Riverview
PSYCHIATRIC CENTER

Report to the Court Master

Response to the Recommendations from the Report by

Elizabeth Jones, Consultant

January 22, 2015

Treatment Planning

Recommendation 1: Prior to his/her treatment team meeting, the class members should be provided the opportunity to meet with a peer specialist in order to prepare for the discussion and to clearly outline any preferences for treatment or discharge planning. Recovery-oriented approaches to treatment, including employment, should be consistently explored with and offered to class member, despite disinterest or refusal at the time of admission.

Response: It is standard procedure for any member of the treatment team, or any staff the patient feels comfortable with (including Peer Support staff who meet with patients on an ongoing basis) to meet with the patient prior to the treatment team meeting. The purpose of this discussion is to help the patient prepare for the meeting and organize their thoughts about their needs, treatment, and questions they may have for the meeting. Staff encourage patients to use the 'Your Input is Essential' form to help them prepare for their meeting and staff can assist patients in completing it.

The hospital agrees that employment is central to many people's sense of being and is an integral part of the Recovery framework at Riverview. Patient engagement in discussions about employment in treatment team meetings are based on the patient's stage in the Prochaska model of "Stages of Change." As patients move from the pre-contemplative to contemplate stages the staff will engage in treatment planning with the patient that is more concrete in nature about their willingness and ability to seek employment. The treatment team will then help the patient move to the preparation, action and maintenance phases of employment. These identified steps allows for a patient's successful progression of achievement in employment.

A Performance Improvement Team worked on a new policy regarding the "Levels System" in the hospital. The policy was approved in November, 2014 . The "Levels System" is intended to ensure that patients have access to all therapeutic activities in the hospital and in the community that are part of a patient's transition plan and that are consistent with their clinical and medical conditions. The patient works with the treatment team at every team meeting to determine the patient's level. A patient's freedom to engage in a variety of activities depends on his or her level which includes both employment opportunities in the hospital and as part of a transition plan back into the community. A grid that defines goals for the various levels is posted on each unit with the intent of helping patients identify and work toward key criteria/goals to advance and maintain their levels.

The entire treatment planning process at Riverview has been revised and updated based on feedback from our regulatory bodies. Dr. Kirby, Clinical Director, led an interdisciplinary team on creation of a new treatment plan and nursing leadership has developed a new nursing procedure that aligns with feedback from our regulators and is consistent with the treatment plan.

Attachment A: Nursing Procedure on Treatment Planning.

Status: In place, ongoing

Individual Responsible for Implementation: Director of Nursing

Quality Improvement Measure: Treatment Team Coordinators will document all patient engagement in preparation for Treatment Team meetings. The daily chart audit form used by Treatment Team Coordinators/Auditors will be updated by Medical Records to reflect which patients received pre-treatment team meeting engagement.

Budget Consideration: Funding for 4 Treatment Team Coordinator positions in the supplemental budget. The positions are currently staffed by unit personnel who have been temporarily reassigned to manage these tasks.

1/2/15 Addendum: The development of the current treatment plan was based on the regulatory guidance from the Center for Medicaid and Medicare Services and The Joint Commission. The implementation of the plan has been reviewed by the Maine Division of Licensing and Regulatory Services (DLRS) that found the plan compliant with regulations. The hospital's policy on Treatment Planning was updated in October 2014 (Attachment D). The hospital previously supplied the Court Master with the procedure for implementation of the treatment plan. We have attached the treatment planning documents used with all patients in the hospital (Attachment E).

Treatment is available to all patients, as outlined in their treatment plans. If a patient cannot engage in certain treatment activities safely, those activities are not available to the patient until he or she is safe to participate. In that case, the patient's treatment plan will include interventions to assist the patient in becoming safe to pursue additional treatment. Staff work with patients who are not safe to help them reach a point that will open up additional treatment activities for them. Availability of treatment does not depend on the unit on which the patient is staying.

Recommendation 2: Riverview's leadership should take immediate steps to ensure that the principles of the Recovery model are clearly defined, articulated and supported throughout each of the four units.

Response: We are incorporating the principles of the recovery model into the units with the structure of the treatment team meetings and treatment plans. Patients are invited and supported to participate in choosing their treatment, including treatment groups, leisure activities, and possible employment opportunities. This revision puts the patient in the driver's seat for their own recovery. Riverview has initiated staff trainings (mindfulness, non-violent communication, motivational interviewing and mental health first aid) to change the culture and shift it toward one that will incorporate recovery principles of health, home, purpose, and community. Even before Ms. Jones visit, the Department had identified serious deteriorations in all clinical systems at Riverview. Under new leadership, the hospital has worked to reestablish appropriate organizational and management structures. In particular, the hiring and placement of nurse managers on all units and the hiring of nurse educators now provide the infrastructure through which our vision of recovery can be provided and reinforced. All clinical leaders are participating in training on the use of recovery in patient engagement. The hospital also values patient engagement in higher level decision making by including patients as co-chairs on Performance Improvement Teams. We believe this addition of the patient voice on these teams not only helps the staff focus on patient needs, but also helps staff and patients focus on recovery as an integral part of treatment.

