LPN	5.0	4.0
	MHW II	8.0	no data
	MHW I	17.0	no data
	Totals	37.25	
	Vacancies = ?		

Appendix C - Continued (5 of 5)

Ward	Positions	Budgeted FTE's	Actual FTE's
Greenlaw Lower	Unit Director	0.25	0.25
	RN III	1.0	1.0
	RN II	1.0	0.0
	LPN	6.0	3.0
	MHW II	9.0	no data
	MHW I	24.0	no data
	Totals	41.25	
	Vacancies = ?		
Greenlaw Middle	Unit Director	0.25	0.25
	RN III	3.0	3.0
	RN II	1.6	0.6
	LPN	4.0	3.0
	MHW II	9.0	no data
	MHW I	23.0	no data
	Totals	40.85	
	Vacancies = ?		

AMHI PSYCHIATRIC UNITS - MINIMUM STAFFING PLAN

The following are the guidelines for coverage for safety:
The #'s include licensed coverage. Add 1 MHW for COR or 1-1
(ADM & ADOL include COR count)

Admis SNL	Adult SSU	Young Adult SSM	Pre disch SNU	Older Adult SNM	ADOL	ALP	High Security FOR	SSL FTU
5 if census ↓ 15 7 if census ↓ 25 8 ↑ 25	6 7↑55	6	4 M-F (including meds & RN	6 7↑55	6	4 M-F	2 Add 1 if Census Over 8	4
as above	6 7↑55	6	3	6 7↑55	6	4 M-F	2 Add 1 if Census Over 8	4
6 if census ↓ 25 7↑25	5	5	3	5	5	4	2	4

minimum core staffing
adds: 1 for each 1;1
1 for appts
1 for sick calls

APPENDIX E

DEPARTMENT OF HUMAN SERVICES - BUREAU OF MEDICAL SERVICES

DIVISION OF LICENSING AND CERTIFICATION

INTERMIDIATE CARE FACILITIES SURVEY REPORT FORM INFORMATION

Name of Facility: NH. Unit A.I.H.I Town Augusta Date: 6/1/89
Lower Greenlaw

The following items are to be completed by the appropriate person in the facility and returned to the surveyor by the afternoon of the first day of survey.

. Total number of patients on day of survey: 35

. Nursing Activities:

A. Number of completely bedfast patients: 0

B. Number of strictly bed/chair residents: 13

C. Number of residents requiring full assistance with eating: 9

D. Number of residents requiring partial assistance with eating: 7

E. Number of residents normally eating in dining room: 14

F. Number of residents with indwelling catheters: 0

G. Number of incontinent residents (bowel/bladder): _____

Number of residents in bowel retraining program: 29 Bladder: 29
24
33

I. Number of residents with decubiti: 1

J. Number of residents receiving special skin care: 26
(Ointments, dressings, lamp treatments, etc.)

K. Number of residents on intake and output measurements: 0

L. Number of residents in restraints: 15

Geriatric Chairs 12
Posey belts (buckled or tied) 2
Posey Belts (locked) 0
Other (describe) Vest 6, Diaper 5, Lapcobe 3

M. Number of non-ambulatory on second floor and/or above: N/A

Dietary:

A. Number of therapeutic diets: 23 Mechanical Diets: 12

B. Number of tube feedings: 0

Name and position of person responsible for completing this information:

... Sandra [illegible] Title: LPN

level 1 0
level 2 7
level 3 28

Marriott

Marriott Corporation
Health Care Division East

10 Tower Lane
Avon, CT 06001

Ted W. Kinkel
Regional Vice President
203/678-1023

August 7, 1989

Mr. William Thompson
Interim Superintendent
Augusta Mental Health Institute
Arsenal Street
Augusta, ME 04330

Dear Mr. Thompson:

The consulting report on the Food and Nutrition Services Department that was prepared at your request is enclosed for your review and comments. We hope that you find this report helpful in your effort to maximize the quality of patient care and the overall operation at AMHI.

Of course, we stand ready to answer any questions that you may have regarding our findings and recommendations. Thank you for giving Marriott the opportunity to provide this service to the health care community and the State of Maine. We are pleased and complimented that you called on us in a time of need and that we were able to respond.

Sincerely yours,

Ted W. Kinkel, R.D.