The Staff and Organizational Development Office provides an array of educational programs to assist staff in maintaining their skills in working with aggressive/violent patients. A basic principle on the MOAB program is identifying escalating behaviors and then using de-escalation techniques with patients prior to significant events. The training also covers how to safely manage patients who become aggressive or violent. MOAB is designed to help the patient return to a base line of non-violence so he or she can successfully engage in treatment. Educational programming is offered on Mental Health First Aid, Mindfulness, Non-Violent Communication, Motivational Interviewing, Working with Patients Who have a History of Sex Abuse and Trauma, Personal Medicine, and Recovery Model of Care. All of these sessions are aimed at providing staff the tools to help the patient on their road to recovery and re-engagement for a successful transition back into the community.

Leadership has included recovery messaging in its monthly newsletter, Recovery, is a focus of community meetings and client fora and a new document "RPRC and Recovery" was just published in November 2014 and sent to staff to keep them focused on the four principles of recovery at Riverview.

Inculcation of the Recovery Model into the culture of the hospital is led by a team of staff across disciplines in the hospital, including:

- Jay Harper, Superintendent
- Brendan Kirby, MD, Clinical Director
- Susan Bundy, Director of Staff and Organizational Development
- Elizabeth Houghton-Faryna, Director of Psychology Internship Program
- Madeline Orange, Nurse Educator
- Chris Monahan, Recovery Training Specialist

Attachment B: RPC and Recovery

Status: In place, ongoing

Individual Responsible for Implementation: Superintendent

Quality Improvement Measure: 100% of patient records will include documentation of the patient's input into their individualized treatment plan and that the input was used during the Treatment Team meeting.

Budget Consideration: Unit staff increases requested in the supplemental budget, includes:

3 Nurse I positions
3 Nurse II positions
2 Nurse III positions
4 MHW I positions
16 Acuity Specialist positions
4 Psychiatrist positions
2 Occupational Therapist positions.

Training budget increase of $60,000 submitted

Recommendation 3: Riverview's clinical leadership should work with nursing and Mental Health Worker staff to design and implement case conferences or Grand Rounds so that there is greater knowledge, skills and support in working with class members with challenging behaviors

Response: The Clinical Director and Director of Psychology identify high risk cases that are reviewed in a number of fora. Medical staff present cases for review at Peer Review Committee. On a broader basis, cases are discussed at weekly Clinical Case Conference (Grand Rounds). More intricate cases are presented to Dartmouth faculty during professorial visits or with a number of faculty members through audio-visual conferencing. Training front-line staff in working with patients who exhibit challenging behaviors is essential to the patient's recovery and an emphasis is placed on ensuring front-line staff attendance at these presentations by providing coverage on the unit so they can attend. The case conferences are taped so that they can be viewed at a later time on the units or in the training room. There is a monthly meeting on each unit led by the Clinical Director, Director of Nursing and Director of Psychology designed to solicit staff concerns on patient care and other issues. These meetings take the latest clinical thinking about patients on a unit and provide it directly to the front-line staff. These sessions are held during the time when 1st and 2nd shift staff can attend. The Charge Nurse then provides the information to the 3rd shift staff.

Status: In place, ongoing

Individual Responsible for Implementation: Clinical Director

Quality Improvement Measure: The list of case conferences and Grand Rounds will be maintained. The roster of staff participation will be maintained by the Staff and Organizational Development Office. These data will be reported in the Quarterly Report.

Budget Consideration: See Recommendation # 2 budget consideration.

1/2/15 Addendum (rev. 1/22): The hospital believes the case conferences and other training activities described above, including consultation with Dartmouth faculty (who provide links to other experts as necessary) are currently providing the appropriate level of knowledge, skills and support for staff in working with patients who exhibit challenging behaviors. However, these strategies are not intended to be exhaustive, and if different training activities or consultation is necessary, the hospital will take the necessary steps to make that happen.

Recommendation 4: Efforts should be initiated to intensify the opportunities offered to class members on the Forensic Units in order to increase their social skills and their knowledge and performance competencies about subjects of interest to them.

Response: Lower Saco was merged back with the hospital on October 24, 2014. Provided that patients have a level to leave the unit, Lower Saco patients now have access to full hospital services. There is currently a schedule of available groups on Lower Saco which includes groups that promote social skills and interpersonal relationships, in addition to groups at the treatment mall. Discussion with patients about social skills and their interests is incorporated into treatment team meetings and safety meetings. Individual therapy is also available to patients that could benefit from 1:1 therapy with a psychologist. Staff is available to work with patients in group and individual settings to explore patients' individual interests and incorporate those into their treatment plans. Clarification of the role of personal responsibility as an aspect of recovery will be a focus of a person's recovery where appropriate.

Attachment C: Harbor Mall Winter Program Description

Status: In place, ongoing.

Individual Responsible for Implementation: Director of Psychology

Quality Improvement Measure: Patient Individualized Treatment Plans will contain documentation of participation in all treatment activities. Treatment Team Coordinators will conduct daily chart audits to ensure documentation.

Budget Consideration: Funding for 4 Treatment Team Coordinator positions requested.

1/2/15 Addendum: Active treatment occurs on Lower Saco Unit as well as in the Treatment Mall. Group and individualized treatment is provided to patients in both the Lower Saco Main and Lower Saco SCU (Attachment F). Treatment disciplines that provide group or individual treatment include: Nurses, Mental Health Workers, Psychologists, Treatment Recovery Specialists, Rehabilitation Services, and the Chaplain.

Recommendation 5: Riverview should be managed as a single Hospital and the exclusion of Lower Saco from the federal Medicaid program should be reconsidered as an urgent priority.

Response: Lower Saco was merged back with the hospital on October 24, 2014. Provided that patients have a level to leave the unit, Lower Saco patients now have access to full hospital services, including treatment mall groups, café, gym, and other activities held within the common areas of the hospital.

Status: Completed

Individual Responsible for Implementation: Superintendent

Quality Improvement Measure: Completed

Budget Consideration: Staffing requests noted above.

Recommendation 6: In order to ensure that any limitations are not in violation of the Consent Decree, restrictive practices, including access to outdoor areas, should be reviewed with involvement by class members and mental health workers.

Response: As noted above, Lower Saco patients now have access to all outdoor activities approved by the hospital. A specialized limited access to hospital grounds was available through a Lower Saco policy prior to the re-merging of the hospital. Cancellation of activities should always be the exception rather than the rule on any unit in the hospital. During the community meetings held on each unit, staff will review the availability of all activities. Any cancellation should be specific to a patient based on his/her ability to safely participate. The cancellation and the reason will be noted in the patient's record.

Status: Completed

Individual Responsible for Implementation: Superintendent

Quality Improvement Measure: Unit activity logs will be reviewed on a monthly basis to determine whether any limitations in a patient's access to treatment or services occurred. Unit community meetings will include a standing agenda item to review whether any restrictive practices were in place.

1/2/15 Addendum: The patients on Lower Saco receive treatment on their unit (see Attachment F) and have access to the Treatment Mall, café and gymnasium. (Attachment C). Patients on the Lower Saco SCU have access to treatment on their unit (Attachment F). Patients in the SCUs do not have access to additional treatment at the Treatment Mall until it is safe for them to leave the unit. The levels system of the hospital was revised based on guidance from patients and meets the requirements of Paragraph 159 of the Settlement Agreement and Part B, Section III(H) of the Rights of Recipients of Mental Health Services. Consistent with the recommendation of Elizabeth Jones, the development of the levels systems was actually co-led by a patient. It is not only patient focused but also patient developed.

Staff are trained on the Rights of Recipients at orientation. Patients on the two special care units maintain their rights including access to visitors, telephone, mail, exercise, outdoor activities, and exercise of religion.

Seclusion and Restraint

Recommendation 7: The use of seclusion and restraint requires continued independent review to ensure that there are adequate alternatives designed and implemented for any class member potentially subject to such restrictive measures. Specifically, class members with a history of unacceptable behavior, such as aggression towards peers and/or staff, need to be reviewed again by the treatment team, and, if necessary, by an independent clinical consultant, to determine whether sufficiently individualized interventions are being designed and consistently implemented to replace unacceptable behavior with appropriate alternative behaviors.

Response: As a response to increased forensic admissions and increase in patient and staff assaults, the hospital switched to the *Management of Aggressive Behavior* (MOAB) technique in 2014. Hospital leadership reviewed a variety of behavioral techniques available for use in psychiatric facilities and determined that MOAB was the best available product. MOAB is used in psychiatric centers throughout the country and has been accepted by State Licensure, CMS, and The Joint Commission as an accepted practice at RPC. MOAB training presents principles, techniques and skills for recognizing, reducing and managing aggressive behaviors. The program also provides humane and compassionate methods of helping patients with behavioral issues.