TK/mmf
Enclosure

cc: C. Kelsey
M. Smith
P. Bridger

"EXECUTIVE BRIEF"

CONSULTING VISIT PERFORMED BY

THE HEALTH CARE SERVICES DIVISION OF MARRIOTT CORPORATION

for

FOOD AND NUTRITION SERVICES

AUGUSTA MENTAL HEALTH INSTITUTE

AUGUSTA, MAINE

Marriott corporation
Health Care Services

STATEMENT OF PURPOSE

At the request of Mr. William Thompson, Interim Superintendent, Augusta Mental Health Institute, management from the Health Care Services Division of Marriott Corporation performed an on-site consulting visit to the Food and Nutrition Services Department.

The purpose of this visit was to develop a report for Augusta Mental Health management designed to evaluate the status of the department in the following key result areas:

- Quality of Food and Clinical Services
- Food Service Systems and Equipment
- Labor Efficiency and Productivity

In addition to this status report, we have made recommendations regarding the future steps that may be taken to ensure quality of patient and resident care and maximum efficiency in the use of resources.

CONSULTING TEAM MEMBERS

The representatives of the Marriott Consulting Team who have prepared the components of this report come from varied health care backgrounds and speciality areas with extensive industry experience. In order to assist in your appraisal of the quality of the consulting report, it is important to know these team members.

Theodore W. Kinkel, R.D., Regional Vice President, Marriott Health Care Services, New England Region. Mr. Kinkel is responsible for food and nutrition services in over sixty acute care hospitals, nursing homes and specialty hospitals. He is a registered dietitian and earned an M.B.A. in Institutional Management and B.A. in Hotel and Restaurant Management from Michigan State University. He brings over 20 years of industry experience which includes seven years as a food service director, five years in human resources and training, and the remainder supervising multi-unit health care operations. He is a major, Army Medical Specialty Corps, in the United States Army Reserve and a member of the American Dietetic Association.

Peri Bridger, R.D.,Human Resource Manger, Marriott Health Care Services, New England Region. Ms. Bridger is responsible for human resource aspects of the region employing over 300 management and clinical professionals. She is active in recruitment, retention, training, benefit administration, EEO/Affirmative Action, and wage and salary administration. She graduated Cum Laude from Villa Maria College with a B.S. in Dietetics and is currently completing her masters degree. Her past experience includes two years as the Regional Clinical Manager responsible for food and nutritional standards in 55 health care facilities in the Southeastern United States. She has worked as a chief dietitian in a major community hospital as well as a food

service director responsible for acute care and a skilled nursing home in New York State. She possesses expertise in the areas of Quality Assurance as well as State and Federal Standards for Nutritional Services. She is a member of the American Dietetic Association and is a licensed Dietitian in the State of Georgia.

Martin Smith, Food Service Director, Hale Hospital, Haverhill, MA. Mr. Smith is responsible for all aspects of the food service and clinical program at this 181 bed acute care hospital. He earned an M.S. in Industrial Management from Clarkson University and holds a B.S. in Accounting. He has extensive experience in food production, purchasing, patient food service systems and public cafeteria operations. He has over twenty years of industry experience as food service director in hospitals ranging in size from 120 to 600 beds. Mr. Smith's major assignments include experience in municipal hospitals dealing with organized labor.

METHODOLOGY

The site visit to the Augusta Mental Health Institute was conducted on July 19, 1989. Both the food service and clinical programs were extensively reviewed through interviews with key members of administration and staff to include:

Mr. William Thompson, Interim Superintendent

Mr. Richard L. Hanley, M.Ed., Assistant to the Superintendent.

Mr. Richard E. Besson, Chief of Hospital Services

Mr. Daniel D. Spofford, R.D., Director, Food and Nutrition Services

Ms. Mona VanWart, R.D.

Mr. Lee Corbin, Food Service Manager

Patient meal service observation was conducted in all units and selected records and documents reviewed that pertained to nutrition standards of care and clinical quality assurance. The facilities, equipment and spatial relationships were reviewed in order to evaluate labor productivity as well as the ability of the department to provide wholesome, nourishing and tasty food prepared under hygienic conditions and served at optimum temperatures.