As of January 1, 2014 hospital leadership daily reviews all incidents that involve assault to ensure compliance with hospital policy and procedure. If needed, the Risk Manager conducts a Fact Finding, Investigation or Root Cause Analysis to help leadership and staff understand what happened during an event and to recommend changes, if needed.

As soon as possible after an event staff meet with the patient to review the existing treatment plan and make changes as necessary to ensure patient safety. This ensures that the patient's treatment needs are being addressed contemporaneously to any aggressive events that they perpetuated or were involved in. The hospital is aligning the staff and patient post-event debriefing forms to better evaluate the circumstances of patient events.

The hospital clinical staff presents case conferences on the most challenging patients. Psychiatrists and psychologists review cases and present their findings to a cross-disciplinary team with two purposes: 1) engender discussion about the treatment of the specific patient and 2) use collective learning to identify

opportunities for therapeutically engaging other challenging patients in the hospital.

Dartmouth School of Medicine faculty continues to provide an independent review panel on cases brought to them. These cases present because of the complexity of care or because of a patient's history of behavioral issues. These independent reviews provide clinical staff with state-of-the-art clinical insight.

Status: In place, ongoing

Individual Responsible for Implementation: Director of Nursing

Quality Improvement Measure: The Risk Manager reviews 100% of cases of seclusion and restraint events including the content and timeliness of events. The hospital sends weekly reports of seclusion and restraint events to the Court Master. The Staff and Organizational Development Office will conduct its first annual review of the MOAB program and present results to Executive Leadership in January 2015.

Budget Consideration: In addition to staff increases detailed earlier, the hospital is requesting funding for the Director of Integrated Quality and Informatics position be full time at Riverview; currently the position is funded by Dorothea Dix and is shared between the two hospitals. Also funding is requested for a Performance Improvement Manager and an Investigator to work in Integrated Quality and Informatics.

Recommendation 8: The reporting requirements by Paragraphs 188 and 189 of the Consent Decree should be completed as mandated.

Paragraph 188

Response: The Staff and Organizational Development Office at Riverview oversee all training for employees. In the fall of 2013, a determination was made to change from NAPPI to MOAB as a behavioral management tool for front line staff. MOAB is used by behavioral health organizations on a national basis. Trainers from across disciplines were trained in the fall of 2013 to train unit staff and all new employees. This has been the primary behavior management tool used by the hospital since February 2014. In January 2015, an annual review of the MOAB program will occur.

The hospital's endeavor to create a safe and secure environment for everyone is being operationalized through increased emphasis on skill development for line staff. Additional training funds have been allocated for this purpose.

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Dartmouth School of Medicine faculty continues to provide an independent review panel on cases brought to them. These cases present because of the complexity of care or because of a patient's history of behavioral issues. These independent reviews provide clinical staff with state-of-the-art clinical insight.

On October 17, 2014, the hospital engaged the services of the Director of Mental Health Services and Director of Quality Improvement from Maine General Medical Center (MGMC) to participate with the department's hospital survey team to conduct an audit of seclusion and restraint services at Riverview. The staff from MGMC made findings that were consistent with the hospital's survey team in terms of strengths and weaknesses. MGMC also uses the MOAB technique in their Behavioral Health Unit. In 2015, Riverview will engage the MGMC team to conduct reviews with the hospital survey team on seclusion/restraint.

Status: In place, Ongoing

Individual Responsible for Implementation: Staff and Organizational Development Director

Quality Improvement Measure: On an annual basis (starting in January 2015), the Staff and Organizational Development Office will present a report to Executive Leadership at the hospital on the Behavioral Management system being used. The report will include (but is not limited to) information on:

- Documentation on certification and external reviews of behavioral management system
- Number of staff trained
- Number of staff retrained
- Results of inter-rater reliability tests for trainers
- Number of staff injuries

- Number of patient injuries
- Number of incident reports showing that staff varied from techniques
- Review of fact-findings or investigations where behavioral management system failed to achieve goals
- Findings from external reviews of the MOAB program

Paragraph 189

Response: Starting on September 1, 2014, the hospital has sent the Court Master a weekly document on seclusion and restraint events. The hospital did receive an email from the Court Master on November 12, 2014 stating that the current reporting fulfills the requirements of paragraph 189 in the Consent Decree. If additional reporting is requested by the Court Master, the hospital will comply.

Hospital leadership reviews all incident reports on a daily basis and the Risk Manager enters the information into a spreadsheet. A determination is made after daily review if a Fact Finding, Investigation or Root Cause Analysis should be conducted. All hospital data related to seclusion and restraint are entered into Meditech and are submitted to National Research Institute monthly for quarterly distribution to CMS, The Joint Commission and the hospital.

If a patient has a series of events within a two week period, the Risk Manager prepares and sends to the Clinical Director a report of incidents with a request for a clinical review. The Clinical Director reviews the documentation and makes a determination about further review frequently consulting with attending providers as part of the clinical review. The development of a state of the art educational ethos backed by our university affiliations has developed markedly through 2014 and continues to expand. The separation between our patients' most challenging behaviors and in-depth discussion, backed by appropriate faculty expert opinion, has lessened considerably. Staff increasingly understand a need to engage in discussion with and about our patients to provide the best available care.

Status: In place, ongoing.

Individual Responsible for Implementation: Director of Integrated Quality and Informatics

Quality Improvement Measure: The Risk Manager reviews 100% of all incident reports for seclusion and restraint daily to determine whether further actions are required. A summary report of 100% of all seclusion and restraint events are sent to the Court Master weekly.

Budget Consideration: Request for funding for the Director of Integrated Quality and Informatics, Performance Improvement Manager, Investigator and an Office Assistant positions.

1/2/15 Addendum (rev.1/22): The hospital follows Life Safety standards as required by The Joint Commission and CMS to inspect all equipment annually to ensure that it is in good working order with no defective parts. All equipment used in seclusion and restraint will be added to the list for annual inspections by the Support Services staff at the hospital. The hospital will use a consultant to review seclusion and restraint programs and techniques at the hospital for patient safety and compliance with regulatory and Consent Decree requirements.

Counsel for the plaintiffs will receive the same paragraph 189 reports as submitted to the Court Master.

Adequacy of Staffing

Recommendation 9: In light of the current demographics of admissions to Riverview, the adequacy of staffing requires further independent review. It is highly recommended that staffing ratios be determined by acuity rather than by census on the units.

Response: Riverview is not unique in the world of inpatient psychiatric facilities in trying to best match patient acuity and needs with the right mix of staff. In the spring of 2014, the hospital tested a proposed scale for assessing patient acuity to determine appropriate staffing. An article in the *Journal of Psychiatric and Mental Health Nursing* pointed to the problems encountered at Riverview. Staffing by acuity in mental health facilities is problematic because the scales are not reliable or predictable in accounting for the arrival of new patients and/or the level of acuity of patients at any point in time.

An article in the *New England Journal of Medicine*, "The Four Habits of High Value Health Care Organizations," identifies the challenges of health care systems developing scales that are valid and reliable across individualized treatment pathways. Intermountain Healthcare in Utah and Idaho is developing a scoring system for psychiatric patients that will inform the ongoing work at Riverview in developing and testing scales that can be used for treatment planning and staffing. The growing body of research across the healthcare field in development of standard approaches to uncommon and complex conditions will inform the work at Riverview in its quest to optimize staffing placement with the acuity of the patients.

In the first quarter of 2015, the hospital will develop a scoring model based on the Intermountain Healthcare Model and will test it on one unit of the hospital. Clinical and administrative staff will monitor and revise the model until it successfully addresses the clinical needs of the unit. After successful implementation of the model, it will be expanded unit by unit until all units have successfully implemented and maintained the system with full implementation anticipated no later than December 2015.

The hospital has instituted a program of hiring, training and deploying Acuity Specialists on the two acute units. The work of the Acuity Specialists focuses on identifying patients with acute presentation and deploying the appropriate level of staff resources to assist with their care. The Acuity Specialists have been successful in helping to defuse volatile situations. The hospital has requested 16 additional Acuity Specialist to use across all four units. Four of these positions are requested in FY15 supplemental budget and 12 are requested in the FY16 budget.

It should be noted that the hospital has consistently met or exceeded the minimum level of staffing required by census model in the Consent Decree.

Status: In place, ongoing

Individual Responsible for Implementation: Director of Nursing

Quality Improvement Measure: The hospital will continue to monitor the staffing ratio as defined in the Consent Decree. In addition, the Integrated Quality team will work with Clinical Leadership to establish measurements to test the reliability and validity of data used with acuity based models to ensure that, in addition to meeting the Consent Decree's minimum staffing ratios, staffing is sufficient to carry out Consent Decree requirements. .

1/2/15 Addendum: The hospital has not fully implemented acuity based staffing at this time. As detailed above, the hospital will test models to determine what will work at Riverview with full implementation by December 2015. This iterative process recognizes the request for additional staffing proposed in the Governor's budget is dependent on legislative action. As there as many moving parts of this change in staffing the hospital cannot further define specific actions and timeframes until the Legislature acts on budget requests.