FINDINGS

SERVICE LEVELS AND PROGRAM QUALITY

FOOD SERVICE PROGRAM

STRENGTHS

Levels of sanitation were consistent and no deficiencies were noted.

The resident menu appeared appropriate for regional and ethnic preferences.

Food was adequately and appropriately seasoned.

Meats were properly prepared and those tasted were "fork" tender.

Staff was friendly, uniforms and hair coverings were in place with a neat and clean appearance.

Checklists and logs existed for sanitation inspections, dish machine temperature, refrigerator temperatures.

Storage areas were neat, orderly and clean with no raw foods stored above or adjacent to cooked foods. Thermometers were in place.

The staff displayed an awareness of the principles of food safety to include proper food handling.

Some scratch or "homemade" preparation is emphasized in the preparation of soups and stocks.

AREAS FOR IMPROVEMENT

The procurement system which emphasizes on-site warehousing of significant quantities of inventory, encourages product slippage and overproduction leading to waste and increased cost.

Food production systems used to instruct cooks on quantities to prepare are inadequate.

Food temperatures at the point of service did not consistently meet federal and state Standards. Because of the age of equipment, delivery distances, and number of people involved in serving, food temperatures will be, at best, marginal and can routinely be expected to be non compliant with federal and state minimum requirements.

The decentralized kitchens, by their nature, encourage food waste and loss of supervisory control.

Food was not generally displayed attractively and the plate presentation was extremely institutional. No garnishing program was in evidence.

CLINICAL PROGRAM: To evaluate and appreciate the challenges in the clinical program, an understanding of the clinical needs of the patients is required. AMHI is a facility that provides for all age groups from pediatrics to geriatrics. The care is strongly focused towards mental health rehabilitation but inevitably carries with it a myriad of

other medical diagnosis. Optimum nutrition care is the foundation for the well being and potential improvement of any patient. Currently, AMHI is staffed with one clinical dietitian and one diet technician to meet the needs of approximately 380 patients.

Greenlawn and Senior Rehabilitation is a 100 patient, long term care unit with intermediate level of care requirements. A registered dietitian should attend IDT meetings six hours a week at a minimum. This ensures active communication between the dietitian and other healthcare members regarding the goals and outcomes of each individual patient's care plan. The State guidelines require that these patients, at a minimum, receive annual comprehensive assessments and quarterly updates in the medical record. The ability to meet this minimum requirement in a thorough and effective manner requires individual time in observation of food and nutrient intake. In addition, proper follow through and training with the dietary department staff is critical for the delivery of meals that are therapeutically accurate. This patient services division requires at least 24 hours per week of clinical dietitian time. Given the anticipated future intensity of federal and state requirements and the fact that some of these residents will be classified as "skilled", the attention to clinical time in this area is imperative.

The Psychiatric Divisions (North, South and Marquardt) treat approximately 255 patients of varying diagnosis and age. Of these, 27% or 70 patients are on modified diets. This component of the facility, if under state regulation, would more than fill a full time registered dietitians time schedule.

Administrative components of the patient clinical program consist of inservice training, quality assurance, routine interdepartmental communications, policy and procedure development, personnel administration, monthly reports, menu development and analysis, etc.. These functions are on-going each and every week.

STRENGTHS

Nutritional screening and assessment is being conducted on all new admissions by the physician assistants in the Psychiatric Sites.

Physicians actively ordering dietitian consults which average about 15 per month.

The dietitian has appropriately prioritized her attention and time toward the Greenlawn and Senior Rehabilitation Units which consists of 100 patients with intermediate level of care requirements.

AREAS FOR IMPROVEMENT

The dietitian has no clinical support from the dietetic technician because she is consumed in the supervision of dietary aides in the decentralized serving sites.

There are no proactive nutrition programs in place such as patient or nursing staff education.

The psychiatric patients are not benefiting from the dietitian's and dietetic technician's nutrition education and teaching expertise.

Although nutritional assessment is being conducted by the physician assistants, the AMHI dietitian does not have time to respond to their findings with positive nutritional intervention.

Patient adherence to modified diets and the staffs ability to deliver appropriate diets with the current decentralized food delivery system is questionable at best.

Only minimal clinical dietitian involvement exists in teaching, discharge planning, development of halfway house menu protocols, and drug-nutrient interaction.

Administrative programs are not being optimally performed.