Recommendation 10: The use of "float" staff, especially those recently hired at Riverview, requires review in order to reduce the likelihood of risk due to unfamiliarity with and knowledge of the individuals with challenging behaviors or the need for specialized interventions. This review is especially critical for any assignment to the Forensic Units.

Response: The Director of Nursing is currently reviewing staffing models to be used in the hospital. In 2015, the hospital will move to a unit-based staffing model to enhance the continuity of care for all patients. To make the staffing model effective the hospital has initiated:

- Restructured orientation for unit staff
- Mentoring of new staff by experienced personnel
- Regular monitoring of new staff by the nursing education staff
- Development of a skills based competency model before staff are assigned to acute units

The new staffing model timeline will align with the acuity based staffing model defined in Recommendation 9. These processes will need to work in a synchronized

fashion to be most successful with a unit by unit roll-out and full implementation by December 2015.

Status: In development

Individual Responsible for Implementation: Director of Nursing

Quality Improvement Measure: 100% of new staff on acute units will have received and passed competency based skills training before being assigned.

Budget Consideration: In addition to the positions enumerated above, the hospital is requesting a "mentoring stipend" so that senior nurses can be reimbursed to train new nurses on the units. This will increase the skill set for new staff.

Recommendation 11: There should be consideration of supplemental pay for staff assigned to the Lower Saco unit.

Response: The hospital already has a supplemental pay system in place for staff who have forensic training and work on either Lower Saco or Lower Kennebec. The supplemental pay is $1 per hour when trained staff work on either of those units.

Reduced training budgets at Riverview over the past several years have severely limited the hospital's ability to provide ongoing staff training. In the spring of 2015, the forensic training will be reinstituted for front line staff. Those who successfully complete the training, and are working on either Lower Kennebec or Lower Saco will be eligible for the supplemental pay.

Status: In place, ongoing

Individual Responsible for Implementation: Human Resources Manager

Quality Improvement Measure: The Human Resource office reviews its payroll records to ensure that staff who are eligible for the supplemental pay are receiving it according to Human Resource guidance.

Budget Consideration: The hospital has requested an increase in the training budget.

1/2/15 Addendum (rev. 1/22): All hospital staff are eligible to participate in this training program.

Recommendation 12: Discussions should be held with Mental Health Workers and nursing staff to determine what additional measures are required to reduce the pressures experienced by staff and the resulting effects on the class members hospitalized for treatment.

Response: The hospital, in coordination with DHHS Human Resources, conducts an annual survey of staff to review factors that influence their ability to excel in the workplace. The hospital and Human Resources have developed a revised survey that focuses on specific issues such as communications, accountability, safety, reporting, and dignity and respect. The survey has been distributed within the past 30 days and the DHHS Office of Quality Improvement will collect and analyze the data and then it will be reported to leadership at Riverview. Leadership will work with DHHS Human Resources on issues revealed in the survey.

In November 2014, the hospital filled all Nurse IV positions so there is leadership on each unit. This relieved the Director of Nursing and Assistant Director of Nursing from providing direct coverage of units so they could focus on nursing leadership and training issues. The two nurse educator positions were filled in the summer of 2014 which provides unit based training for staff. This combination of nursing leadership and education staffing provides all front-line staff with access to unit based leadership and unit based training.

The Superintendent meets with staff at Town Hall sessions where staff are able to bring forth issues. In addition, starting in July 2014, the Clinical Director, Director of Psychology and Director of Nursing have been meeting with patients and staff on each unit monthly. These meetings are providing patients an opportunity to be in dialog with hospital clinical leadership about their needs.

Status: In place, ongoing

Individual Responsible for Implementation: Superintendent

Quality Improvement Measure: Action steps will be developed based on the results of the DHHS Human Resources survey. The results of the survey and subsequent action steps will be reported to the Quality Improvement Committee and distributed to staff and included in the Quarterly Report.

1/2/15 Addendum: The request of the plaintiff's counsel regarding obtaining consultation on creation of trauma treatment for staff and patients is outside the scope of the Settlement Agreement. Nonetheless, the hospital notes that is has

expanded training and support of staff through current budget initiatives and will continue to be open to additional training needs for staff.

Recommendation 13: Qualification for Mental Health Workers should not be reduced.

Response: The hospital agrees with this recommendation. The hospital has upgraded the requirements for the Mental Health Workers to require a MHRT (Mental Health Rehabilitation Technician) certification. Over the past year, the hospital has had the position requirements increased to allow for candidates with higher education and is moving to a staffing model which will require a minimum of a bachelor's degree specifically targeted toward human services.

The relevant skills required for the Certified Nurse Assistant (CNA) position at Riverview consists primarily of taking vital signs and on an as needed basis assisting with ADLs (activities of daily living). These skills can easily be taught at the hospital and the MHRT skills are more applicable to the needs of the patients at RPC.

Status: In place, ongoing

Individual Responsible for Implementation: Superintendent

Quality Improvement Measure: 100% of Mental Health workers meet and maintain the competencies required for their positions.

Reporting of Abuse, Neglect and Exploitation

Recommendation 14: Continuing effort is required to ensure that all staff understand the mandate for reporting any suspected abuse, neglect, or exploitation of class members.

Response: In February 2014, the Acting Risk Manager identified an alleged case of patient abuse that was not reported to Adult Protective Services and had not been investigated at the hospital. Upon discovery, the hospital notified Adult Protective Services and started an internal investigation. The Division of Licensing and Regulatory Services conducted an independent investigation of the incident. The Human Resources Office of DHHS conducted an independent review of personnel actions of the event. The Maine Board of Nursing conducted an investigation of the actions of nurses involved in the incident. A common question raised in all the investigations focused on the responsibility of reporting all incidents of abuse and neglect at the hospital.

On April 22, 2014 the Superintendent notified all hospital staff via email that:

> "every employee is charged with the responsibility to report abuse. Many times it is not clear whether what you may have witnessed is abuse or not. If you believe that it is, report it. We would rather be over reporting than under reporting. Every report yields an opportunity for improvement no matter whether found substantial or not. Please review the attached policy (PC.3.10.2 Allegations of client Mistreatment Including Abuse, Neglect, Exploitation."

The importance of this obligation is being stressed in all new employee orientation. Hospital leadership, including nurse managers for each unit, reviews all incident reports daily. The Risk Manager follows through with Adult Protective Services to ensure that all reporting has been completed. Since the email on required reporting in April 2014, the hospital has had a 21% increase in average monthly reporting on all incidents on the units. Either unit staff or the Risk Manager have reported all required events to Adult Protective Services since April 2014.

In July 2014, the Commissioner asked the hospital to conduct an audit of all incidents from March 2013 through March 2014 which was the time when correctional personnel were in the hospital. A review of approximately 2,600 incident reports was conducted by the Safety Officer at the hospital. The review covered all units at the hospital not just the Lower Saco Unit where correctional officers were stationed. The first step of the review focused on finding every

occasion in which pepper spray, Taser, or handcuffs were deployed or were un-holstered but not deployed in the hospital. The second step in the review was to determine whether external reporting had been endorsed on the Incident Report and whether an internal investigation had been conducted. Forty-four events were ultimately discovered; six of the incident forms indicated the event had been reported to Adult Protective Services. There were 29 handcuff events (handcuffs used in all 29 events), 6 pepper spray events (pepper spray used in 4 out of 6 events), and 9 Taser events (Taser used in 5 out of 9 events).

All of the 44 events have now been reported to Adult Protective Services as well as DHHS Human Resources. Adult Protective Services is currently conducting an audit and has found a discrepancy between what was reported on the Incident Report forms and their records; there are cases that had been reported to them at the time of the incident but that were not indicated on the Incident Report form. The hospital is waiting for a final report from Adult Protective Services and will share with the Court Master once it is received. The Human Resources office is conducting a review of personnel policies and has identified policies that state that reports of actions by Corrections Officers would be handled completely separately through their chain of command. After their policy review, the Human Resources office will determine whether hospital personnel actions will follow. Hospital management has made clear to all personnel that these policy statements were inadequate to satisfy the hospital's obligations under the Settlement Agreement to report abuse, neglect or exploitation of patients, and these policies are no longer in effect.

The hospital acknowledges the seriousness of the failure to report these 44 incidents. As noted above, management has communicated clearly to all staff the importance of the obligation to report all incident that involve actions of potential abuse, neglect or exploitation of patients, regardless of whether these actions were taken by patients, staff, contractors or law enforcement. The corrective and remedial measures that the hospital has already undertaken, as described herein, should prevent a recurrence of the failure to report.

By January 1, 2015, the hospital will implement a departmental on-line reporting system for reporting all allegations of abuse, neglect and exploitation to Adult Protective Services. This system provides an email verification form that will be distributed to the Court Master, Patient Advocate, and Superintendent.

Status: In place, ongoing.

Individual Responsible for Implementation: Risk Manager

Quality Improvement Measure: 100% of incidents of abuse, neglect or exploitation are reported to Adult Protective Services. This will be monitored by a monthly review of incident reports. On a bi-monthly basis, the hospital's survey team (comprised of quality improvement staff from both Riverview and Dorothea Dix) will conduct an audit of the patient records for seclusion/restraint events to ensure that all events have been reported.