The lack of administrative time has eroded the key relationship with nursing that is essential to communicating individual needs of patients.

LABOR PRODUCTIVITY

GENERAL OBSERVATIONS

The clinical component, consisting of the dietitian and dietetic technician, is severely understaffed to meet the nutritional needs of the patient population.

The current decentralized food service system lends itself to labor inefficiency due to duplication of effort, high employee waiting time, and the inability to supervise operations adequately.

The current decentralized system, by its very nature, builds in increased staff requirements.

Food and Nutrition employees are performing house keeping work and housekeeping employees are performing Food and Nutrition Department work.

FOOD SERVICE SYSTEMS AND EQUIPMENT

GENERAL OBSERVATIONS

The decentralized kitchens contain numerous individual single tank dishwashers that are very old and ineffective in cleaning and sanitizing. These machines will require replacement in the very near future at significant capital investment.

The decentralized serving warming units are old and not in optimum condition. To maintain food hot, the wells should be filled with water to provide moist heat. Unfortunately, the high heat and moisture content contribute further to patient discomfort in the dining rooms. The warming units do not have radiant strip heaters installed above the food to provide additional heat maintenance capability.

The decentralized kitchens are not well planned for labor efficiency or presentation of food. They are extremely inefficient.

Because of the building layout and number of kitchens, meal time supervision is not possible from responsible individuals in Food and Nutrition. If a problem occurs in more than one area, it is doubtful that it can adequately be corrected and addressed.

The central kitchen is large and spacious. Much of the equipment is too large for the intended use. It offers excellent space to support a

centralized tray make-up system. Floor surfaces were in good condition considering the age of the facility.

The patient dining rooms are outdated, unattractive, and generally not conducive to a positive patient atmosphere and high morale on the part of staff.

Ample refrigeration exists in the form of walk-in refrigerators.

PREFACE TO RECOMMENDATIONS

The recommendations that follow are intended to provide a basis for dialogue between AMHI administration, "user groups", and the Food and Nutrition Services that will provide clear direction for this department. It was very evident to the members of the consultant team that the present director, Mr. Daniel D. Spofford possess significant, accurate insight regarding the needs of the food and clinical program. He speaks with great care and concern for the patients of AMHI and his thoughts and recommendations, which are overall reasonable, appropriate and valid, require the support of the Department of Mental Health and Mental Retardation.

Although our visit was conducted over an intensive one day period, we feel that we have developed an accurate picture of the needs of the department. Our viewpoint has taken on a fairly global perspective. It will be up to the leadership of AMHI to accept, reject or modify our recommendations and build a detailed plan of action with complete costs, staffing, and service implications. This will provide the ownership of the plan that is vital to its' success.

In order for AMHI to take its' rightful place as a provider of quality care, "bold" action is required in the Food and Nutrition Services Department. This will require not only the expenditure of capital resources but the involvement of many individuals and groups to identify the strategic direction of the department. You can be assured that if the planning process is conducted adequately and the funds are spent appropriately, patients will benefit from improved food and clinical services and the State of Maine will be rewarded with a model food service program that is cost effective and meets all state and federal requirements.

RECOMMENDATIONS

A **STRATEGIC PLAN** should be developed by the Food and Nutrition Services Department. This plan should address Food and Nutrition Service requirements and cover, as a minimum, the following areas:

I. Departmental goals, operational parameters and a program plan that take into consideration:

A. Patient needs as determined by their psychological, medical, and nutritional status as well as their plan of care. Attention should be given to:

1. Patient mobility
2. Need for socialization
3. Security
4. Safety
5. Patient psychiatric status
6. Patient medical status
7. Patient nutritional status
8. Patient supervision capability
9. Modified and therapeutic diet requirements
10. Self care status, i.e., ability to feed

B. The impact of current and future state and federal regulations and standards required to maintain approval by the Joint Commission on Healthcare Organization.

C. Level of service required such as selective versus non selective menu.

D. The future needs of an aging population with increased medical requirements.

E. The styles, and mixes of styles of service appropriate for this population. That is to say:

1. Will meal tray service be a more appropriate mode of service versus decentralized cafeteria style service?

2. Is it possible that nursing units requiring cafeteria service can be consolidated together?

3. Could the current employee and patient vending area be relocated to allow for the installation of a higher ambience consolidated patient dining room?