1/2/15 Addendum: The hospital is in compliance with both the Consent Decree and the contract with Disability Rights Center on required reporting of incidents. The hospital has implemented an online reporting system and is providing required verification to both the Court Master and the Patient Advocates in compliance with paragraph 192. The reporting process is as follows:

1) Any staff member who identifies an incident as potential abuse, neglect or exploitation completes an Incident Reporting form.
2) The staff member notifies, via telephone, the family, guardian, Administrator on Call, Superintendent and Patient Advocate.
3) The staff member next completes the on-line notification to Adult Protective Services (APS).
4) APS immediately sends a verification email to the Risk Manager, which includes all of the information submitted.
5) The staff member has the unit Nurse Manager review the Incident Report before it is submitted to the Nurse On Duty (NOD). The NOD compiles the Incident Reports and provides them to the Risk Manager for review the following morning (M-F).
6) The Risk Manager downloads the verification reports from APS and matches them to Incident Reports. All Incident Reports and verification reports are reviewed at the daily 7:45 Administrative Meeting.
7) The Risk Manager ensures that the APS verification reports are forwarded to the Court Master and to the Patient Advocates as soon as possible that morning.

<u>Recommendation 15:</u> With consultation from class members and staff on the units, there should an examination of the weaknesses and vulnerabilities that could lead to abuse, neglect and exploitation at Riverview.

Response: First, for each incident, supervisory staff conduct two debriefings: one with the patient and one with staff who were present. In each of these sessions, the question is asked how things could have gone better which gets at the root

concepts of weakness and vulnerability. The staff and patient debriefing forms are being revised to ensure that all relevant questions are asked at both debriefing sessions. The hospital regularly collects, analyzes, and reports the data on all alleged incidents of abuse, neglect and exploitation.

Second, there is a weekly community meeting on each unit where staff and patients come together to address issues. Leadership has directed that a standing agenda item be added to address the issue of safety on the unit. Again, this query will address potential abuse, neglect and exploitation issues. Patient fora are held on a monthly basis and provide an opportunity for patients to meet directly with the superintendent to discuss issues; a standing agenda item will be about feelings of safety.

Third, the Department conducts a staff survey to query personnel about a variety of issues including feelings of safety in the hospital. The surveys are managed by the DHHS Office of Quality Improvement with the results reported to leadership at the hospital. DHHS Human Resources and Staff Development plan to conduct staff focus groups on each of the units after the completion of the current survey. Questions about patient and staff safety will be included in the focus groups.

Fourth, at the time of discharge all patients are asked to participate in a national hospital survey about satisfaction and quality of care. These results are reported in the Quarterly Report. Peer Support Services work with patients to complete the survey. The participation rate has been low over the past several years. The hospital will work with Peer Support Services to increase the participation rate in the survey.

Status: In place, ongoing

Individual Responsible for Implementation: Director of Integrated Quality and Informatics

Quality Improvement Measure: A content analysis will be conducted on all debriefing forms to determine themes and patterns. The results from this analysis will be shared with leadership and included in the Quarterly Report. Results of staff surveys will be included in the Quarterly Report. The results of the patient discharge survey will continue to be included in the Quarterly Report.

1/2/15 Addendum: After an event, the staff meets with the patient within 72 hours. Timeliness of the meeting is part of the quality improvement review. As part of the

meeting, the debriefing information is used as part of the discussion to inform any changes to the patient's treatment plan (per CMS and TJC requirements).

Recommendation 16: The Consent Decree language should be modified to specify that timely reporting of abuse and neglect cases should be made to Adult Protective Services (APS), Licensing, the Court Master and Plaintiffs' Counsel.

Response: The Department believes it has described in significant detail for the Court Master its corrective actions related to improved reporting, including timely reporting of abuse and neglect. The Department understands that one intended outcome of the Settlement Agreement is to develop systems that will outlive the Consent Decree. The Department believes that, with the Court Master monitoring the staying power of the corrective actions and quality improvement processes in place, modification of the Settlement Agreement is unnecessary.

Status: In place, ongoing

Individual Responsible for Implementation: Risk Manager

Quality Improvement Measure: 100% of alleged cases of abuse, neglect or exploitation are reviewed and reported as required by statute, rule, and Consent Decree. The Court Master and Patient Advocate will receive copies of the validation form received after submitting reports to Adult Protective Services. A monthly summary report of all allegations of abuse, neglect and exploration is prepared for the hospital's Human Rights Committee. Substantiated claims of abuse, neglect or exploitation are noted in the hospital's quarterly report.