F. The role of the "Clinical" component (dietitians and dietetic technicians). The expectations of these individuals should compliment their resource capability.

II. Resources necessary to accomplish the stated objectives and operational parameters.

As a consulting team with a heavy orientation and bias to operations, we have approached AMHI as if we had the authority and responsibility as managers to run the operation ourselves. We simply attempted to answer the question: "How would we responsibly run it?" Again, we recommend that serious consideration be given to the following recommendations for resource allocation:

A. The physical facilities require remodeling. It is felt that the best use of resources can be gained by:

1. Converting to centralized tray service utilizing a chilled food concept with rethermalization on the nursing units for patients that do not have the ability or freedom to move about the campus. The chilled food concept should be of a design that uses rapid chilling and holding of product for a maximum shelf life of 5 days. You are urged to keep the system as simple as possible. A sophisticated and costly chilled food system is not necessary due to your menu requirements, patient population and employee skill level. The rethermalization tray system should also be a basic system that will withstand abuse, deliver a quality product where hot foods are hot and cold foods are cold. Again, a sophisticated system with high cost is not necessary. There are several very good ones on the commercial market.

2. Consolidating, upgrading and relocating patient cafeterias to one facility in the present vending and canteen area. Many psychiatric health care facilities are increasingly emphasizing cafeteria style service. This would allow the patients to make their own food choice or be served according to their diet prescription.

B. A diet office management computer system that will control patient menus, ensure that modified diets are delivered as prescribed, and provide increased production systems and cost controls should be purchased. Currently, we are only aware of one system commercially available that is appropriate. The total cost of this system to include hardware and software does not exceed $12,000.00. It is relatively simple and the start up time is short.

C. The Food and Nutrition Department requires restructuring and reorganizing to provide increased clinical and supervisory capability. As a minimum, one additional Registered Dietitian and one more Registered Dietetic Technician are needed. Depending upon the mix of patients served by tray versus those served cafeteria style as well as the number of remote cafeterias, total staffing may be reduced from its current level. Of course, final staffing levels will be determined by the evolving policies and procedures of the institution, the physical resources and constraints and the ability of management to provide the leadership necessary to gain maximum labor efficiency and productivity. The more centralization of services designed into the program plan, the more resources that can be shifted into the clinical program without an increase in full time equivalents. It must be recognized that a "chilled food system" requires management in adequate numbers and knowledge to ensure a quality product. Hours can be shifted with the proper food service systems and facilities from staff to clinical and supervisory.

ServiceMASTER

The ServiceMaster Company

East Management Services
40 Accord Park Drive
Norwell, MA 02061
617/871-3150

August 10, 1989

Mr. William Thompson
Chief Executive Officer
Augusta Mental health Institute
Hospital Street
Box 724
Augusta, Maine 04330

Dear Mr. Thompson:

As you know, I recently spent several days at the August Mental Health Institute evaluating the Housekeeping Department. During this evaluation process I toured the facility, conducted a survey, and met with various members of the Housekeeping Department. The procedure and format I used was almost identical to our standard survey, with one or two exceptions.

The success of any survey depends largely on cooperation and the amount of information gathered during the survey. Thanks to the cooperation of Mr. Paul DePlanche and his staff, I was able to gather a fair amount of information in a relatively short period of time.

General Observations

The Housekeeping Department at the Augusta Mental Health Institute is doing a good job. The quality in all the areas of the facility I toured was good. Obviously, there were exceptions in some areas, but generally the level of cleanliness should meet all regulatory agency requirements.

The quality in several buildings, particularly the Greenlaw and Marquardt buildings, was outstanding. This is a credit to the people working in these areas, particularly the supervisor, Mr. Oneil Michaud.

The Housekeeping staff appears to be well trained, hard working, and highly motivated. I was impressed with the staffs' dedication, and their commitment to providing the patients, residents, and staff with a clean and safe environment.

Employee morale seemed to be good, although several people indicated it was rather low due to the negative publicity associated with AMHI in recent months. However, managements recent efforts relative to employee recognition is clearly beginning to pay dividends, i.e. recognition of length of service on name tags is an excellent idea.

Equipment

The Housekeeping Department is in dire need of "state-of-the-art" equipment. I was amazed at the results the department is achieving with so little and outdated equipment. During one tour, one of the Housekeeping Supervisors made a point of showing me two old floor machines, both still in service. He and the two machines have something uniquely in common - they have both been at AMHI for 31 years!

Not only is the equipment old, there is not enough of it. The staff is in the process of being augmented to provide weekend coverage. At least one supervisor indicated he did not have enough equipment to train these people with. Some of this equipment is as basic as mops and buckets.

Following is a list of modern equipment which would enhance the department's cleaning capabilities.

1. Buffers or floor machines with solution tanks mounted on the buffers.

2. Stainless steel buckets and equipment should be utilized whenever and wherever feasible.

3. The Housekeepers are currently using old shopping carts (donated by a local supermarket) to transport their cleaning products and supplies as they move from room to room. These should be replaced by carts designed specifically for cleaning in a health care facility.

4. The Department is responsible for cleaning 2200 pairs of drapes and curtains annually - in a bathtub. One or two portable drapery cleaning machines would increase productivity, and eliminate hours of tedious, repetitive work.

5. High speed buffers or burnishers are already in use at AMHI. However, due to the many corridors consideration should be given to battery power burnishers. This would increase productivity and eliminate a potential hazard, the electrical cord extending from the machine to the electrical outlet.

6. The Department could use more industrial type vacuums for cleaning large areas, picking up water, and floor stripping solutions.

7. Matting and carpet runners should also be bought for various entrances, especially during the winter months. Carpet runners are effective in reducing "tracking" during inclement weather, and reduce the probability of falls due to wet and slippery floors.

8. Modern wall cleaning equipment should also be purchased and put into use. The procedure now being used is time consuming, and can be difficult to work with in areas with extremely high ceilings.

Staffing

Even though I did not do an indepth analysis of the staffing, I believe there are enough people in the department to fulfill their present duties and responsibilities. I understand that the department is in the process of expanding its services to include weekend coverage. Due to the size and complexity of this hospital, this coverage should also be extended to evenings. This evening shift need not be extensive. One or two individuals carrying beepers could answer calls as needed. Routine office cleaning could also be transferred to evenings without the need for additional staff.

There seems to be a tendency at AMHI to assign additional responsibilities to the Housekeeping Department without considering how much time and staffing will be needed to accomplish these functions. Routine cleaning of the recently installed air conditioners is such an example. The obvious danger here is overloading. Once this point is reached, the staff is forced to decide what functions or duties will not be done today.

Recommendations

In order to accurately determine how many people are actually needed to clean the hospital standardized work rates should be developed. Once these rates are developed effective work schedules can then be written and implemented. Written work schedules are very effective in monitoring work assignments, avoid duplication of services, overlaps, and more importantly gaps in service.

Work schedules should be written and implemented throughout the hospital. A great deal of the information essential to operating this department is not documented, but communicated orally. If two or three key people decide to leave at the same time, this lack of documentation would become painfully apparent.

Although the hospital is clean, there appears to be no standardized cleaning procedures. Cleaning methods and procedures vary from area to area. Cleaning techniques and procedures are also communicated verbally. Formal written policies and procedures need to be developed for all cleaning procedures.

Housekeeping duties and responsibilities should be clearly defined and written. This would enable the director to manage his department more effectively. It would also let the user - patients and staff - know what they can expect from the Housekeeping Department.

In some areas, dining rooms and diet kitchens, cleaning responsibilities are shared with food service or the dietary department. This appears to be a source of confusion for the nursing staff because they are never quite sure who cleans what. I believe diet kitchens, dining rooms, and food distribution areas, other than the main kitchen, should all be cleaned by the Housekeeping Department.

Since I only spent several days at AMHI gathering the information for this report, I don't pertain to know everything there is to know about the Housekeeping Department. Undoubtedly, I have overlooked certain functions of the department which should have been addressed. However, I do feel fairly confident that I did acquire an understanding of the department during those few days. Therefore, I feel confident that this report has some merit.

Thank you for providing ServiceMaster this opportunity to serve you in a unique manner. We also appreciate the privilege you have afforded us to serve the Augusta Mental Health Institute, and the State of Maine.

Sincerely,

Michael T. Faucher

Michael T. Faucher
Area Manager